

# Consultation Paper Insurance 2020

Diagnostic and Treatment Protocols  
for Automobile Accident Victims

Insurance Division

8 February 2020

FINANCIAL AND  
CONSUMER SERVICES  
COMMISSION



COMMISSION DES SERVICES  
FINANCIERS ET DES SERVICES  
AUX CONSOMMATEURS

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# Introduction

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Established in 2013, the Financial and Consumer Services Commission (the Commission) is responsible for the administration and enforcement of provincial legislation that regulates insurance, securities, pensions, credit unions, trust and loan companies, co-operatives and a wide range of consumer legislation.

Our mission is to protect consumers and enhance public confidence in our financial and consumer marketplaces through the provision of regulatory and educational services.

The Commission proposes that New Brunswick adopt diagnostic and treatment protocols for automobile accident victims. The intention is to ensure accident victims who suffer strains, sprains or whiplash associated disorders can access treatment quickly, which in turn can lower long-term costs. This consultation paper is intended for a variety of stakeholders that each play a role in the victim's recovery.

Diagnostic and treatment protocol regulations already exist in Alberta and Nova Scotia and many of the proposals in this paper draw from those regulations. We believe the best approach draws on the lessons learned in other jurisdictions, while considering factors unique to the New Brunswick landscape. We encourage stakeholders to reach out to colleagues in those jurisdictions that already have protocols and to share any concerns or opportunities for New Brunswick that may be highlighted.

We appreciate you taking the time to participate in this consultation and look forward to hearing from you.

# Background

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In 2011, the New Brunswick Auto Insurance Working Group submitted their report recommending certain changes to the insurance system in New Brunswick. One of these recommendations was to mandate the Superintendent of Insurance to implement protocols that made funds available for accident victims to access early diagnosis and treatment for their injuries.

Unfortunately, under the current New Brunswick insurance system, many accident victims face significant barriers or delays in receiving a diagnosis and beginning the required treatment. The barriers faced can be different in each case and can be linked to the circumstances of the accident victim. Common barriers include:

- Some accident victims do not have access to a family doctor who can see them quickly and who can provide the necessary referrals to the appropriate medical practitioner to begin treatment and recovery.
- Those without a family doctor may not know how to navigate the complexities of the system, which involves knowing where to seek treatment, who to see and what they are entitled to.
- Many accident victims do not have the financial means to pay for services up-front and then wait to be reimbursed by their insurer. This is often required in the current system. Accident victims may not be working, which often increases the precariousness of their financial situation. When faced with these financial challenges, accident victims may choose to forego treatment, resulting in longer recovery times, increased costs and unnecessary grief for accident victims.
- Many treatments require pre-approval from the insurer. Navigating this in a timely manner so that treatment and subsequent recovery is not delayed can be difficult.
- Under the current system, accident victims must exhaust their personal or workplace health insurance before they can access section B Benefits, meaning those benefits are unavailable if they are needed for a medical issue unrelated to their accident.

In addition to the obstacles for the patient in the current system, there can also be obstacles for those in the medical field. Dealing with lawyers, insurers and others involved in the treatment process can be challenging and cumbersome.

In jurisdictions where they have been implemented, diagnostic and treatment protocols have resulted in:

- quicker access to diagnosis and treatment
- greater predictability in the treatment journey
- greater flexibility in treatment options
- greater simplicity and clarity in the payment process<sup>1</sup>

A survey of claim data from Alberta following the implementation of the diagnostic and treatment protocols demonstrated:

- a significant decline in accident victims going without treatment in the weeks following their accident

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<sup>1</sup> Nova Scotia, CFN Consultants (Atlantic) Report, *NS Auto Insurance Final Report*, (Halifax, 2011) at page 37

- fewer cases requiring specialized medical intervention
- an increase in claim closure during the 13-26-week post-injury period<sup>2</sup>

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<sup>2</sup> *A Survey of Injury Claims Data After Introduction of Injury Care Protocols in Alberta, Canada* – Barbara Sulzenko-Laurie, BA (Hons); Viivi Riis, MSc; and, Elena Grubisic, MSc, 2010.

