


PROVINCE OF BRITISH COLUMBIA
ORDER OF THE LIEUTENANT GOVERNOR IN COUNCIL

Order in Council No. 595, Approved and Ordered November 9, 2018



Lieutenant Governor

Executive Council Chambers, Victoria

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and consent of the Executive Council, orders that

- (a) the Insurance (Vehicle) Regulation, B.C. Reg. 447/83, is amended as set out in the attached Appendix 1,
- (b) effective April 1, 2019, the Insurance (Vehicle) Regulation, B.C. Reg. 447/83, is amended as set out in the attached Appendix 2 and
- (c) effective April 1, 2019, the Minor Injury Regulation, as set out in the attached Appendix 3, is made.



Attorney General



Presiding Member of the Executive Council

(This part is for administrative purposes only and is not part of the Order.)

Authority under which Order is made:

Act and section: *Insurance (Vehicle) Act*, R.S.B.C. 1996, c. 231, ss. 42 (2) (d.1), 45.1, 104 (1) (a), 105 (2) (b)

Other: OIC 1897/83

R20246233

APPENDIX 1

- 1 The Insurance (Vehicle) Regulation, B.C. Reg. 447/83, is amended by adding the following section:*

Limit of liability – loans and advance payments

- 67.1** For the purposes of section 83 (1) (c) of the Act, the prescribed circumstance is that
- (a) a person has a claim for damages respecting a loss or expense similar to a loss or expense covered by benefits within the meaning of section 1.1 of the Act,
 - (b) the person receives a loan or an advance payment in relation to the loss or expense, and
 - (c) the person must repay the loan or advance payment, in full or in part, if the person receives or is entitled to receive an award of damages, or enters into a settlement, in relation to the claim.

APPENDIX 2

- 1 Section 1 (1) of the Insurance (Vehicle) Regulation, B.C. Reg. 447/83, is amended*

- (a) by adding the following definitions:*

“acupuncturist” means a person entitled to practise acupuncture under the *Health Professions Act* or a similar law of another jurisdiction;

“chiropractor” means a person entitled to practise chiropractic under the *Health Professions Act* or a similar law of another jurisdiction;

“counsellor” means a person

- (a) who is a member in good standing of an association whose members provide the health care services of clinical or counselling psychology,
- (b) who holds a master’s degree or doctorate in psychology, psychiatry, social work or clinical or counselling psychology, and
- (c) whose health care services of clinical or counselling psychology are overseen by a person who is a member of a health profession as defined in the *Health Professions Act* or a similar law of another jurisdiction;

“dentist” means a person entitled to practise dentistry under the *Health Professions Act* or a similar law of another jurisdiction; ,

- (b) by repealing the definition of “dependent child” and substituting the following:*

“dependent child” means any of the following:

- (a) a person under 19 years of age for whose support an insured is legally liable and who is dependent on the insured for financial support;
- (b) a person 19 years of age or older who resides with an insured and receives most of the person’s financial support from the insured because of a mental or physical disability;
- (c) a child of an insured who is born after the death of the insured and survives for at least 60 days after birth; ,

(c) *by repealing the definition of “head of household”,*

(d) *by adding the following definitions:*

“**kinesiologist**” means a person

- (a) who is a member in good standing of an association whose members provide the health care services of kinesiology, and
- (b) whose health care services of kinesiology are overseen by a person who is a member of a health profession as defined in the *Health Professions Act* or a similar law of another jurisdiction;

“**massage therapist**” means a person entitled to practise massage therapy under the *Health Professions Act* or a similar law of another jurisdiction;

“**occupational therapist**” means a person entitled to practise occupational therapy under the *Health Professions Act* or a similar law of another jurisdiction;

“**physician**” means the following:

- (a) a medical practitioner;
- (b) a person who is a registrant of a college under a similar law to the *Health Professions Act* in another jurisdiction;

“**physiotherapist**” means a person entitled to practise physical therapy under the *Health Professions Act* or a similar law of another jurisdiction;

“**psychologist**” means a person entitled to practise psychology under the *Health Professions Act* or a similar law of another jurisdiction; ,

(e) *in the definition of “rehabilitation” by striking out “of his injuries,” and substituting “of the injured person’s injuries,” and*

(f) *in the definition of “territory” by striking out “section 34 (1.1) of the Act” and substituting “section 34 (2) (a) of the Act”.*

2 *Section 1 is amended by adding the following subsection:*

(2.1) For the purposes of the definition of “health care practitioner” in section 1 (1) of the Act,

- (a) the following classes of persons are prescribed with respect to paragraph (c) of that definition:
 - (i) acupuncturist;
 - (ii) chiropractor;
 - (iii) dentist;
 - (iv) massage therapist;
 - (v) occupational therapist;
 - (vi) physiotherapist;
 - (vii) psychologist, and
- (b) the following classes of persons are prescribed with respect to paragraph (d) of that definition:
 - (i) counsellor;

(ii) kinesiologist.

