Newfoundland and Labrador Regulation 2024

NEWFOUNDLAND AND LABRADOR
REGULATION 36/24

Automobile Accident Diagnostic and Treatment Protocols Regulations
under the
Automobile Insurance Act
(O.C. 2024- 085)

(Filed June 20, 2024)

Under the authority of section 60 of the *Automobile Insurance Act*, the Lieutenant-Governor in Council makes the following regulations.

Dated at St. John's, June 19, 2024.

Krista Quinlan
Clerk of the Executive Council

Analysis

Short title

1. These regulations may be cited as the *Automobile Accident Diagnostic and Treatment Protocols Regulations.*

2. In these regulations,

Definitions

(a) "Act" means the *Automobile Insurance Act;*

(b) "acupuncturist" means an acupuncturist as defined in the *Acupuncturists Regulations*;

(c) "adjunct therapist" means

(i) an acupuncturist,

(ii) a dentist,

(iii) a massage therapist,

(iv) a nurse,

(v) an occupational therapist, or

(vi) a psychologist;

(d) "applicant" means a patient or health care practitioner who sends in a completed claim form to an insurer in accordance with section 29;

(e) "authorization" means a written authorization by a health care practitioner for the diagnosis and treatment of a strain, sprain or whiplash associated disorder injury;

(f) "business day" means any day other than a

(i) Saturday,

(ii) Sunday, or

(iii) a holiday;

(g) "chiropractor" means a chiropractor as defined in the *Chiropractors Act, 2009*;

(h) "claim form" means the form approved by the superintendent for the purposes of these regulations and includes forms for assessments, treatment plans and reports;

(i) "dentist" means a practitioner as defined in the *Dental Act, 2008*;

(j) "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;

(k) "health care practitioner" means

(i) a chiropractor,

(ii) a physiotherapist,

(iii) a medical practitioner, or

(iv) a nurse practitioner;

(l) "history" means, in respect of a patient's injury,

(i) how the injury occurred,

(ii) the patient's current symptoms,

(iii) the patient's relevant past, including physical, psychological, emotional, cognitive and social past, and

(iv) how the patient's physical functions have been affected by the injury;

(m) "IMC register" means the register of injury management consultants referred to in section 25;

(n) "injury management consultant" means a person who is entered on the IMC register in accordance with section 26;

(o) "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;

(p) "massage therapist" means a massage therapist as defined in the *Massage Therapy Act, 2005*;

(q) "medical practitioner" means a medical practitioner as defined in the *Medical Act, 2011*;

(r) "nurse" means a registered nurse as defined in the *Registered Nurses Act, 2008*;

(s) "nurse practitioner" means a nurse practitioner as defined in the *Registered Nurses Act, 2008*;

(t) "occupational therapist" means an occupational therapist as defined in the *Occupational Therapists Act, 2005*;

(u) "patient" means an insured as defined in the Act;

(v) "physiotherapist" means a physiotherapist as defined in the *Physiotherapy Act, 2006*;

(w) "protocols" means the diagnostic and treatment protocols established by these regulations;

(x) "psychologist" means a registered psychologist as defined in the *Psychologists Act, 2005*;

(y) "spine" means the column of bone known as the vertebral column that surrounds and protects the spinal cord;

(z) "sprain" means an injury to

(i) one or more tendons,

(ii) one or more ligaments, or

(iii) tendons and ligaments;

(aa) "strain" means an injury to one or more muscles;

(bb) "treatment plan" means a treatment plan referred to in section 19; and

(cc) "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:

(i) objective, demonstrable, definable and clinically relevant neurological signs, or

(ii) a fracture to or a dislocation of the spine.

PART I
APPLICATION AND OPERATION

Application

3. (1) These regulations apply only where

(a) a patient elects to be diagnosed and treated in accordance with the protocols for a sprain, strain or whiplash associated disorder 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 whiplash associated disorder injury in accordance with the protocols.

(2) These regulations, except subsection 6(3), subsection 24(7) and Part IV, cease to apply in respect of an injury on the earlier of

(a) 90 days after the date of the accident; or

(b) when the maximum number of visits authorized by these regulations has been reached.