# 1. How the Protocols Work and Key Definitions

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The protocols allow accident victims who have suffered certain injuries to be diagnosed and to have access to treatments in accordance with established medical best practices. Following an accident, victims can attend a “health care practitioner” for diagnosis and to be treated a set number of times based on their injury. The accident victim can access these treatments without pre-approval from their insurer. The Commission proposes that “health care practitioner” mean physicians, chiropractors and physiotherapists. These individuals would be the leaders of the protocol system and would be empowered to authorize treatments, make referrals without pre-approval from the insurer, and to bill the insurer directly. This is consistent with regulations in Alberta and Nova Scotia.

The protocols are not mandatory for accident victims, but merely provide an additional option for them. If accident victims wish to seek a treatment that falls outside of those provided by the protocols, they are free to pursue that treatment under standard Section B procedures.

In the early stages of treatment, the health care practitioner will be required to complete a “treatment plan,” which sets out the course of treatment for the patient. As part of the treatment plan, the health care practitioner can make referrals to an “adjunct therapist” if they consider the referral necessary to treat or rehabilitate the injury. An “adjunct therapist” will also be permitted to bill the insurer directly. The Commission proposes that “adjunct therapist” mean massage therapists, acupuncturists and occupational therapists and any person designated by the Superintendent of Insurance.

If the diagnosis is uncertain, or the injury is not resolving as anticipated, the health care practitioner can request an assessment from an Injury Management Consultant (IMC), which are discussed further in Section 5 of this paper. The IMC can recommend that treatment under the protocols continue, or if appropriate, continue outside of the protocols. If this is the case, the claimant can then rely on their normal Section B benefits.

To align with Alberta and Nova Scotia, the Commission proposes that those providing diagnosis and treatment under the protocols be required to do so in accordance with the principles of “evidence informed practice.” This refers to a style of medical practice which puts emphasis on research and data-based decisions to determine what works best for a patient considering their situation. The Commission proposes adopting a definition that is widely accepted and consistent with the intentions of the protocols.

In addition to some of the key definitions discussed in this section, the Commission proposes a number of other definitions that closely mirror those from the Nova Scotia and Alberta Regulations. These definitions can be found in Appendix “A” to this consultation paper.

## **Consultation Questions:**

- 1.1 What are your comments on modelling the New Brunswick protocols after the Alberta and Nova Scotia Regulations? Please elaborate on your response.
- 1.2 Do you have any comments on the proposed definition of “health care practitioner” (being physicians, chiropractors and physiotherapists)? Please elaborate on your response and explain if and how the definition should be amended.

- 1.3 Do you have any comments on the proposed definition of “adjunct therapist (defined to include: massage therapists, acupuncturists, occupational therapist and any person designated by the Superintendent of Insurance)? Please elaborate on your response and explain if and how the definition should be amended.
- 1.4 Do you have any comments on the proposed definition of "evidence informed practice" and do you believe it is an appropriate standard to apply to those authorized to provide diagnoses and treatment under the protocols?
- 1.5 Do you have any comments on any of the proposed definitions set out in Appendix “A”?
- 1.6 Please comment on any other matters related to this section.

## 2. Diagnosis and Treatment of Strains and Sprains

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The Commission proposes that strains and sprains be diagnosed in the same manner as set out in the Alberta and Nova Scotia Regulations. This is by a health care practitioner using evidence informed practice and with reference to the International Classification of Diseases in accordance with the following process:

- taking a history of the patient;
- examining the patient;
- making any ancillary investigations considered necessary; and
- Identifying
  - For strains, the muscle or muscle groups injured;
  - For sprains, the tendons or ligaments, or both, that are involved and the specific anatomical site of the injury.

