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INTERPRETATIVE BULLETIN

Diagnostic and Treatment Protocols Regulations

Introduction

On 02 December 2024, the Automobile Accident Diagnostic and Treatment Protocols Regulations, issued under the **Automobile Insurance Act**, come into force. The implementation of these diagnostic and treatment protocols marks the completion of recommended changes to the **Automobile Insurance Act** and the **Insurance Companies Act** following the Public Utilities Board's Review of Automobile Insurance in Newfoundland and Labrador in 2017-2019 and following targeted consultations with the public, health care professionals, and the insurance industry to gather input and feedback on the proposed protocols.

These protocols require automobile insurance companies to adopt processes that allow accident victims to seek treatment immediately, from a provider of their choice, without advance approval from the insurance company. Participation is voluntary for health care practitioners; those who choose to provide services under the new protocols will bill the insurance company directly for their services. This will eliminate the need for the accident victim to pay up front and wait for reimbursement from the insurance company.

This will mean that accident victims can get quicker and more affordable treatment, specific to the most common types of injuries resulting from an automobile accident: sprains, strains and whiplash associated disorders.

These protocols will make it easier for people who have been injured in an automobile accident to begin their recovery, without having to pay for health care services out of pocket. Accident victims will also no longer be required to exhaust their private health insurance coverage before claiming coverage under their automobile insurance policy. Pursuant to section 8 of the Automobile Accident Diagnostic and Treatment Protocols Regulations, this bulletin describes the anticipated roles and general expectations of those persons affected by, or who have an interest in, the implementation of the protocols, including injured motorists, insurers, and health care practitioners, and it outlines the manner in which the protocols are administered and implemented.

Definitions

For the purposes of this bulletin:

- “Adjunct therapist” means an acupuncturist, a dentist, a massage therapist, a nurse, an occupational therapist, or a psychologist.

- "Evidence-informed practice" means the conscientious, explicit and judicious use of current best practice in making decisions about the care of a patient that integrates individual clinical expertise with the best available external clinical evidence from systematic research.

- "Health care practitioner" means a chiropractor, a physiotherapist, a medical practitioner, or a nurse practitioner.

- “Injury Management Consultant” means a medical practitioner, a chiropractor, a physiotherapist or a nurse practitioner who is registered on the Injury Management Register established and maintained by the Superintendent of Insurance.

- "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 for 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

- "Spine" means the column of bone known as the vertebral column that surrounds and protects the spinal cord.

- "Sprain" means an injury to one or more tendons, one or more ligaments, or to both tendons and ligaments.

- "Strain" means an injury to one or more muscles.

- "Whiplash associated disorder injury" means an injury resulting from the sudden forceful movement of the spine other than one that exhibits one or both of the following:
    a. objective, demonstrable, definable, and clinically relevant neurological signs, or
    b. a fracture to or a dislocation of the spine

Claims and Billing

If you have been injured in an automobile accident in Newfoundland and Labrador, you are entitled to accident benefits coverage through your automobile insurance plan. The benefits you receive depend on the type of injury you have.

If your injury is a sprain, strain or a whiplash associated disorder I or II, your health care practitioner does not have to seek approval of the insurer for payment for treatment of these injuries if you provide notice of your claim. Your health care provider will be able to bill the automobile insurer for all the treatment services outlined in the Automobile Accident Diagnostic and Treatment Protocols Regulations that are not covered by Newfoundland and Labrador's Medical Care Plan (MCP).

In order to make a claim under these regulations, a patient must first complete a claim form detailing the nature of the injury sustained in an automobile accident, as well as the details of the accident. The claim form must be sent to the insurer 10 business days after the date of the accident, unless the insurer determines that this deadline is unreasonable.

If the claim is submitted by the health care practitioner, by an injury management consultant or by an adjunct therapist, the claim must be verified by the patient. If the claim is submitted directly by the patient, the claim must include a receipt for the benefit provided and evidence that the claim is authorized under the regulations.

After the insurer receives the claim form, the insurer has five business days to notify the patient that the insurer approves or refuses the claim. Where an insurer does not notify the patient of its decision within those five days, the insurer is deemed to have approved the claim and is liable for payment.

After the insurer receives a claim for the payment authorized by the regulations, the insurer shall pay that claim within 30 days.

If a patient misses an appointment or is late for an appointment, the insurer is not responsible for reimbursing the primary health care practitioner for that time. The primary health care practitioner may charge the patient a late or missed appointment fee.

Adjunct therapy treatments will only be paid for under DTPR when directed by the primary health care practitioner and when documented on the Treatment Plan (Form NL-2). This includes any type of adjunct therapy. Patients who seek adjunct therapies are urged to consult first with their primary healthcare practitioner.