3 *The heading of Part 2 is repealed and the following substituted:*

PART 2 – CERTIFICATES .

4 *Section 3 is amended by striking out “an owner’s certificate” and substituting “a certificate”.*

5 *Section 5 is repealed.*

6 *Section 7 is amended by striking out “do not” and substituting “does not” and by striking out “an owner’s certificate” in both places and substituting “a certificate”.*

7 *Section 9 (3) is amended by striking out “in the certificate” and substituting “in the owner’s certificate” and by striking out “on the owner’s certificate” and substituting “on the certificate”.*

8 *Section 11 (1) is amended*

(a) in the definition of “applicant” by striking out “a new or renewal certificate;” and substituting “a new owner’s certificate or renewal of an owner’s certificate;”, and

(b) by repealing the definitions of “base rate premium” and “certificate”.

9 *Section 78 is amended*

(a) by repealing the definitions of “chiropractor”, “dentist” and “head of household”,

(b) in the definition of “homemaker” by striking out “the male or female member” and substituting “the member”, and

(c) by repealing the definitions of “medical practitioner” and “physiotherapist”.

10 *Section 79 is amended*

(a) in subsection (1) by striking out “that arises out of the use or operation of a vehicle and”, and

(b) in subsection (2) by striking out “unless he” and substituting “unless the cyclist or pedestrian” and by striking out “in a certificate.” and substituting “in an owner’s certificate or a driver’s certificate.”

11 *Section 87 is amended by striking out “medical adviser.” and substituting “medical advisor.”*

12 *Section 88 is amended*

(a) by adding the following subsection:

(0.1) In this section:

“British Columbia consumer price index” means the annual average All-items Consumer Price Index for British Columbia, as published by Statistics Canada under the authority of the *Statistics Act* (Canada);

“fiscal year” means the period beginning on April 1 in one year and ending on March 31 in the next year. ,

(b) by repealing subsection (1) and substituting the following:

- (1) If an insured is injured in an accident for which benefits are provided under this Part, the corporation must, subject to this section, pay as benefits all reasonable expenses incurred by the insured as a result of the injury for necessary
- (a) health care services listed in Column A of Table 1 or Table 2, as applicable, of Schedule 3.1 and provided by the applicable health care practitioner,
 - (b) occupational therapy provided by an occupational therapist, and
 - (c) dental, hospital, ambulance and professional nursing services, speech therapy, prostheses and orthoses.

(c) by adding the following subsections:

- (1.01) For the purposes of subsection (1) (a), a treatment of a health care service
- (a) that is in addition to the number of treatments listed in Column D of Table 1 of Schedule 3.1 corresponding to that health care service, or
 - (b) that is provided more than 12 weeks after the date of the accident
- is not a necessary health care service unless the corporation’s medical advisor or the insured’s physician certifies to the corporation in writing that, in the opinion of the medical advisor or physician, the treatment is necessary for the insured.
- (1.2) Subject to subsection (1.3), the benefits paid under subsection (1) must not,
- (a) for each health care service referred to in subsection (1) (a), exceed the fee limit set out in Column B or C, as applicable, of Table 1 of Schedule 3.1 corresponding to that health care service,
 - (b) for occupational therapy, exceed the fee limit of \$112 per hour, and
 - (c) for each health care service referred to in subsection (1) (a) that is provided by a physician, exceed the fee limit set out in Column B of Table 2 of Schedule 3.1.
- (1.3) For the fiscal year beginning on April 1, 2020, and for each fiscal year after that, each fee limit referred to in subsection (1.2) must be determined annually by multiplying
- (a) the fee limit amount for the immediately preceding fiscal year, and
 - (b) the sum of
 - (i) 1, and
 - (ii) the annual percentage change in the British Columbia consumer price index, as determined under subsection (1.5) and rounded to the nearest 1/10 of a percentage point.