In terms of the criteria for diagnosis, both Alberta and Nova Scotia use the same medical resource. This is the table found at page 32 of *Orthopaedic Physical Assessment* by David J. Magee (6<sup>th</sup>), (2013). The Commission proposes using this resource as well, as long as there is not a more appropriate resource that could be effectively used for this purpose. The tables have been reproduced in Appendix “B” with the permission of *Elsevier Inc.*

In addition to providing direction on the diagnosis of strains and sprains, the protocols will also provide direction on their treatment. The Commission proposes mirroring treatments found in the Alberta and Nova Scotia Regulations. The proposed treatment process can be found in Appendix “B” as well.

### **Consultation Questions:**

- 2.1 Do you have any comments on the process set out in Appendix “B” for diagnosing strains and sprains? Please elaborate on your response.
- 2.2 Do you have any comments on the use of *Orthopaedic Physical Assessment* by David J. Magee as a resource for diagnosing strains and sprains? Is there a resource that you believe is more appropriate? Please elaborate on why it is more appropriate.
- 2.3 Do you have any comments on the treatment process set out in Appendix “B” for strains and sprains? Please elaborate on your response.
- 2.4 Please comment on any other matters related to this section.



## 3. Diagnosis and Treatment of Whiplash I and II Injuries

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The Commission proposes mirroring the diagnostic and treatment processes for whiplash injuries set out in the Alberta and Nova Scotia Regulations. The processes and classification system used in those Regulations are based on the *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders* (Quebec Task Force), which was a task force sponsored by a public insurer in Canada.<sup>3</sup> This is understood to be a standard resource in the field of whiplash related injuries and has proven effective for use in the other jurisdictions. The proposed diagnosis criteria can be found in Appendix “C”.

Just as with the strain and sprain injuries, a health care practitioner must use evidence-informed practice in diagnosing a whiplash injury. They must also diagnose by:

- taking a history of the patient;
- examining the patient;
- making any ancillary investigations considered necessary; and
- identifying the anatomical sites.

In addition to providing direction on the diagnosis of whiplash I and whiplash II injuries, the protocols will also provide direction on their treatment.

The proposed treatment for whiplash I or II injury is outlined in Appendix “C”. Throughout the treatment, a health care practitioner would be authorized to approve the necessary diagnostic imaging, laboratory testing, specialized testing, necessary medication (except narcotics) and any necessary supplies, in accordance with any guidelines that may be published by the Superintendent.

### **Consultation Questions:**

- 3.1. Do you have any comments on the process set out in Appendix “C” for diagnosing whiplash injuries? Please elaborate on your response.
- 3.2. Do you have any comments on the process set out in Appendix “C” for treating whiplash injuries? Please elaborate on your response.
- 3.3. Is the *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders* an appropriate and up-to-date resource for this purpose?
- 3.4. Do you have any comments on the pre-approved tests for whiplash injuries found in Appendix “C”?
- 3.5. Please comment on any other matters related to this section.

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<sup>3</sup> *Scientific Monograph of the Quebec Task Force on Whiplash Associated Disorders: Redefining “Whiplash” and its management* (Hagerstown, Md.: J.B. Lippincott Company, 1995).

## 4. Administration, Treatment Plans and Limits

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The Commission proposes that, under the protocols, the health care practitioner providing the majority of care be required to complete a Treatment Plan (“The Plan”) in a form provided by the Superintendent. The Plan, which is required shortly after the health care practitioner first assesses the patient, will outline the treatment going forward, including functional goals/outcomes, expected number of medical visits, and any referrals being made. A completed Plan must be provided to the insurer, patient, and all practitioners providing treatment, including any adjunct therapists.

Under the protocols, accident victims will be pre-approved for a set number of treatment visits. This includes an initial appointment for diagnosis and then an additional number of subsequent visits based on the diagnosed injury type and level. The current limits in Alberta and Nova Scotia are the same and the Commission proposes adopting those limits in New Brunswick. The limits are:

- combined total of 10 visits to a physiotherapist, chiropractor or adjunct therapist for a 1<sup>st</sup> or 2<sup>nd</sup> degree strain or sprain or for a whiplash I injury.
- Combined total of 21 visits to a physiotherapist, chiropractor or adjunct therapist for a 3<sup>rd</sup> degree strain or sprain or for a whiplash II injury.