Physician visits are covered by Newfoundland and Labrador MCP as an insured service.

Should the DTPR treatment visits be insufficient to address a patient's injury, the patient can still claim additional treatment visits when necessary, just not under the DTPR.

Necessary additional treatments are not pre-authorized, and are subject to insurer review and approval.

Necessary additional treatments are first paid using available extended health benefits (e.g., Blue Cross or similar employee benefit plans, including health spending accounts), and second, using the patient's Section B Accident Benefits coverage of their Automobile Policy. Fees for necessary treatments outside DTPR are not prescribed and should be a reasonable amount.

Refusal of Claims

An insurer may only refuse a claim for the following reasons:

a. the person who suffered the injury is not an insured person under a contract that provides accident benefits;
b. the insurer is not liable to pay as a result of an exclusion contained in the Special Provisions, Definitions and Exclusions of a contract that provides accident benefits;
c. there is no contract of insurance in existence that applies with respect to the person who suffered the injury; or
d. the injury was not caused by an accident arising out of the use or operation of an automobile.

Even after a claim has been approved, or deemed to have been approved, the insurer may subsequently deny liability on these 4 grounds.

Claims subject to the receipt of Workplace NL benefits are exempt from the Diagnostic and Treatment Protocols.

Sprains and Strains

Diagnosis

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 primary health care practitioner using the following process:

1. Take a history of the patient;
2. Examine the patient;
3. Make an ancillary investigation; and
4. Identify:
    a. The muscle or muscle groups injured; or
    b. The tendons or ligaments, or both, that are involved and the specific anatomical site of the injury.

Strain

Where a strain is diagnosed, a health care practitioner shall determine the degree of severity of the injury using the diagnostic criteria set out in the following table:

	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	Minor	Moderate to major	None to minor
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

Extracted from Orthopedic Physical Assessment by David J. Magee, (6th edition), (2014) at page 32, and reproduced with permission from Elsevier Inc.

Sprain

Where a sprain is diagnosed, a health care practitioner shall determine the degree of severity of the injury using the diagnostic criteria set out in the following table:

	1st degree sprain	2nd degree sprain	3rd degree sprain
Definition of the degree of sprain	Few fibres of ligament torn (partial tear, no instability or opening of the joint)	About half of ligament torn (partial tear with some instability indicated by partial opening of the joint on stress maneuvers)	All fibres of ligament torn (complete tear with complete opening of the joint on stress maneuvers)
Mechanism of injury	Overstretch Overload	Overstretch Overload	Overstretch Overload
Onset	Acute	Acute	Acute
Weakness	Minor	Minor to moderate	Minor to moderate

	1st degree sprain	2nd degree sprain	3rd degree sprain
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)
Range of Motion	Decreased	Decreased	May increase or decrease depending on swelling. Dislocation or subluxation possible

Extracted from Orthopedic Physical Assessment by David J. Magee, (6th edition), (2014), at page 32, and reproduced with permission from Elsevier Inc.

Treatment

In treating strains or sprains, a health care practitioner shall:

1. Educate the patient with respect to the following matters:
   a. The desirability of an early return to work, to educational or training programs, if applicable, and to normal daily living activities.
   b. An estimate of the probable length of time that symptoms will last; and
   c. The expected course of recovery.

2. Manage inflammation and pain as required, by the protective use of ice, by elevating the injured area, by compression and by using reasonable and necessary equipment to protect a sprained joint during the acute phase of recovery.

3. Teach the patient about maintaining flexibility, balance, strength, and the functions of the injured area.

4. Advise the patient about self-care and the patient's expected return to work, to educational or training programs, if applicable, and to normal daily living activities.

5. Discuss the disadvantage of dependence on health care providers and passive modalities of care for extended periods of time.

6. Provide treatment that is appropriate and that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury; and

7. Refer the patient to an adjunct therapist, where, in the opinion of the health care practitioner, that adjunct therapy is necessary for the treatment or rehabilitation of the injury and it is linked to the continued clinical improvement of the patient.

For a third degree strain or sprain, a healthcare practitioner shall additionally treat these strains or sprains with 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. where surgery is required, post-operative rehabilitation therapy.

NOTE: A health care practitioner may not use a visit to treat a first degree or second 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.

Authorized Treatments for Payment

Treatments that are authorized for payment and do not require prior approval from the insurer include:

a. one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and claim form, if required;
b. visits to a physiotherapist, chiropractor, or adjunct therapist necessary to provide the treatment described above;
c. necessary diagnostic imaging, laboratory testing and specialized testing;
d. necessary medication as determined by the health care practitioner; and
e. acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.
f. For a 1st or 2nd degree strain/sprain, not more than a combined total of 10 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment; and
g. For a 3rd degree strain/sprain, a combined total of 21 medical, physical therapy, chiropractic, and adjunct therapy visits for treatment.