- (1.4) Despite subsection (1.3) (b) (ii), if the annual percentage change as determined under subsection (1.5) is a negative number, the annual percentage change is rounded up to zero.
- (1.5) The annual percentage change referred to in subsection (1.3) (b) (ii) must be calculated using the following formula:

$$APC = \frac{CPI1 - CPI2}{CPI2}$$

where

- APC = the annual percentage change in the British Columbia consumer price index;
- CPI1 = the sum of the 12 individual monthly British Columbia consumer price indexes for the consecutive 12 month period ending on December 31 of the fiscal year immediately preceding the fiscal year for which the fee limit is being determined;
- CPI2 = the sum of the 12 individual monthly British Columbia consumer price indexes for the consecutive 12-month period immediately preceding the 12 month period referred to in the description of CPI1.

- (1.6) The fee limit amount determined under subsection (1.3) must be rounded to the nearest dollar and an amount ending in .50 must be rounded up to the next dollar. ,
- (d) in subsection (2) by striking out “medical adviser,” and substituting “medical advisor,”**
- (e) in subsection (2) (c) (ii) by striking out “motor vehicle”,**
- (f) in subsection (2) by adding the following paragraph:**
- (d.1) reimbursement to the insured for costs incurred from time to time by the insured for the purchase of health care supplies or of health care services not referred to in subsection (1), not exceeding the amount set out in section 3 (3) of Schedule 3; ,
- (g) in subsection (2) (e) (i) by striking out “and his post-injury” and substituting “and post-injury”,**
- (h) in subsection (2) (e) (ii) by striking out “to his pre-injury status” and substituting “to the insured’s pre-injury status”,**
- (i) in subsection (6) by striking out “by another insurer.” and substituting “by another insurer, except expenses referred to in subsection (1) (a) and (b).”, and**
- (j) by repealing subsections (7) and (8) and substituting the following:**

- (7) The maximum amount payable by the corporation under this section for health care services, except for the health care services listed in Column A of Table 1 or Table 2 of Schedule 3.1, is the amount set out in a payment schedule for that service established by the Medical Services Commission under section 26 of the *Medicare Protection Act*, as that schedule is amended from time to time, for that service.

13 *Section 90 (1) is amended by striking out “medical adviser or vocational adviser” and substituting “medical advisor or vocational advisor”.*

14 *Sections 92, 93 and 94 are repealed and the following substituted:*

Death benefits

- 92** (1) The corporation must pay, if the death of an insured is caused by an accident for which benefits are provided under this Part, a death benefit as follows:
- (a) if the deceased insured is survived by one spouse and no dependants, a single lump sum amount of \$30 000 payable to the spouse;
 - (b) if the deceased insured is survived by one spouse and one or more dependants,
 - (i) a single lump sum amount of \$30 000 payable to the spouse, and
 - (ii) a single lump sum amount of \$6 000 payable to each dependant;
 - (c) if the deceased insured is survived by more than one spouse and no dependants,
 - (i) a total amount of \$30 000 divided equally among the spouses and payable to each spouse, and
 - (ii) a single lump sum amount of \$6 000 payable to each spouse;
 - (d) if the deceased insured is survived by more than one spouse and one or more dependants,
 - (i) a total amount of \$30 000 divided equally among the spouses and payable to each spouse, and
 - (ii) a single lump sum amount of \$6 000 payable to each spouse and to each dependant;
 - (e) if the deceased insured is survived by no spouse and one dependant, a single lump sum amount of \$30 000 payable to the dependant;
 - (f) if the deceased insured is survived by no spouse and more than one dependant,
 - (i) a total amount of \$30 000 divided equally among the dependants and payable to each dependent, and
 - (ii) a single lump sum amount of \$6 000 payable to each dependant.
- (2) The corporation must pay a death benefit as set out in subsection (3) or (4), as applicable, if
- (a) the death of an insured is caused by an accident for which benefits are provided under this Part, and