What constitutes a single visit

4. For the purpose of these regulations, one visit to a health care practitioner or another person authorized to provide treatment under these regulations constitutes a single visit, irrespective of the number of injuries treated during the visit.

Scope of practice of health care practitioners

5. Nothing in these regulations permits a health care practitioner to do anything that is outside the scope of that health care practitioner's practice as determined by the health care practitioner's governing body and legislation.

Authorizations

6. (1) An authorization shall be

(a) in writing; and

(b) issued within 90 days of the date of the accident in which the patient was injured.

(2) An authorization expires 90 days after the date of the accident in which the patient was injured.

(3) Notwithstanding subsection (2), where approved by an insurer, an authorization shall continue to be valid after the time period referred to in subsection (2).

(4) A health care practitioner may issue an authorization for that health care practitioner to provide the treatment described in section 12 or 17.

Application for additional services or supplies

7. Nothing in these regulations prevents or limits a patient or a health care practitioner from applying to an insurer for approval for a service or supply in addition to the limits specified in these regulations, and the insurer may, where the patient has access to accident benefits under a contract, approve the additional service or supply.

Interpretative bulletins and information circulars

8. 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 of the protocols;

(b) respecting the administration, implementation and operation of the protocols; and

(c) respecting any other matter the superintendent considers appropriate under these regulations.

Fees and disbursements

9. (1) The superintendent may set the fees and disbursements or the maximum fees and disbursements to be charged or paid for any service, activity or function authorized under these regulations, including the following:

(a) diagnostic imaging;

(b) laboratory testing;

(c) specialized testing;

(d) supplies;

(e) treatments;

(f) visits;

(g) therapy;

(h) assessments;

(i) reports; and

(j) claim forms.

(2) The fees and disbursements or maximum fees and disbursements set under subsection (1) shall be published in the Gazette.

(3) Where the superintendent sets the fees and disbursements or the maximum fees and disbursements under subsection (1), a person shall not charge or collect a fee or a disbursement that is greater than those fees and disbursements.

PART II
DIAGNOSTIC AND TREATMENT PROTOCOLS

Division 1
Diagnostic and Treatment Protocol for Strains and Sprains

Protocol established for strains and sprains

10. Sections 11 to 13 are established as the protocol for the diagnosis and treatment of strains and sprains.

Developing the diagnosis for strains and sprains

11. (1) Using evidence-informed practice and referring to the International Classification of Diseases, a health care practitioner shall diagnose a strain or sprain by

(a) taking a history of the patient;

(b) examining the patient;

(c) making an ancillary investigation; and

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

	First Degree Strain	**Second Degree Strain**	**Third 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
Pain on stretch	yes	yes	not if it is the only tissue injured; however, other structures may suffer first degree or second 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

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

	First Degree Sprain	**Second Degree Sprain**	**Third 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 first degree or second 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

Treatment for strains and sprains

12. (1) A healthcare practitioner shall treat a strain or sprain by

(a) educating the patient with respect to the following:

(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, or

(C) the patient's normal daily activities,

(ii) an estimate of the probable length of time that symptoms will last, and

(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, and

(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

(i) self-care, and

(ii) the patient's expected return to one or more of the activities described in clauses (1)(a)(i)(A) to (C);

(e) discussing the disadvantage of depending on health care providers and passive modalities of care for extended periods of time;

(f) providing 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

(g) any other treatment by an adjunct therapist 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.

(2) In addition to the treatment described in subsection (1), a healthcare practitioner shall treat a third degree strain or sprain 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.

(3) Notwithstanding subsections (1) and (2), 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.

Diagnostic and treatment authorization for strains and sprains

13. (1) A health care practitioner may authorize, for a first degree, second degree or third 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 claim form, if required;

(b) visits to a physiotherapist, chiropractor, or adjunct therapist necessary to provide the treatment described in section 12;

(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.

(2) The maximum number of treatment visits authorized under this protocol for the treatment of strains or sprains is prescribed in section 20 or 21.