Whiplash Associated Disorder Injuries

Diagnosis

Using evidence-informed practice, a diagnosis of a Whiplash Associated Disorder (WAD) injury is to be established by a primary health care practitioner using the following process:

1. Take a history of the patient, examine the patient, make an ancillary investigation, and identify the anatomical sites of the injury.

WAD I Diagnosis

If the patient is diagnosed with a WAD injury, a healthcare practitioner shall use the following criteria to diagnose a whiplash associated disorder 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; and
d. no fracture to or dislocation of the spine.

Where a WAD I injury is diagnosed, further investigation of the injury is not warranted, unless a health care practitioner believes there is cause to do so.

WAD II Diagnosis

A health care practitioner shall use the following criteria to diagnose a whiplash associated disorder 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; and
d. no fracture to or dislocation of the spine.

An investigation to determine a whiplash associated disorder II injury and to eliminate 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; or
b. for thoracic, lumbar and lumbosacral spine injuries, radiographic series appropriate to the region of the spine that is injured, where 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, or
    v. a history of cancer.

NOTE: The use of magnetic resonance imaging or computerized tomography is not authorized under this protocol, unless
   a. a diagnosis cannot be determined from 3 plain view films; or
   b. there are objective neurological or clinical findings.

Treatment

In treating a WAD I or WAD II injury, a health care practitioner shall:

1. Educate the patient with respect to the following matters:
   a. The desirability of an early return to work, to educational or training programs, if applicable, and to normal daily living activities.
   b. An estimate of the probable length of time that symptoms will last; and
   c. The expected course of recovery.
   d. The length of the treatment process
   e. That there is likely no serious currently detectable underlying cause of the pain
   f. That the use of a soft collar is not advised, and
   g. 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;
2. Advise the patient about self-care and the patient's expected return to work, to educational or training programs, if applicable, and to normal daily living activities.
3. Discuss the disadvantage of dependence on health care providers and passive modalities of care for extended periods of time.
4. Prescribe medication, where appropriate, including analgesics, for the sole purpose of short-term treatment of spinal injuries, but not including narcotics
5. Where appropriate, manage pain, prescribe exercise, allow an early return to normal activities, prescribe cryo or thermal therapy, or prepare the patient for a return to work, to educational or training programs, if applicable, or to normal daily living activities.
6. Provide treatment that is appropriate and that, in the opinion of the health care practitioner, is necessary for the treatment or rehabilitation of the injury; and
7. Refer the patient to an adjunct therapist, where, in the opinion of the health care practitioner, that adjunct therapy is necessary for the treatment or rehabilitation of the injury and it is linked to the continued clinical improvement of the patient.

Authorized Treatments for Payment

Treatments that are authorized for payment and do not require prior approval from the insurer include:

a. one visit to a health care practitioner for an assessment of the injury, including the preparation of a treatment plan and claim form, if required;
b. visits to a physiotherapist, chiropractor or adjunct therapist necessary to provide the treatment described above;
c. necessary diagnostic imaging, laboratory testing and specialized testing;
d. necessary medication as determined by the health care practitioner; and

e. acquisition of necessary supplies to assist in the treatment or rehabilitation of the injury.
f. For a WAD I injury, not more than a combined total of 10 visits to a physiotherapist, a chiropractor, or an adjunct therapist; and
g. For a WAD II injury, not more than a combined total of 21 visits to a physiotherapist, a chiropractor, or an adjunct therapist

Referral to an Injury Management Consultant

A health care practitioner may authorize a single visit by a patient to an Injury Management Consultant (IMC) if the primary health care practitioner:

a. is uncertain about an injury to which these protocols apply or is uncertain about the diagnosis or treatment of the injury, or
b. requires another opinion or report because the health care practitioner believes that the injury is not resolving appropriately, or that it is not resolving within the time expected.
c. has reassessed the patient after a diagnosis of a strain, sprain or WAD injury and the patient has alerting factors that may influence prognosis.

After an IMC has assessed a patient on an authorized visit, the IMC shall prepare a report which shall include one of the following:

a. advice about the diagnosis or treatment of the patient; or
b. a recommendation for a multi-disciplinary assessment of the injury, or an aspect of the injury, and the health care practitioners that should be included in that assessment.

The single authorized visit and the costs and expenses related to an assessment and report by an IMC may be claimed under these regulations. Further visits and assessments are not authorized under these regulations unless approved by the insurer.

