



Province of Alberta

INSURANCE ACT

DIAGNOSTIC AND TREATMENT PROTOCOLS REGULATION

Alberta Regulation 116/2014

Extract

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ALBERTA REGULATION 116/2014

Insurance Act

**DIAGNOSTIC AND TREATMENT
PROTOCOLS REGULATION**

Table of Contents

1 Definitions

Part 1

Application and Operation

- 2 Application of this Regulation
- 3 Authorization for additional services or supplies
- 4 Interpretative bulletins and information circulars
- 5 Prescribed fees

Part 2

Diagnosis and Treatment Protocols

Division 1

Diagnosis and Treatment Protocol for Strains and Sprains

- 6 Protocols established
- 7 Developing the diagnosis for strains or sprains
- 8 Treatment protocols for strains and sprains
- 9 Diagnostic and treatment authorization for strains and sprains

Division 2

**Diagnostic and Treatment Protocol for WAD Injuries —
Cervical, Thoracic, Lumbar and Lumbosacral**

- 10 Protocols established
- 11 Developing the diagnosis for WAD injuries
- 12 Diagnostic criteria: WAD I and WAD II injuries
- 13 Treatment protocols: WAD I and WAD II injuries
- 14 Diagnostic and treatment authorization

Division 3

Treatment Limits and Referrals

- 15 Aggregate limits on visits
- 16 Referral to injury management consultant

Part 3 Injury Management Consultants Register

- 17 Register established
- 18 Eligibility requirements
- 19 Ceasing to be an injury management consultant

Part 4 Claims and Payment of Claims

- 20 Definitions
- 21 Priority of this Part
- 22 Claims
- 23 Decision by insurer
- 24 Failure of insurer to respond
- 25 Subsequent denial of liability
- 26 Making and paying claims
- 27 Sending notices
- 28 Multiple claims

Part 5 Review and Repeal

- 29 Review
- 30 Repeal
- 31 Coming into force

Definitions

1(1) In this Regulation,

- (a) “chiropractor” means a person who is a regulated member of the Alberta College and Association of Chiropractors under the *Health Professions Act*;
- (b) “evidence-informed practice” means the conscientious, explicit and judicious use of current best practice in making decisions about the care of a patient, integrating individual clinical expertise with the best available external clinical evidence from systematic research;
- (c) “health care practitioner” means
 - (i) a chiropractor,
 - (ii) a physical therapist, or
 - (iii) a physician;
- (d) “history”, in respect of a patient’s injury, means

- (i) how the injury occurred,
 - (ii) the current symptoms the patient is experiencing,
 - (iii) the patient's relevant past history, including physical, psychological, emotional, cognitive and social history, and
 - (iv) how the patient's physical functions have been affected by the injury;
- (e) "IMC register" means the register of injury management consultants established under section 17;
- (f) "injury management consultant" means a health care practitioner who is entered on the IMC register in accordance with Part 3;
- (g) "insurer" has the same meaning as it has in the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (h) "International Classification of Diseases" means the most recent edition of the publication titled the *International Statistical Classification of Diseases and Related Health Problems*, Canada, published by the Canadian Institute of Health Information, based on a publication issued from time to time titled the *International Statistical Classification of Diseases and Related Health Problems*, published by the World Health Organization;
- (i) "patient" means an insured person as defined in the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (j) "physical therapist" means a person who is a regulated member of the College of Physical Therapists of Alberta under the *Health Professions Act*;
- (k) "physician" means a person who is a regulated member of the College of Physicians and Surgeons of Alberta under the *Health Professions Act*;
- (l) "prescribed claim form" means the form established by the Minister under section 803 of the *Insurance Act*;
- (m) "protocols" means the diagnostic and treatment protocols established by this Regulation;
- (n) "spine" means the column of bone known as the vertebral column that surrounds and protects the spinal cord;

- (o) “sprain” means an injury to one or more of the tendons or ligaments, or to both;
- (p) “strain” means an injury to one or more muscles;
- (q) “Superintendent” means the Superintendent of Insurance appointed under the *Insurance Act*;
- (r) “WAD injury” means a whiplash associated disorder other than one that exhibits one or both of the following:
 - (i) objective, demonstrable, definable and clinically relevant neurological signs;
 - (ii) a fracture to or a dislocation of the spine.

(2) For the purpose of section 573 of the Act, “assessment” includes diagnosis.