Division 2
Diagnostic and Treatment Protocol for Whiplash Associated Disorder Injuries — Cervical, Thoracic, Lumbar and Lumbosacral

Protocol established for whiplash associated disorder injuries

14. Sections 15 to 18 are established as the protocol for the diagnosis and treatment of whiplash associated disorder injuries.

Developing the diagnosis for whiplash associated disorder injuries

15. Using evidence-informed practice, a health care practitioner shall diagnose a whiplash associated disorder injury by

(a) taking a history of the patient;

(b) examining the patient;

(c) making an ancillary investigation; and

(d) identifying the anatomical sites of the injury.

16. (1) Where a whiplash associated disorder injury is diagnosed, 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.

(2) Where a whiplash associated disorder I injury is diagnosed, further investigation of the injury is not warranted, unless a health care practitioner believes there is cause to do so.

(3) Where a whiplash associated disorder injury is diagnosed, 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.

(4) 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.

(5) 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.

17. A health care practitioner shall treat a whiplash associated disorder I or whiplash associated disorder II injury by

(a) educating the patient with respect to the following:

(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, or

(C) the patient's normal daily activities,

(ii) an estimate of the probable length of time that symptoms will last,

(iii) the estimated course of recovery,

(iv) the length of the treatment process,

(v) that there is likely no serious currently detectable underlying cause of the pain,

(vi) that the use of a soft collar is not advised, and

(vii) 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

(i) self-care, and

(ii) the patient's expected return to one or more of the activities described in clauses (a)(i)(A) to (C);

(c) discussing the disadvantage of depending on health care providers and passive modalities of care for extended periods of time;

(d) prescribing medication, where appropriate, including analgesics, for the sole purpose of short-term treatment of spinal injuries, but not including narcotics;

(e) any of the following, as appropriate:

(i) pain management,

(ii) exercise,

(iii) early return to normal activities,

(iv) cryo and thermal therapy, or

(v) preparing the patient for a return to one or more of the activities described in clauses (a)(i)(A) to (C);

(f) providing 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

(g) any other treatment by an adjunct therapist 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 whiplash associated disorder injuries

18. (1) A health care practitioner may authorize, for a whiplash associated disorder I or whiplash associated disorder II injury,

(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 in section 17;

(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.

(2) The maximum number of treatment visits authorized under this protocol for the treatment of a whiplash associated disorder is prescribed in section 20 or 21.

Division 3
Treatment Plans, Limits and Referrals to Injury Management Consultants

Treatment plans

19. (1) A treatment plan describing the treatments that will be provided under the protocols shall be prepared on a claim form.

(2) An insurer is not required to approve claims or provide payment for more than one treatment plan per patient per accident.

(3) A patient's treatment plan shall be completed by the health care practitioner that intends to provide the majority of treatment or will be actively coordinating the care and treatment visits of the patient.

(4) A health care practitioner shall provide copies of a patient's treatment plan to

(a) the patient's insurer;

(b) all health care practitioners providing treatment to the patient; and

(c) the patient.

(5) Before treating a patient under the protocols, a health care practitioner shall ask the patient if any other health care practitioner has been contacted about the patient's injury and, where other health care practitioners have been contacted, the health care practitioner shall

(a) document any actions taken by the other health care practitioners; and

(b) contact the patient's insurer to ensure no other treatment plan has been submitted or is anticipated.

Maximum number of visits authorized for treatment under protocols – single injury

20. (1) Where a patient has been diagnosed and treated under the protocols for a single injury, only one visit to a health care practitioner for assessment of the patient's injury is authorized.