- (b) the deceased insured is a deceased dependent child within the meaning of subsection (8).
- (3) If the deceased insured is survived by one parent
- (a) who was legally liable to financially support the deceased insured and on whom the deceased insured was dependent, or
 - (b) with whom the deceased insured resided at the time of death and from whom the deceased insured received most of the insured's financial support because of a mental or physical disability,
- the corporation must pay a death benefit in a single lump sum amount of \$3 000 to the surviving parent.
- (4) If the deceased insured is survived by more than one parent
- (a) who was legally liable to financially support the deceased insured and on whom the deceased insured was dependent, or
 - (b) with whom the deceased insured resided at the time of death and from whom the deceased insured received most of the insured's financial support because of a mental or physical disability,
- the corporation must pay a death benefit in a total amount of \$3 000 divided equally among the surviving parents and payable to each surviving parent.
- (5) If
- (a) the death of an insured is caused by an accident for which benefits are provided under this Part,
 - (b) the deceased insured is a deceased dependent parent within the meaning of subsection (9), and
 - (c) the deceased insured is survived by a child with whom the deceased insured, at the time of death, resided and who provided most of the deceased insured's financial support,
- the corporation must pay a death benefit in a single lump sum amount of \$3 000 to the surviving child.
- (6) Any benefits payable under this section to a dependent child of a deceased insured must be paid in accordance with section 92 of the Act.
- (7) An entitlement to benefits payable under this section must be determined as of the date of the death of the insured.
- (8) For the purposes of subsection (2), “**deceased dependent child**” means any of the following:
- (a) a deceased insured who, at the time of death, was under 19 years of age and for whose support a parent was legally liable and who was dependent on the parent for financial support;
 - (b) a deceased insured who, at the time of death, was 19 years of age or older, resided with a parent and received most of the insured's financial support from the parent because of a mental or physical disability.

- (9) For the purposes of subsection (5), a “**deceased dependent parent**” means a deceased insured who was a parent who, at the time of death, resided with a child and received most of the insured’s financial support from the child.

15 Section 95 is amended

- (a) *in subsection (1) by striking out “under section 92 or 93 shall be” and substituting “under section 92 must be”, and*
- (b) *by repealing subsection (2).*

16 Section 98 (1) is amended by striking out “shall” and substituting “must” and by striking out “medical practitioner, dentist, physiotherapist or chiropractor” and substituting “health care practitioner”.

17 Section 99 (1) is amended by striking out “shall” and substituting “must” and by striking out “medical practitioner, dentist, physiotherapist or chiropractor” and substituting “health care practitioner”.

18 Section 100 (1) and (2) is amended by striking out “under section 92 or 93” and substituting “under section 92”.

19 Section 103 is repealed and the following substituted:

Limitation

- 103** (1) An insured must not commence an action in respect of benefits under this Part unless
- (a) the insured has substantially complied with the provisions of sections 97 to 100 that are applicable to the insured, and
 - (b) the action is commenced as follows:
 - (i) if the insured has issued written notice to the corporation under subsection (3) and the corporation has issued a written response, the action must be commenced by the later of the following:
 - (A) within 3 months after the date of the response from the corporation;
 - (B) within 2 years after the date of the accident for which the benefits are claimed;
 - (C) if benefits have been paid, within 2 years after the date the last benefit payment under this Part was made;
 - (ii) if the insured has issued written notice to the corporation under subsection (3) and the corporation has not issued a written response, subject to subsection (2), the action may be commenced at any time;
 - (iii) if the insured has not issued written notice to the corporation under subsection (3), the action must be commenced within 2 years after
 - (A) the date of the accident for which the benefits are claimed, or
 - (B) if benefits have been paid, the date the last benefit payment under this Part was made.

- (2) If the corporation issues a written response to a notice issued under subsection (3), the action must be commenced in accordance with subsection (1) (b) (i).
- (3) An insured may issue written notice to the corporation of the insured's intention to commence an action in respect of benefits under this Part if the insured makes a claim for benefits under this Part
 - (a) that has been denied, or
 - (b) for which the corporation has not made a payment in accordance with section 101.
- (4) The notice referred to in subsection (3) must be
 - (a) in the form established by the corporation,
 - (b) sent by registered mail addressed to the claim office dealing with the insured's claim, and
 - (c) received by the corporation within 2 years after the later of the following:
 - (i) the date of the accident for which benefits are claimed;
 - (ii) if benefits have been paid, the date the last benefit payment under this Part was made.
- (5) The written response by the corporation referred to in subsections (1) (b) (i) and (2) must be either personally delivered to the insured or forwarded to the insured by registered mail to the last known address of the insured.