Part 1

Application and Operation

Application of this Regulation

2(1) This Regulation applies only in cases where

- (a) a patient wishes to be diagnosed and treated in accordance with the protocols for a sprain, strain or WAD injury caused by an accident arising from the use or operation of an automobile, and
- (b) a health care practitioner chooses to diagnose and treat the patient’s sprain, strain or WAD injury in accordance with the protocols.

(2) This Regulation, except section 16(5) and Part 4, ceases to apply in respect of an injury

- (a) 90 days after the date of the accident, or
- (b) when the aggregate number of visits authorized by this Regulation has been reached,

whichever occurs first.

Authorization for additional services or supplies

3 Nothing in this Regulation prevents or limits a patient or a health care practitioner from applying to an insurer for an authorization for a service or supply in addition to the limits specified by this Regulation, and the insurer may, in accordance

with the *Automobile Accident Insurance Benefits Regulations* (AR 352/72), approve the additional service or supply.

Interpretative bulletins and information circulars

- 4** The Superintendent may issue interpretative bulletins and information circulars
- (a) describing the anticipated roles and general expectations of those persons affected by or who have an interest in the implementation, application and administration of the protocols;
 - (b) respecting the administration, implementation and operation of the protocols;
 - (c) respecting any other matter the Superintendent considers appropriate.

Prescribed fees

- 5(1)** The Superintendent may prescribe the fees and disbursements or the maximum fees and disbursements to be charged or paid for any service, diagnostic imaging, laboratory testing, specialized testing, supply, treatment, visit, therapy, assessment or making a report under this Regulation, or any other activity or function necessitated by, described in or referred to in this Regulation.
- (2)** The fees and disbursements or maximum fees and disbursements prescribed under subsection (1) must be published in The Alberta Gazette.
- (3)** If the Superintendent prescribes maximum fees and disbursements under subsection (1), no person shall charge or collect a fee or a disbursement that is greater than those maximum fees or disbursements, as the case may be.

Part 2 Diagnosis and Treatment Protocols

Division 1 Diagnosis and Treatment Protocol for Strains and Sprains

Protocols established

- 6** Sections 7 to 9 are established as protocols for the diagnosis and treatment of strains and sprains.

Developing the diagnosis for strains or sprains

7(1) With reference to the International Classification of Diseases and using evidence-informed practice, a diagnosis of a strain or sprain is to be established by a health care practitioner using the following process:

- (a) taking a history of the patient;
- (b) examining the patient;
- (c) making an ancillary investigation;
- (d) identifying
 - (i) the muscle or muscle groups injured, or
 - (ii) the tendons or ligaments, or both, that are involved and the specific anatomical site of the injury.

(2) If a strain or sprain is diagnosed, the diagnostic criteria to be used to determine the degree of severity of the injury are set out in the following tables, extracted from *Orthopedic Physical Assessment* by David J. Magee, (6th edition), (2014), pg 32, with permission from Elsevier Inc.:

1. Diagnosis of strains:

	1st degree strain	2nd degree strain	3rd degree strain
Definition of the degree of strain	Few fibres of muscle torn	About half of muscle fibres torn	All muscle fibres torn (rupture)
Mechanism of injury	Overstretch Overload	Overstretch Overload Crushing	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Moderate to major (reflex inhibition)	Moderate to major
Disability	Minor	Moderate	Major
Muscle spasm	Minor	Moderate to major	Moderate
Swelling	Minor	Moderate to major	Moderate to major
Loss of function	Minor	Moderate to major	Major (reflex inhibition)
Pain on isometric contraction	Minor	Moderate to major	None to minor

	1st degree strain	2nd degree strain	3rd degree strain
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal
Palpable defect	No	No	Yes (if detected early)
Range of motion	Decreased	Decreased	May increase or decrease depending on swelling

2. Diagnosis of sprains:

	1st degree sprain	2nd degree sprain	3rd degree sprain
Definition of the degree of sprain	Few fibres of ligament torn	About half of ligament torn	All fibres of ligament torn
Mechanism of injury	Overstretch Overload	Overstretch Overload	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Minor to moderate	Minor to moderate
Disability	Minor	Moderate	Moderate to major
Muscle spasm	Minor	Minor	Minor
Swelling	Minor	Moderate	Moderate to major
Loss of function	Minor	Moderate to major	Moderate to major (instability)
Pain on isometric contraction	None	None	None
Pain on stretch	Yes	Yes	Not if it is the only tissue injured; however, other structures may suffer 1st degree or 2nd degree injuries and be painful
Joint play	Normal	Normal	Normal to excessive
Palpable defect	No	No	Yes (if detected early)