If the patient is suffering from more than one injury, they would be entitled to either 10 visits or 21 visits based on the combination of injuries. If the multiple injuries they suffer are 1<sup>st</sup> or 2<sup>nd</sup> degree strains or sprains or a whiplash I injury, they would be entitled to 10 visits. If any of the injuries they suffer are a 3<sup>rd</sup> degree strain or sprain or a whiplash II injury, they would be entitled to the 21 visits.

Under the Nova Scotia and Alberta Regulations, a patient or health care practitioner can make a claim by completing the claim form within 10 business days from the date of the accident. The Regulations indicate that if that time-frame is not reasonable, the form should be completed as soon as practicable. After receiving the claim form, the insurer must send the applicant a decision notice within five (5) business days. The insurer can only refuse the claim if:

- the person injured does not meet the definition of “patient” under the Regulation;
- the insurer is not liable because of exclusions in the Standard Automobile Policy;
- there is no existing contract between the insurer and the person injured; or
- the injury did not arise from the use of an automobile.

If an insurer does not respond to the applicant, they are deemed to have approved the claim. An insurer may later refuse an approved claim by sending notice to all parties but may only refuse for the reasons previously mentioned. The insurer must pay any claim for treatment that is authorized under the protocols within 30 days of receiving, as long as all required invoices, receipts, forms and patient verifications are provided.

The health care practitioner who provided the majority of treatment must prepare a concluding report on a form provided by the Superintendent which must be sent to the insurer after treatment is complete. As part of a precaution against fraud, the health care practitioner must send the final invoice they sent to the insurer to the patient as well, along with a letter that includes the following statement:

“We have billed your insurer the amounts shown on the attached invoice for the goods and services listed. Please check the invoice and report any errors to us and to your insurer.”

**Consultation Questions:**

4.1. Do you have any comments on the Treatment Plan process? Please elaborate on your response.

4.2. Do you have any comments on the proposed number of medical visits? Please elaborate on your response.

4.3. Do you have any comments on the proposed timeframes for completing the forms and for approval and denial of claims by insurers? Please elaborate on your response.

4.4. Do you have any comments on the proposed possible grounds for refusing a claim? Please elaborate on your response.

4.5. Please comment on any other matters related to this section.

## 5. Injury Management Consultants

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As part of the diagnostic and treatment protocol system, the Commission proposes using Injury Management Consultants (“IMCs”) as an additional resource for diagnosis/treatment. These are individuals who the patient can be referred to when a diagnosis is uncertain, or the injury is not resolving in the expected manner.

The Commission proposes that to qualify as an IMC, you must be a practising and licensed physician, chiropractor or physiotherapist, be knowledgeable about the biopsychosocial model and about assessing acute and chronic pain, be experienced in rehabilitation and disability management, and use evidence informed practices. To qualify as an IMC in Alberta and Nova Scotia, one must complete a form supplied by the licensing body that includes declarations from the applicant that they meet the various statutory requirements. The licensing body reviews the forms and forwards them to the Superintendent of Insurance, who bears final responsibility for approving them. The Commission proposes a similar arrangement with the licensing bodies in New Brunswick (links: [Alberta Form](#) and [Nova Scotia Form](#)).

A referral to an IMC would occur when the health care practitioner is uncertain about which protocols should apply to the patient’s injury or they require another opinion, either because the injury is not resolving in the expected manner or the diagnosis is different from another health care practitioner’s. Additionally, an IMC could be used if the patient is unable to perform the essential tasks of their employment, profession, training or education, even after reasonable accommodation measures have been taken.

Once a referral is made, an IMC would complete an assessment on the patient that would include advice about the diagnosis or treatment or a recommendation for a multi-disciplinary assessment of the injury. Visiting the IMC would be paid for under the protocols and would not count toward the previously discussed total visit limits.