20 *The following sections are added to Part 7:*

Transitional – disability benefits, funeral expenses and death benefits

- 104.1** (1) For the purposes of section 80 (1), the applicable amount of disability benefits set out in section 2 of Schedule 3
- (a) as it read immediately before April 1, 2019 continues to apply in relation to disability benefits payable by the corporation under section 80 (1) (a) under a certificate issued before April 1, 2019, and
 - (b) as it reads on April 1, 2019 applies in relation to disability benefits payable by the corporation under section 80 (1) (a) under a certificate issued on or after April 1, 2019.
- (2) For the purposes of section 84, the maximum amount per week as set out in section 2 of Schedule 3
- (a) as it read immediately before April 1, 2019 continues to apply in relation to disability benefits for homemakers payable by the corporation under section 84 (1) under a certificate issued before April 1, 2019, and
 - (b) as it reads on April 1, 2019 applies in relation to disability benefits for homemakers payable by the corporation under section 84 (1) under a certificate issued on or after April 1, 2019.
- (3) For the purposes of section 91, the amount set out in section 4 of Schedule 3,

- (a) as it read immediately before April 1, 2019 continues to apply in relation to burial and funeral expenses payable by the corporation under section 91 under a certificate issued before April 1, 2019, and
 - (b) as it reads on April 1, 2019 applies in relation to burial and funeral expenses payable by the corporation under section 91 under a certificate issued on or after April 1, 2019.
- (4) Sections 92 and 93 and sections 5 and 6 of Schedule 3 as they read immediately before April 1, 2019 continue to apply in relation to death benefits payable by the corporation under those sections under a certificate issued before April 1, 2019, and section 92 as it reads on April 1, 2019 applies in relation to death benefits payable by the corporation under that section under a certificate issued on or after April 1, 2019.

Transitional – medical or rehabilitation benefits

- 104.2** Section 88 as it reads on April 1, 2019 applies in relation to medical or rehabilitation benefits payable under section 88 under a certificate that is valid on April 1, 2019 regardless of the date of issue of the certificate or the date of the accident.

Transitional – limitation

- 104.3** Section 103 as it read immediately before April 1, 2019 continues to apply in relation to an action in respect of benefits under this Part in relation to an accident that occurred before April 1, 2019, and section 103 as it reads on April 1, 2019 applies in relation to an action in respect of benefits under this Part in relation to an accident that occurs on or after April 1, 2019.

21 *Section 148.2 (4) (a) is amended by striking out “a vehicle accident” and substituting “an accident”.*

22 *Section 154 is repealed.*

23 *Section 168 (5) is amended by striking out “policy” in both places and substituting “certificate”.*

24 *Section 2 of Schedule 3 is amended*

(a) in paragraph (a) by striking out “\$300” and substituting “\$740”, and

(b) in paragraph (b) by striking out “\$145” and substituting “\$280”.

25 *Section 3 of Schedule 3 is amended by adding the following subsections:*

- (3) The maximum amount that may be reimbursed under section 88 (2) (d.1) for health care supplies, health care services or a combination of health care supplies and health care services is \$1 000.
- (4) The amount referred to in subsection (3) is part of the maximum amounts set out in subsection (2).

26 Section 4 of Schedule 3 is amended by striking out “\$2 500.” and substituting “\$7 500.”

27 Sections 5, 6, 7 and 8 of Schedule 3 are repealed.

28 The following Schedule is added:

SCHEDULE 3.1

HEALTH CARE SERVICES, FEE LIMITS AND PRE-AUTHORIZED TREATMENTS

Definition

- 1 In this Schedule, “registered care advisor” has the same meaning as in the Minor Injury Regulation.

Table 1

Item	Column A Health Care Service	Column B Fee Limit for Assessment Visit and Report	Column C Fee Limit for Standard Treatment	Column D Number of Pre-Authorized Treatments
1	Acupuncture	\$105	\$88	12
2	Chiropractic	\$199	\$53	25
3	Counselling	\$210	\$120	12
4	Kinesiology	\$135	\$78	12
5	Massage therapy	\$107	\$80	12
6	Physiotherapy	\$250	\$79	25
7	Psychology	\$340	\$195	12

Table 2

Item	Column A Health Care Service Provided by Physician	Column B Fee Limit for Health Care Service Provided by Physician
1	Standard assessment and report	\$120
2	Extended assessment and report	\$325
3	Re-assessment and report	\$210
4	Initial registered care advisor assessment and report	\$380
5	Follow-up registered care advisor assessment	\$120

29 Schedule 7 is repealed.

APPENDIX 3

MINOR INJURY REGULATION

Contents

PART 1 – DEFINITIONS

- 1 Definitions
- 2 Prescribed injury for definition of “minor injury”
- 3 Prescribed criteria for definition of “serious impairment”

PART 2 – RULES IN RELATION TO MINOR INJURIES

- 4 Burden of proof
- 5 Multiple injuries
- 6 Limit on damages for non-pecuniary loss