	1st degree sprain	2nd degree sprain	3rd degree sprain
Range of motion	Decreased	Decreased	May increase or decrease depending on swelling; dislocation or subluxation possible

Treatment protocols for strains and sprains

8 A strain or sprain is to be treated by

- (a) educating the patient with respect to at least the following matters:
 - (i) the desirability of an early return to one or more of the following, as applicable:
 - (A) the patient's employment, occupation or profession;
 - (B) the patient's training or education in a program or course;
 - (C) the normal activities of the patient's daily living;
 - (ii) an estimate of the probable length of time that symptoms will last;
 - (iii) the expected course of recovery;
- (b) managing inflammation and pain, as required,
 - (i) by the protected use of ice;
 - (ii) by elevating the injured area;
 - (iii) by compression;
 - (iv) by using reasonable and necessary equipment to protect a sprained joint during the acute phase of recovery;
- (c) teaching the patient about maintaining flexibility, balance, strength and the functions of the injured area;
- (d) giving advice about self-care and expected return to one or more of the activities described in clause (a)(i)(A) to (C);

- (e) discussing the disadvantage of extended dependence on health care providers and passive modalities of care;
- (f) subject to section 9(3), providing treatment that is appropriate and within the scope of practice of the health care practitioner providing it, and that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury;
- (g) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the patient.

Diagnostic and treatment authorization for strains and sprains

9(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 1st degree, 2nd degree or 3rd degree strain or sprain,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication as determined by the health care practitioner;
- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 15, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 1st degree or 2nd degree strain or sprain, not more than a combined total of 10 physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 8.

(3) Under these protocols, a health care practitioner may not use a visit to treat a 1st degree or 2nd degree strain or sprain to a peripheral joint by a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop.

(4) Within the practitioner's scope of practice, a health care practitioner may authorize, for a 3rd degree strain or sprain,

- (a) necessary diagnostic imaging, laboratory testing and specialized testing;
- (b) necessary medication as determined by the health care practitioner;
- (c) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(5) Subject to the limits described in section 15, within the practitioner's scope of practice, a health care practitioner may authorize, for the treatment of a 3rd degree strain or sprain, a combined total of 21 physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 8, and in particular definitive care of specific muscles, muscle groups, tendons or ligaments at specific anatomical sites, including, as required,

- (a) immobilization,
- (b) strengthening exercises,
- (c) surgery, and
- (d) if surgery is required, post-operative rehabilitation therapy.

Division 2 Diagnostic and Treatment Protocol for WAD Injuries — Cervical, Thoracic, Lumbar and Lumbosacral

Protocols established

10 Sections 11 to 14 are established as protocols for the diagnosis and treatment of WAD injuries.

Developing the diagnosis for WAD injuries

11 Through the use of evidence-informed practice, a diagnosis of a WAD injury is to be established by a health care practitioner using the following process:

- (a) taking a history of the patient;
- (b) examining the patient;
- (c) making an ancillary investigation;
- (d) identifying the anatomical sites.

Diagnostic criteria: WAD I and WAD II injuries

12(1) If a WAD injury is diagnosed, the following criteria are to be used to diagnose the WAD I injury:

- (a) complaints of spinal pain, stiffness or tenderness;
- (b) no demonstrable, definable and clinically relevant physical signs of injury;
- (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- (d) no fractures to or dislocation of the spine.

(2) If a WAD I injury is diagnosed, no further investigation of the injury is warranted, unless there is cause to do so.

(3) If a WAD injury is diagnosed, the following criteria are to be used to diagnose the WAD II injury:

- (a) complaints of spinal pain, stiffness or tenderness;
- (b) demonstrable, definable and clinically relevant physical signs of injury, including
 - (i) musculoskeletal signs of decreased range of motion of the spine, and
 - (ii) point tenderness of spinal structures affected by the injury;
- (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- (d) no fracture to or dislocation of the spine.