The IMCs could serve as a valuable second opinion in many cases and could, in some instances, bring an easier resolution to the process. Requirements to be registered as an IMC would be set by the Superintendent and it is anticipated that the requirements would be similar to those in the Alberta and Nova Scotia Regulations.

### **Consultation Questions:**

- 5.1. Do you have any comments on the use of IMCs? Please elaborate on your response.
- 5.2. What should be the qualifications of an IMC? Please elaborate on your response.
- 5.3. What are the appropriate roles and duties of an IMC? Please elaborate on your response.
- 5.4. Please comment on any other matters related to this section.

## Providing Feedback

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The Commission is publishing this Consultation Paper for a **60 day comment period**. Please send your comments in writing on or before **18 April 2020**.

All submissions should refer to “**Consultation Paper – Insurance 2020 – Diagnostic and Treatment Protocols**”. This reference should be included in the subject line if the submission is sent by email. Regardless of whether you are sending your comments by email, you should also send or attach your submissions in an electronic file in Microsoft Word format.

### **Please address your submission to:**

E-mail: [consultation@fcnb.ca](mailto:consultation@fcnb.ca)

Alternatively, submissions may be sent by mail or fax to:

Insurance Division c/o David Weir  
Financial and Consumer Services Commission  
200-225 King St.  
Fredericton, NB E3B 1E1  
Fax: (506) 453-7435

We cannot keep submissions confidential as they may be subject to a request under the *Right to Information and Protection of Privacy Act*. Additionally, any submissions or comments received during the comment period may be published; therefore, you should not include personal information directly in comments. It is important that you state on whose behalf you are making the submission.

### **If you have any questions, please refer them to:**

David Weir  
Senior Technical Advisor, Insurance  
Financial and Consumer Services Commission  
Tel: (506) 658-3060

Toll Free: (866) 933-2222  
Email: [david.weir@fcnb.ca](mailto:david.weir@fcnb.ca)

## Appendix A – Certain Proposed Definitions

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“adjunct therapist” means any of the following:

- (i) a massage therapist,
- (ii) an acupuncturist,
- (iii) an occupational therapist as defined in the *Occupational Therapy Act*;
- (iv) any person designated by the Superintendent of Insurance

“chiropractor” means a chiropractor as defined in the *Chiropractors Act*;

“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 while recognizing patient preference and individual patient considerations in the determination of treatment;

“health care practitioner” means any of the following who is licensing to practice their profession in the Province:

- (i) a physician,
- (ii) a chiropractor, or
- (iii) a physiotherapist:

“history”, in respect of a patient’s injury, means

- (i) how the injury occurred
- (ii) the current symptoms the patient is experiencing
- (iii) anything the health care practitioner considers relevant from the patient’s past, including physical, physiological, emotional, cognitive and social history,
- (iv) how the patient’s physical functions have been affected by the injury.

“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;

“patient” means an insured defined in Section 224 of the *Insurance Act*;

“physiotherapist” means a physiotherapist as defined in the *Physiotherapy Act*

“physician” means a person who is regulated member of the College of Physicians and Surgeons of New Brunswick under the *Medical Act*;

“spine” means the column of bone, known as the vertebral column, that surrounds and protects the spinal cord, and includes all of the following categorizations of the column according to the level of the body: cervical spine (neck), thoracic spine (upper and middle back) and lumbar or lumbosacral spine (lower back);

“sprain” means an injury to one or more tendons, to one or more ligaments, or to both tendons and ligaments;

“strain” means an injury to one or more muscles;

“whiplash-associated disorder injury” means a whiplash-associated disorder other than one that exhibits one or all of the following:

- (i) neurological signs that are objective, demonstrable, definable and clinically relevant;
- (ii) a fracture to the spine or dislocation of the spine;

## Appendix B – Proposed Diagnosis Table and Treatment for Strains and Sprains

Tables from *Orthopaedic Physical Assessment* by David J. Magee (6<sup>th</sup>), (2013), reproduced with the permission of Elsevier Inc.