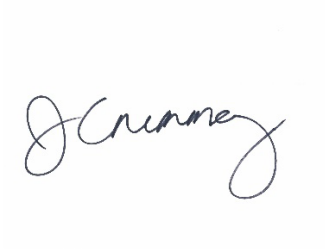
Privacy Information for Health Care Practitioners

Newfoundland and Labrador's Forms have been developed taking into account the limits on personal information collection, use and disclosure in relevant federal and provincial privacy legislation.

Relevant and necessary information about your patient is collected, used or disclosed by the insurer with your patient's consent. Anonymized statistical claims information is used by the insurance industry for rating purposes, and by the Government of Newfoundland and Labrador for policy analysis. The business contact information you provide as a primary health care practitioner will be used by the insurer and others to facilitate communication with you as necessary.

Note: If a claimant requests that their primary health care practitioner not disclose certain information required by prescribed claim forms, the insurer may decline the claim.

Questions and inquiries may be directed to 709-729-2595 or fsrd@gov.nl.ca.



Jennifer Crummey
Superintendent of Insurance
November 29, 2024

Appendix A

Patient Education

One of the key aspects of the DTPR is its emphasis on patient education. The following is an example of the kind of information and education you could provide to a patient with a grade I or II WAD injury when appropriate.

To the patient:

1. On the basis of your symptoms and the examination, you have grade I (or II) WAD. This means most likely that you have a strain/sprain of muscles and/or ligaments and that you do not have a fracture, injury to nerves, or other serious damage that we can detect.

2. The symptoms you are experiencing are normal and common for your type of injury. Additional physical and psychological conditions or symptoms may also arise from the WAD injury, and typically resolve with the injury. Most people recover from this injury within 6 weeks, and you should have no long-term problems.

3. It is rare that people have chronic pain and trouble working or enjoying their usual lifestyle after the injury. There are things you can do to help reduce the chance of this happening. And there are other things you may do that will increase the chance of chronic pain happening. As long as you focus on what you can do to recover, you will do well.

4. It is important to maintain normal activities or modified activities as much as possible. At first, these activities might be painful, but evidence suggests that resuming normal activities will help improve your recovery. There is no evidence that normal activities, even though they may hurt, will cause any long-term harm.

5. Start with exercise and good posture maintenance early. Whiplash patients/patients who exercise daily, despite the fact that these exercises may hurt initially, do better than those who rest and hope the pain will go away on its own.

6. Avoid using a cervical collar. While collars may offer temporary relief, using a collar actually prolongs recovery.

7. Avoid relying solely on non-exercise (passive) therapies. In general, whiplash patients/patients who use these types of passive therapies instead of exercise, or people who have an expectation that others will cure them, do not do well. The best approach with the best chance of recovery is to exercise daily.

8. Do not rely on medications to completely eliminate pain. There is no evidence that medications speed recovery from whiplash injury. Medications may help in the short term if they ease the pain and allow people to keep active and exercise regularly. Over-the-counter medications are known to be the safest and should be used first. Other pain killers and medications cause many side effects including sedation, dizziness, dry

mouth, poor concentration, and poor memory, ringing in the ears, visual disturbance, and headache.

9. Although it may be difficult not to, paying too close attention and continually worrying about the symptoms will, in fact, make the symptoms more severe. The same is true for talking with friends and family members about the amount of pain. The best approach is to try to relax, carry on with normal activities, exercise appropriately and understand that it might take some time, but the pain will go away.

10. Aches and pains, headaches and many other symptoms are common in life, especially if life becomes stressed. Don’t assume that problems noticed months later are caused by the injury. It is natural for people to pay closer attention to their bodies after an injury. The best distraction from pain and the natural tendency to pay more attention to symptoms is to continue normal, everyday activities despite the hurt, keep a regular schedule, and keep stress levels down.

Appendix B

Recommended IMC Report Format

The prescribed IMC fee amount includes for up to one hour of an IMC's time. If the time taken by an IMC to complete all aspects of this service, including an assessment and reporting, is expected to exceed or exceeds one-hour, the IMC may seek authorization to charge an additional fee from the insurance company.

A recommended IMC report format is:

1. Statement of the purpose for the examination and relevant issues.
2. Review of relevant information from the primary health care practitioner.
3. Relevant history of the injury including:
    - o Mechanism of injury;
    - o Previous history of injury to the same part of the body; and
    - o Progress of recovery that includes review of consultation(s), investigation(s), and treatment, as well as response to treatment.
4. Relevant medical history – physical, psychological, emotional, cognitive, and surgical history.
5. Current status of patient, including present complaints.
6. Details of examination including:
    - o General;
    - o Regional;
    - o Musculoskeletal;
    - o Neurological; or
    - o Any functional limitations.
7. Any further investigation and assessment carried out.
8. Diagnosis and prognosis.
9. Recommended treatment or further assessment.