(4) An investigation to determine a WAD II injury and to rule out a more severe injury may include

- (a) for cervical spine injuries, radiographic series in accordance with *The Canadian C-Spine Rule for Radiography in Alert and Stable Trauma Patients*, published in the *Journal of the American Medical Association*, October 17, 2001 – Volume 286, No. 15;
- (b) for thoracic, lumbar and lumbosacral spine injuries, radiographic series appropriate to the region of the spine that is injured, if the patient has one or more of the following characteristics:
 - (i) an indication of bone injury;

- (ii) an indication of significant degenerative changes or instability;
- (iii) an indication of polyarthritis;
- (iv) an indication of osteoporosis;
- (v) a history of cancer.

(5) The use of magnetic resonance imaging or computerized tomography is not authorized under these protocols, unless 3 plain view films are equivocal or there are objective neurological or clinical findings.

Treatment protocols: WAD I and WAD II injuries

13 A WAD I or WAD II injury is to be treated by

- (a) educating the patient with respect to at least the following matters:
 - (i) the desirability of an early return to one or more of the following, as applicable:
 - (A) the patient's employment, occupation or profession;
 - (B) the patient's training or education in a program or course;
 - (C) the normal activities of the patient's daily living;
 - (ii) an estimate of the probable length of time that symptoms will last, the estimated course of recovery and the length of the treatment process;
 - (iii) reassurance that there is likely no serious currently detectable underlying cause of the pain;
 - (iv) that the use of a soft collar is not advised;
 - (v) the probable factors that are responsible for other symptoms the patient may be experiencing that are temporary in nature and that are not reflective of tissue damage;
- (b) giving advice about self-care and expected return to one or more of the activities described in clause (a)(i)(A) to (C);

- (c) discussing the disadvantage of extended dependence on health care providers and passive modalities of care;
- (d) prescribing medication, including the appropriate use of analgesics, which may include short-term use of non-opioid analgesics, non-steroidal anti-inflammatory drugs or muscle relaxants for the sole purpose of treating spinal injury, but under these protocols narcotics are not authorized for reimbursement for the treatment of WAD injuries;
- (e) any of the following as appropriate:
 - (i) pain management;
 - (ii) exercise;
 - (iii) early return to normal activities;
 - (iv) cryo and thermal therapy;
 - (v) preparing the patient for a return to one or more of the activities described in clause (a)(i)(A) to (C);
- (f) providing treatment that is appropriate and within the scope of practice of the health care practitioner providing it, and that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury;
- (g) any other adjunct therapy that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury and that is linked to the continued clinical improvement of the patient.

Diagnostic and treatment authorization

14(1) Within the practitioner's scope of practice, a health care practitioner may authorize, for a WAD I or WAD II injury,

- (a) one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and prescribed claim form, if required, which is in addition to the visits that may be authorized under subsection (2);
- (b) necessary diagnostic imaging, laboratory testing and specialized testing;
- (c) necessary medication as determined by the health care practitioner;

- (d) acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.

(2) Subject to the limits described in section 15, within the practitioner's scope of practice, a health care practitioner may authorize,

- (a) for the treatment of a WAD I injury, not more than a combined total of 10 physical therapy, chiropractic and adjunct therapy visits to provide the treatment as described in section 13, and
- (b) for the treatment of a WAD II injury, not more than a combined total of 21 physical therapy, chiropractic and adjunct therapy visits to provide the treatment described in section 13.

Division 3 Treatment Limits and Referrals

Aggregate limits on visits

15(1) Except as otherwise specifically provided in this Regulation, if a patient is diagnosed and treated under these protocols for 2 or more injuries,

- (a) only one visit for an assessment of the injuries by a health care practitioner is authorized by these protocols;
- (b) if the injuries are diagnosed as a 1st degree strain, 2nd degree strain, 1st degree sprain or 2nd degree sprain or WAD I injury, the cumulative total of visits for the 2 or more injuries that may be authorized under the protocols, without the approval of the insurer, may not exceed 10;
- (c) if one or more of the injuries described in clause (b) and one or more of
 - (i) a 3rd degree strain for which treatment is authorized,
 - (ii) a 3rd degree sprain for which treatment is authorized, or
 - (iii) a WAD II injuryare diagnosed, the cumulative total of visits for the 2 or more injuries that may be authorized under the protocols, without the approval of the insurer, may not exceed 21;
- (d) if 2 or more of

- (i) a 3rd degree strain,
- (ii) a 3rd degree sprain, or
- (iii) a WAD II injury

are diagnosed, the cumulative total of visits for the 2 or more injuries that may be authorized under these protocols, without the approval of the insurer, may not exceed 21.