(2) In addition to the assessment visit authorized under subsection (1), the maximum number of visits authorized for the treatment of a single injury under the protocols is prescribed in the following table:

Single Injury Diagnosed	Total Number of Visits Authorized
first or second degree strain or sprain	combined total of 10 visits to a physiotherapist, chiropractor or adjunct therapist
third degree strain or sprain	combined total of 21 visits to a physiotherapist, chiropractor or adjunct therapist
whiplash associated disorder I injury	combined total of 10 visits to a physiotherapist, chiropractor or adjunct therapist
whiplash associated disorder II injury	combined total of 21 visits to a physiotherapist, chiropractor or adjunct therapist

Maximum number of visits authorized for treatment under protocols – multiple injuries

21. (1) Where a patient is diagnosed and treated under the protocols for 2 or more injuries from a single accident, only one visit to a health care practitioner for assessment of the patient's injury is authorized.

(2) In addition to the assessment visit authorized under subsection (1), the maximum number of visits authorized for the treatment of 2 or more injuries under the protocols is prescribed in the following table:

	Multiple Injuries Diagnosed	Total Number of Visits Authorized
A	2 or more of • first degree strain • second degree strain • first degree sprain • second degree sprain • whiplash associated disorder I injury	combined total of 10 visits to a physiotherapist, chiropractor or adjunct therapist
B	one or more of the injuries in row A plus one or more of • third degree strain • third degree sprain • whiplash associated disorder II injury	combined total of 21 visits to a physiotherapist, chiropractor or adjunct therapist
C	2 or more of • third degree sprain • third degree strain • whiplash associated disorder II injury	combined total of 21 visits to a physiotherapist, chiropractor or adjunct therapist

Limits for treatment by adjunct therapists

22. (1) Notwithstanding section 20 or 21, a visit to the following adjunct therapists shall not count towards the maximum number of visits authorized for the treatment of a strain, sprain or whiplash associated disorder injury:

(a) a dentist;

(b) an occupational therapist; and

(c) a psychologist.

(2) The maximum amount of expenses payable or recoverable in relation to treatment from one or more of the adjunct therapists referred to in subsection (1) shall not exceed $1000.

Assessment of injury to which protocols do not apply

23. Where after an assessment, a physiotherapist or a chiropractor diagnoses an injury as one to which these protocols do not apply, the assessment may be claimed under these regulations.

Referral to injury management consultant

24. (1) A health care practitioner may authorize a single visit by a patient to an injury management consultant of the health care practitioner's choice for an assessment of the patient's injury where the health care practitioner

(a) is uncertain

(i) about an injury to which the protocols apply, or

(ii) about the diagnosis or treatment of the injury; or

(b) requires another opinion or report because the health care practitioner believes that the injury

(i) is not resolving appropriately, or

(ii) is not resolving within the time expected.

(2) A health care practitioner shall seek to reassess a patient where

(a) the patient is diagnosed with a sprain, strain, whiplash associated disorder I injury or whiplash associated disorder II injury; and

(b) the patient has any alerting factors that may influence prognosis.

(3) Following a reassessment under subsection (2), where the patient's injury is not resolving, a health care practitioner shall authorize a single visit by the patient to an injury management consultant for an assessment and report.

(4) On a visit authorized under subsection (1) or (3), an injury management consultant shall complete an assessment and prepare a report that 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.

(5) The visit and the costs and expenses related to an assessment and report by an injury management consultant under subsection (4) may be claimed under these regulations.

(6) The visit to an injury management consultant under this section shall not count towards the maximum number of visits authorized under section 20 or 21.

(7) Notwithstanding anything in these regulations, where approved by an insurer, a health care practitioner may refer a patient for a visit to an injury management consultant for an assessment and report under this section

(a) after the time period referred to in paragraph 6(1)(b); or

(b) after the maximum number of visits authorized under section 20 or 21 has been reached.

(8) Other than a visit, assessment and report authorized under this section, a further visit to or an assessment or report by an injury management consultant in respect of the same injury is not

authorized under these regulations unless approved by the insurer.

PART III
INJURY MANAGEMENT CONSULTANTS REGISTER

Register established

25. (1) The superintendent shall establish and maintain a register of injury management consultants.

(2) The superintendent shall ensure that the IMC register is published in a form and manner that is accessible to the public.