PART 3 – REGISTERED CARE ADVISORS

- 7 Registered care advisors
- 8 Declaration of registered care advisor
- 9 Registered care advisor register
- 10 Referral to registered care advisor
- 11 Assessment and report by registered care advisor
- 12 Restrictions on role of registered care advisor

SCHEDULE

PART 1 – DEFINITIONS

Definitions

- 1 (1) In this regulation:
 - “**Act**” means the *Insurance (Vehicle) Act*;
 - “**activities of daily living**” means the following activities:
 - (a) preparing own meals;
 - (b) managing personal finances;
 - (c) shopping for personal needs;
 - (d) using public or personal transportation;
 - (e) performing housework to maintain a place of residence in acceptable sanitary condition;
 - (f) performing personal hygiene and self-care;
 - (g) managing personal medication;
 - “**college**” means the College of Physicians and Surgeons of British Columbia continued under the *Health Professions Act*;
 - “**current for clinical practice**” means that a physician has practised medicine, excluding research, teaching and administrative work, within the scope of the physician’s certified training and experience for at least 24 weeks in the last 3 years;

“evidence-informed practice” means the current best practice for making decisions about the care of a patient, integrating individual clinical expertise with the best available clinical evidence from systematic research;

“incapacity”, in relation to a claimant, means a mental or physical incapacity that

- (a) is not resolved within 16 weeks after the date the incapacity arises, and
- (b) is the primary cause of a substantial inability of the claimant to perform
 - (i) essential tasks of the claimant’s regular employment, occupation or profession, despite reasonable efforts to accommodate the claimant’s incapacity and the claimant’s reasonable efforts to use the accommodation to allow the claimant to continue the claimant’s employment, occupation or profession,
 - (ii) the essential tasks of the claimant’s training or education in a program or course that the claimant was enrolled in or had been accepted for enrolment in at the time of the accident, despite reasonable efforts to accommodate the claimant’s incapacity and the claimant’s reasonable efforts to use the accommodation to allow the claimant to continue the claimant’s training or education, or
 - (iii) the claimant’s activities of daily living;

“ministry” means the ministry of the minister responsible for the administration of the Act;

“physician” has the same meaning as in the Insurance (Vehicle) Regulation;

“register” means the registered care advisor register established under section 9 [*registered care advisor register*];

“registered care advisor” means a registered care advisor registered on the register;

“TMJ disorder” means an injury that involves or surrounds the temporomandibular joint;

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

- (a) decreased or absent deep tendon reflexes, deep tendon weakness or sensory deficits, or other demonstrable and clinically relevant neurological symptoms;
- (b) a fracture to or dislocation of the spine.

(2) For the purposes of the definition of “diagnostic and treatment protocol” in section 101 (1) [*definitions and interpretation*] of the Act, the protocols established in the Schedule to this regulation are prescribed.

(3) For the purposes of the definition of “minor injury” in section 101 (1) of the Act and this regulation:

“pain syndrome” means a syndrome, disorder or other clinical condition associated with pain, including pain that is not resolved within 3 months;

“psychological or psychiatric condition” means a clinical condition that

- (a) is of a psychological or psychiatric nature, and
- (b) does not result in an incapacity;

“sprain” means an injury to one or more ligaments unless all the fibres of at least one of the injured ligaments are torn;

“strain” means an injury to one or more muscles unless all the fibres of at least one of the injured muscles are torn.

Prescribed injury for definition of “minor injury”

- 2 The following injuries are prescribed injuries for the purposes of paragraph (b) (iv) of the definition of “minor injury” in section 101 (1) of the Act:
- (a) a concussion that does not result in an incapacity;
 - (b) a TMJ disorder;
 - (c) a WAD injury.

Prescribed criteria for definition of “serious impairment”

- 3 For the purposes of paragraph (b) of the definition of “serious impairment” in section 101 (1) of the Act, the claimant’s physical or mental impairment must meet the following prescribed criteria:
- (a) the impairment results in a substantial inability of the claimant to perform
 - (i) the essential tasks of the claimant’s regular employment, occupation or profession, despite reasonable efforts to accommodate the claimant’s impairment and the claimant’s reasonable efforts to use the accommodation to allow the claimant to continue the claimant’s employment, occupation or profession,
 - (ii) the essential tasks of the claimant’s training or education in a program or course that the claimant was enrolled in or had been accepted for enrolment in at the time of the accident, despite reasonable efforts to accommodate the claimant’s impairment and the claimant’s reasonable efforts to use the accommodation to allow the claimant to continue the claimant’s training or education, or
 - (iii) the claimant’s activities of daily living;
 - (b) the impairment is primarily caused by the accident and is ongoing since the accident;
 - (c) the impairment is not expected to improve substantially.