(2) Despite anything to the contrary in this Regulation,

- (a) an authorization by a health care practitioner for anything permitted by these protocols must be in writing and issued within 90 days of the date of the accident in which the patient was injured,
- (b) an authorization under these protocols expires 90 days after the date of the accident in which the patient was injured, unless the authorization is approved by an insurer for use after the 90 days, and
- (c) an authorization may be issued in respect of the person who issues the authorization.

(3) If, after an assessment, a physical therapist or a chiropractor diagnoses an injury as one to which these protocols do not apply, these protocols authorize a claim under Part 4 for the assessment.

Referral to injury management consultant

16(1) A health care practitioner may authorize a visit by, and an assessment of, a patient to an injury management consultant if the health care practitioner

- (a) is uncertain about an injury to which the protocols apply or the diagnosis or treatment of it, or
- (b) believes that the injury
 - (i) is not resolving appropriately, or
 - (ii) is not resolving within the time expected and the practitioner requires another opinion or report.

(2) If a client is diagnosed with a WAD I or WAD II injury and the client has any alerting factor that may influence prognosis, the health care practitioner must seek to reassess the client within 21 days of the accident and, if the injury is not resolving, authorize a visit by the client to an injury management consultant for an assessment and report.

- (3) The injury management consultant may complete an assessment and report that
- (a) provides advice about the diagnosis or treatment of the patient, or
 - (b) recommends a multi-disciplinary assessment of the injury or an aspect of the injury and the persons who should be included in that assessment.
- (4) The visit and the cost and expenses related to an assessment and report by an injury management consultant under this section are authorized to be claimed under Part 4 and are in addition to the aggregate limit on visits referred to in section 15.
- (5) Notwithstanding anything in this section, a referral submitted by a health care practitioner, either 90 days after the date of the accident or after the aggregate number of visits authorized by this Regulation has been reached, and an assessment and report by an injury management consultant is authorized only if the insurer approves it.
- (6) Except for the visit, assessment and report described in this section, no further visit, assessment or report by an injury management consultant in respect of the same injury is authorized by these protocols, unless the insurer approves of it.

Part 3

Injury Management Consultants Register

Register established

- 17(1)** The Superintendent must establish, maintain and administer a register of injury management consultants.
- (2) The Superintendent must ensure that the IMC register is published in a form and manner so that the register is accessible to the public.

Eligibility requirements

- 18(1)** A health care practitioner is an injury management consultant under this Regulation if, in accordance with this Part,
- (a) the Council of the College of Physicians and Surgeons of Alberta notifies the Superintendent that a physician meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register;

- (b) the Council of the Alberta College and Association of Chiropractors of Alberta notifies the Superintendent that a chiropractor meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register;
- (c) the Council of the College of Physical Therapists of Alberta notifies the Superintendent that a physical therapist meets the requirements set out in subsection (2) and the Superintendent enters the name of that person on the IMC register.

(2) A person is eligible to be an injury management consultant if the person

- (a) is an active practising member of that person's profession,
- (b) is knowledgeable with respect to the biopsychosocial model,
- (c) is knowledgeable with respect to assessing acute and chronic pain,
- (d) is experienced in rehabilitation and disability management,
- (e) uses evidence-informed decision-making in his or her practice, and
- (f) meets any additional qualifications established by the Superintendent and approved by the councils of the colleges concerned.

Ceasing to be an injury management consultant

19 A person ceases to be an injury management consultant if

- (a) the council of the profession concerned notifies the Superintendent that the person's name is to be removed from the IMC register, and
- (b) the Superintendent removes the person's name from the IMC register.

Part 4 Claims and Payment of Claims

Definitions

20 In this Part,

- (a) “applicant” means a patient or health care practitioner who sends a completed prescribed claim form to the insurer under section 22;
- (b) “business days” means any day other than a Saturday, Sunday or other holiday as defined in section 28(1)(x) of the *Interpretation Act*;
- (c) “prescribed claim form” means the form established by the Minister under section 803 of the *Insurance Act*.

Priority of this Part

21 If there is any inconsistency or conflict between this Part and Section B - Accident Benefits under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72), this Part prevails.