### Proposed Diagnosis of Strains

	1 <sup>st</sup> Degree Strain	2 <sup>nd</sup> Degree Strain	3 <sup>rd</sup> degree Strain
<b>Definition of the degree of sprain</b>	few fibres of muscle torn	about half of muscle fibres torn	all muscle fibres torn (rupture)
<b>Mechanism of Injury</b>	overstretch overload	overstretch overload crushing	overstretch overload
<b>Onset</b>	acute	acute	acute
<b>Weakness</b>	minor	moderate to major (reflex inhibition)	moderate to major
<b>Disability</b>	minor	moderate	major
<b>Muscle Spasm</b>	minor	moderate to major	moderate
<b>Swelling</b>	minor	moderate to major	moderate to major
<b>Loss of Function</b>	minor	moderate to major	major (reflex inhibition)
<b>Pain on Isometric contraction</b>	minor	moderate to major	no to minor
<b>Pain on stretch</b>	yes	yes	not if it is the only tissue injured; however, often with 3rd degree injuries other structures will suffer 1st or 2nd degree injuries and be painful
<b>Joint play</b>	normal	normal	normal
<b>Palpable defect</b>	no	no	yes (if early)
<b>Crepitus</b>	no	no	no
<b>Range of motion</b>	decreased	decreased	may increase or decrease depending on swelling



## **Proposed Diagnosis of Sprains**

	<b>1<sup>st</sup> Degree Sprain</b>	<b>2<sup>nd</sup> Degree sprain</b>	<b>3<sup>rd</sup> degree sprain</b>
<b>Definition of the degree of sprain</b>	few fibres of ligament torn	about half of ligament torn	all fibres of ligament torn
<b>Mechanism of Injury</b>	overload overstretch	overload overstretch	overload overstretch
<b>Onset</b>	acute	acute	acute
<b>Weakness</b>	minor	minor to moderate	minor to moderate
<b>Disability</b>	minor	moderate	moderate to major
<b>Muscle Spasm</b>	minor	minor	minor
<b>Swelling</b>	minor	moderate	moderate to major
<b>loss of function</b>	minor	moderate to major	moderate to major (instability)
<b>Pain on Isometric contraction</b>	no	no	no
<b>Pain on stretch</b>	yes	yes	not if it is the only tissue injured; however, often with 3rd degree injuries other structures will suffer 1st or 2nd degree injuries and be painful
<b>Joint play</b>	normal	normal	normal to excessive
<b>Palpable defect</b>	no	no	yes (if early)
<b>Crepitus</b>	no	no	no
<b>Range of motion</b>	decreased	decreased	may increase or decrease depending on swelling. Dislocation or subluxation possible

## **Proposed Treatment for Strains and Sprains**

Under the protocols, a health care practitioner must treat a strain or sprain by doing the following:

- Educating patients on
  - The desirability of an early return to one or more of the following: their employment, occupation profession, training, education or daily activities;
  - an estimate of the probable length of time that symptoms will last, the estimated time for recovery and length of the treatment process.
- Managing inflammation and pain by
  - the protected use of ice, by elevating the injured area, by compression and for a sprain, by using reasonable and necessary equipment to protect the sprained joint during the acute phase of recovery.
- Teaching the patient about maintaining flexibility, balance, strength and the functions of the injured area.
- Giving advice about self care.
- Preparing the patient for a return to their employment, occupation, profession, training, education or daily activities.
- Discussing the disadvantage of depending on health care providers and passive modalities of care for extended periods of time.
- Prescribing medication, if appropriate, including analgesics for the sole purpose of short-term treatment of the injury, such as non-opioid analgesics, non-steroidal anti-inflammatory drugs or muscle relaxants, but treatment does not include prescribing narcotics.
- Providing treatment that is appropriate and that the health care practitioner considers necessary to treat or rehabilitate the injury, except treating a 1<sup>st</sup> or 2<sup>nd</sup> degree sprain or strain to a peripheral joint by a brief, fast thrust to move the joints beyond the normal range in the anatomical range of motion.
- Referring the patient for any adjunct therapy that the health care practitioner considers necessary to treat or rehabilitate the injury and is linked to the continued clinical improvement of the patient.
- In the case of a 3<sup>rd</sup> degree strain or sprain, definitive care of specific muscles, muscle groups, tendons or ligament at specific anatomical sites should be completed, including immobilization, strengthening exercises or surgery. If surgery is required, post-operative rehabilitation therapy.