PART 2 – RULES IN RELATION TO MINOR INJURIES

Burden of proof

- 4 In civil proceedings relating to an injury, the burden of proof that the injury is not a minor injury is on the party making the allegation that it is not a minor injury.

Multiple injuries

- 5 If a claimant sustains more than one injury as a result of an accident,
- (a) each injury must be diagnosed separately as to whether the injury is or is not a minor injury,

- (b) if there are one or more minor injuries and one or more non-minor injuries, the total amount of damages assessed for non-pecuniary loss for all the injuries is the sum of
 - (i) the amount of damages assessed for non-pecuniary loss for the minor injuries, and
 - (ii) the amount of damages assessed for non-pecuniary loss for the non-minor injuries, and
- (c) the maximum amount of damages for non-pecuniary loss recoverable by the claimant for all the minor injuries in total must not exceed the minor injury limit.

Limit on damages for non-pecuniary loss

6 (1) In this section:

“**British Columbia consumer price index**” means the annual average All-items Consumer Price Index for British Columbia, as published by Statistics Canada under the authority of the *Statistics Act* (Canada);

“**fiscal year**” means the period beginning on April 1 in one year and ending on March 31 in the next year;

“**minor injury limit**” means,

- (a) for the fiscal year beginning on April 1, 2019, \$5 500, and
- (b) for the fiscal year beginning on April 1, 2020, and for each fiscal year after that, the amount calculated under subsection (2).

(2) For the fiscal year beginning on April 1, 2020, and for each fiscal year after that, the minor injury limit must be determined annually by multiplying

- (a) the minor injury amount for the immediately preceding fiscal year, and
- (b) the sum of

- (i) 1, and
- (ii) the annual percentage change in the British Columbia consumer price index, as determined under subsection (4) and rounded to the nearest 1/10 of a percentage point.

(3) Despite subsection (2), if the annual percentage change as determined under subsection (4) is a negative number, the annual percentage change is rounded up to zero.

(4) The annual percentage change referred to in subsection (2) (b) (ii) must be calculated using the following formula:

$$APC = \frac{CPI1 - CPI2}{CPI2}$$

where

- APC = the annual percentage change in the British Columbia consumer price index;
- CPI1 = the sum of the 12 individual monthly British Columbia consumer price indexes for the consecutive 12 month period ending on December 31 of the fiscal year immediately preceding the fiscal year for which the fee limit is being determined;
- CPI2 = the sum of the 12 individual monthly British Columbia consumer price indexes for the consecutive 12 month period immediately preceding the 12 month period referred to in the description of CPI1.

- (5) The minor injury limit determined under subsection (2) must be rounded to the nearest dollar and an amount ending in .50 must be rounded up to the next dollar.
- (6) For the fiscal year beginning on April 1, 2020, and for each fiscal year after that, the corporation must publish
- (a) the following information that applies to the fiscal year:
 - (i) the minor injury limit;
 - (ii) the calculations made under subsections (2) and (3) that result in the minor injury limit, and
 - (b) the information referred to in paragraph (a)
 - (i) before the end of the fiscal year that immediately precedes the fiscal year referred to in paragraph (a), and
 - (ii) by posting the information on a publicly accessible website maintained by or on behalf of the corporation.

PART 3 – REGISTERED CARE ADVISORS

Registered care advisors

- 7 (1) For the purposes of referrals under Part 7 [*Minor Injuries*] of the Act, registered care advisors are a prescribed class of persons.
- (2) The following are the prescribed requirements and qualifications for registered care advisors:
- (a) a registered care advisor must be a registrant in good standing with the college and registered in one of the full classes of registration with the college;
 - (b) a registered care advisor must be current for clinical practice;
 - (c) a registered care advisor must provide to the college a declaration in accordance with section 8;
 - (d) a registered care advisor must be registered in the registered care advisor register.