Eligibility requirements

26. The superintendent may enter a person on the IMC register where

(a) the person requests the superintendent enter the person on the IMC register;

(b) the person provides the superintendent with proof, satisfactory to the superintendent, that the person is experienced in rehabilitation and disability management; and

(c) the superintendent confirms with the following bodies that the person is an active practising member of that person's profession in good standing:

(i) for a medical practitioner, the College of Physicians and Surgeons of Newfoundland and Labrador,

(ii) for a chiropractor, the Newfoundland and Labrador Chiropractic Board,

(iii) for a physiotherapist, the Newfoundland and Labrador College of Physiotherapists,

(iv) for a dentist, the Newfoundland and Labrador Dental Board, and

(v) for a nurse practitioner, the College of Registered Nurses of Newfoundland and Labrador.

Ceasing to be an injury management consultant

27. (1) A person entered on the IMC register shall notify the superintendent where the person no longer meets the requirements prescribed in section 26.

(2) A person ceases to be an injury management consultant where

(a) the person no longer meets the requirements prescribed in section 26; and

(b) the superintendent removes the person's name from the IMC register.

PART IV
CLAIMS AND PAYMENT OF CLAIMS

Priority of sections 29 to 35

28. Sections 29 to 35 prevail in respect of any inconsistency or conflict between these sections and a contract that provides accident benefits.

Claims

29. (1) A patient or a health care practitioner may not make a claim under these regulations unless

(a) the patient has completed a claim form that includes the following information:

(i) details of the injury, and

(ii) details of the accident that are within the personal knowledge of the patient; and

(b) the insurer has received the completed claim form.

(2) The completed claim form required under subsection (1) shall be sent to the insurer no later than

(a) 10 business days after the date of the accident; or

(b) where the insurer has determined that the deadline in paragraph (a) is not reasonable, within the timeframe set by the insurer.

(3) A patient may appeal a determination of an insurer under paragraph (2)(b) to the superintendent where the patient believes the insurer has not adequately considered the patient's circumstances.

Decision by insurer

30. (1) No later than 5 business days after receiving a completed claim form, an insurer shall notify the applicant in writing that the insurer

(a) approves the claim; or

(b) refuses the claim, including the insurer's reason for refusing the claim.

(2) 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.

Failure of insurer to respond

31. Where an insurer does not notify the applicant in accordance with section 30, the insurer

(a) is deemed to have approved the claim; and

(b) is liable to pay the claim under section 33.

Subsequent denial of liability

32. (1) An insurer that approves a claim, or is deemed to have approved a claim, may subsequently deny liability in accordance with subsections (2) and (3).

(2) An insurer may only refuse a claim under subsection (1) for the reasons prescribed in subsection 30(2).

(3) An insurer may deny liability by sending a notice, in writing, including the reasons why the claim is denied to the following persons:

(a) the patient; and

(b) every person authorized under the claim form that

(i) the patient is authorized to visit, or

(ii) is authorized to provide services or supplies to the patient.

(4) A notice of denial under this section takes effect on the date it is received by the patient and, on and after the date the patient receives the notice of denial, the insurer is not liable to pay any future claim under these regulations relating to the patient's injuries.

Making and paying claims

33. (1) A service, supply, treatment, testing, medication, or other activity or function authorized under these regulations may be the subject of a claim under subsection (2).

(2) An insurer shall pay a claim that is authorized by these regulations or authorized by a health care practitioner or injury management consultant under these regulations no later than 30 days after receiving a claim, provided that

(a) where the claim is submitted by a health care practitioner, injury management consultant or an adjunct therapist, the claim is also verified by the patient; or

(b) where the claim is submitted by the patient, the claim includes

(i) a receipt for the benefit provided, and

(ii) satisfactory evidence that the claim is authorized by these regulations or a health care practitioner under these regulations.

Sending notices

34. A notice required or permitted under this Part 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

35. Where a person has a claim under the protocols and a claim under a contract that provides accident benefits, the claimant shall comply with these regulations and the provisions of the accident benefits, according to the claim or claims made.

Commencement

36. These regulations shall come into force on the date section 6 and subsection 10(5) of the *Automobile Insurance (Amendment) Act*, SNL 2019, c.14 come into force.