In addition to the treatments outlined above, in treating a 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> degree strains or sprains, a health care practitioner would be authorized to approve the necessary diagnostic imaging, laboratory testing, specialized testing, necessary medication (except narcotics) and any necessary supplies, in accordance with any guidelines that may be published by the Superintendent.

# Appendix C – Proposed Diagnosis and Treatment for Whiplash Injuries

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## Proposed Diagnosis of a Whiplash Injuries

The Regulations in Nova Scotia and Alberta sets out that in diagnosing a whiplash injury, the health care practitioner must use the following criteria

For a whiplash I injury:

- complaints of spinal pain, stiffness or tenderness;
- no demonstrable, definable and clinically relevant physical signs of injury;
- no objective, demonstrable, definable and clinically relevant neurological signs of injury; and
- no fractures to or dislocations of the spine.

For a whiplash II injury:

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

The following tests to determine the existence of a whiplash II injury, or to rule out a more severe injury would be pre-approved under the protocols:

- 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*<sup>4</sup>,
- for thoracic, lumbar and lumbosacral spine injuries, radiographic series that are appropriate to the region of the spine that is injured, if the patient has 1 or more of the following characteristics: an indication of bone injury; an indication of significant degenerative changes of instability, an indication of polyarthritis, an indication of osteoporosis, a history of cancer; and
- the use of an MRI is only permitted if a diagnosis cannot be determined from three (3) plain view films and there are objective neurological or clinical findings.

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<sup>4</sup> Stiell IG, Wells GA, Vandemheen KL, et al. The Canadian C-Spine Rule for Radiography in Alert and Stable Trauma Patients. *JAMA*. 2001;286(15):1841–1848

## **Proposed Treatment of Whiplash Injuries**

In addition to providing direction on the diagnosis of whiplash I and whiplash II injuries, the protocols will also provide direction on their treatment. The Commission proposes mirroring treatment direction found in the Alberta and Nova Scotia Regulations. Under the Alberta and Nova Scotia Regulations, a health care practitioner must treat a whiplash I and II injury by doing all the following:

- Educating patients on
  - the desirability of an early return to 1 or more of the following: their employment, occupation, profession, training, education or daily activities;
  - an estimate of the probable length of time that symptoms will last, the estimated time for recovery and length of the treatment process;
  - that there is likely no serious currently detectable underlying cause of pain;
  - the importance of postural and body mechanics control;
  - that the use of a soft collar is not desirable; and
  - the probable factors responsible for other symptoms the patient may be experiencing that are temporary in nature and that are not reflective of tissue damage, including: disturbance of balance, disturbance or loss of hearing, limb pain or numbness, cognitive dysfunction and jaw pain.
- Giving advice on self-care.
- Preparing the patient for a return to their employment, occupation, profession, training, education or daily activities.
- Discussing the disadvantage of depending on health care providers and passive modalities of care for extended periods of time.
- Prescribing medication, if appropriate, including analgesics for the sole purpose of short-term treatment of the injury, such as non-opioid analgesics, non-steroidal anti-inflammatory drugs or muscle relaxants, but treatment does not include prescribing narcotics.
- Recommending pain management (as required), exercise and using heat and ice.
- Providing treatment that is appropriate and that the health care practitioner considers necessary to treat or rehabilitate the injury.
- Referring the patient to any adjunct therapy that the health care practitioner considers necessary to treat or rehabilitate the injury and that is linked to the continued clinical improvement of the patient.