Claims

22 A patient or health care practitioner who wishes to make a claim under this Part must send to the insurer a completed prescribed claim form, which must include

- (a) details of the injury, and
- (b) details of the accident that are within the personal knowledge of the patient,

within 10 business days of the date of an accident or, if that is not reasonable, as soon as practicable after that.

Decision by insurer

23(1) An insurer, within 5 business days of receiving a completed prescribed claim form, must send to the applicant a decision notice

- (a) approving the claim, or
- (b) refusing the claim.

(2) A claim may only be refused by the insurer giving reasons for refusing the claim, but those reasons are limited to the following:

- (a) the person who suffered the injury is not an insured person under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (b) the insurer is not liable to pay as a result of an exclusion contained in the Special Provisions, Definitions and Exclusions of Section B under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);

- (c) there is no contract of insurance in existence that applies with respect to the person who suffered the injury;
- (d) the injury was not caused as a result of an accident arising out of the use or operation of an automobile.

Failure of insurer to respond

24 If an insurer does not send a decision notice back to the applicant within 5 business days of receipt of the applicant's completed prescribed claim form, the insurer

- (a) is deemed to have approved the claim, and
- (b) is liable to pay the claim under section 26, unless the claim is denied under section 25.

Subsequent denial of liability

25(1) If an insurer

- (a) approves a claim, or
- (b) is deemed to have approved a claim

under this Part, the insurer may subsequently deny liability in accordance with subsection (2).

(2) Liability may only be denied if an insurer sends notice in writing to the patient and every person whom, under the prescribed claim form, the insurer is notified the patient is authorized to visit, or who is authorized to provide services or supplies to the patient, giving reasons why liability is denied, but those reasons are limited to the following:

- (a) the person who suffered the injury is not an insured person under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (b) the insurer is not liable to pay as a result of an exclusion contained in the Special Provisions, Definitions and Exclusions of Section B under the *Automobile Accident Insurance Benefits Regulations* (AR 352/72);
- (c) there is no contract of insurance in existence that applies with respect to the person who suffered the injury;
- (d) the injury was not caused as a result of an accident arising out of the use or operation of an automobile.

(3) A valid notice of denial under subsection (2) takes effect on the date it is received by the person to whom it is sent and, after receipt of the notice of denial by the patient, the insurer is not liable, under section 26, to pay any future claim by a person under this Part.

Making and paying claims

26(1) Where anything is authorized under this Regulation, the authorization may be the subject of a claim under subsection (2).

(2) The insurer must, within 30 days after receiving it, pay a claim that is authorized by this Regulation or is authorized by a health care practitioner or injury management consultant under this Regulation, that,

- (a) in the case of an invoice by a health care practitioner, injury management consultant or provider of an adjunct therapy, is also verified by the patient concerned, or
- (b) in the case of a claim by the patient, a receipt for the benefit is provided, together with satisfactory evidence that the claim is authorized by this Regulation or is authorized by a health care practitioner under this Regulation.

Sending notices

27 Where this Part requires or permits a notice to be sent to a person, it may be

- (a) delivered personally,
- (b) mailed,
- (c) faxed, or
- (d) transmitted by e-mail if both parties have agreed to this method of sending and receiving notices.

Multiple claims

28 If a person has a claim under these protocols and a claim for other benefits under provisions of Section B of the *Automobile Accident Insurance Benefits Regulations* (AR 352/72), the claimant must comply with this Regulation and the provisions of Section B, according to the claim or claims made.

Part 5 Review and Repeal

Review

29 This Regulation must be reviewed

- (a) not less than every 2 years from the date this Regulation comes into force, and
- (b) whenever
 - (i) the Council of the College of Physicians and Surgeons of Alberta,
 - (ii) the Council of the Alberta College and Association of Chiropractors of Alberta, or
 - (iii) the Council of the College of Physical Therapists of Alberta

provides written notice to the Superintendent that the protocols should be reviewed.

Repeal

30(1) The *Diagnostic and Treatment Protocols Regulation* (AR 122/2004) is repealed.

(2) Despite subsection (1), the *Diagnostic and Treatment Protocols Regulation* (AR 122/2004) continues to apply in respect of accidents that occur before the coming into force of this Regulation.

Coming into force

31 This Regulation comes into force on July 1, 2014.



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