Declaration of registered care advisor

- 8** (1) In order for a physician to be registered in the register, the physician must provide the college with a declaration
- (a) of the physician's intent to be a registered care advisor,
 - (b) that the physician is current for clinical practice,
 - (c) of what the physician's class of licence issued by the college to the physician is, and what the physician's specialty is, if applicable,
 - (d) that the physician is knowledgeable in evidence-informed practice with specific competencies in the assessment and treatment of
 - (i) musculoskeletal injuries,
 - (ii) acute and chronic pain, or
 - (iii) mental health issues and other psychosocial issues, and
 - (e) of what the physician's business address and business telephone number are that the physician wants to have included in the register.
- (2) After the initial declaration is provided under subsection (1), a physician must provide the college with an annual declaration
- (a) of the physician's intent to continue to be a registered care advisor, and
 - (b) of the matters described in subsection (1) (b) to (e).
- (3) The college may provide to the ministry the following:
- (a) the information in a declaration provided by a physician to the college under subsection (1) or (2);
 - (b) confirmation whether or not the physician is a registrant in good standing with the college and registered in one of the full classes of registration with the college;
 - (c) notice if a physician is no longer a registrant in good standing with the college, if applicable.

Registered care advisor register

- 9** (1) The ministry must
- (a) establish the register, and
 - (b) include the information described in subsection (2) for each physician who
 - (i) is a registrant in good standing with the college and registered in one of the full classes of registration, and
 - (ii) provided to the college a declaration in accordance with section 8 (1) or (2).
- (2) For the purposes of subsection (1) (b), the following information must be included in the register:
- (a) the name of the registered care advisor;
 - (b) the class of licence issued by the college to the registered care advisor, and the registered care advisor's specialty, if applicable;

- (c) the business address and business phone number of the registered care advisor that the registered care advisor wants to have included in the register.
- (3) The ministry must remove a person from the register if
 - (a) the ministry receives a notice from the college under section 8 (4) (c) that the person is no longer a registrant in good standing with the college, or
 - (b) the person makes a written request to the ministry to be removed from the register.
 - (4) The corporation must publish the register on a publicly accessible website maintained by or on behalf of the corporation.
 - (5) For the purposes of the corporation publishing the register under subsection (4), the ministry must provide to the corporation the information to be published and the information the ministry receives from the college under section 8 (2).

Referral to registered care advisor

- 10 (1) A physician whose patient may have suffered a minor injury in an accident must consider, no later than 90 days after the date of the accident that caused the injury, referring the patient to a registered care advisor if one or more of the following circumstances apply:
 - (a) the physician is unable to make a clear diagnosis;
 - (b) the patient is not recovering from the injury as expected by the physician;
 - (c) there are factors complicating the patient's recovery from the injury.
- (2) If, after a referral under subsection (1),
 - (a) a registered care advisor assesses the patient and provides a report to the physician, and
 - (b) one or more of the circumstances set out in subsection (1) (a), (b) and (c) continue to apply,
 the physician may, within the first 9 months following the accident, refer the patient to the same or to a different registered care advisor.

Assessment and report by registered care advisor

- 11 If a registered care advisor accepts a referral under section 10, the registered care advisor must
 - (a) assess the patient's injury within 15 days after the date of the referral,
 - (b) consult with the referring physician as necessary,
 - (c) make a written report that provides advice to the referring physician about the diagnosis or treatment of the patient's injury, and
 - (d) provide the report to the referring physician within 10 days after the date the registered care advisor assesses the patient's injury.

Restrictions on role of registered care advisor

- 12 A registered care advisor who accepts a referral under section 10 must not
 - (a) be the referring physician, or

- (b) deliver the treatment to the patient as recommended in the registered care advisor's report.

SCHEDULE

DIAGNOSTIC AND TREATMENT PROTOCOLS

Definitions

- 1 In this Schedule, “**patient**” means a claimant as defined in section 101 (1) of the Act.

Evidence-informed practice

- 2 A health care practitioner must use evidence-informed practice when
 - (a) establishing a diagnosis of an injury of a patient under this protocol, and
 - (b) providing treatment, or making a referral for treatment, for an injury of a patient under this protocol.

Developing diagnoses for injuries

- 3 (1) If applicable, a health care practitioner must establish a diagnosis for a patient of the following:
 - (a) an abrasion
 - (b) a concussion;
 - (c) a contusion;
 - (d) a laceration;
 - (e) a pain syndrome;
 - (f) a sprain;
 - (g) a strain;
 - (h) a TMJ disorder;
 - (i) a WAD injury.
- (2) When diagnosing a sprain, strain or WAD injury, a health care practitioner must determine the severity of the injury.

Developing diagnoses for pain syndromes and for psychological or psychiatric conditions

- 4 If applicable, a health care practitioner must establish a diagnosis for a patient of a psychological or psychiatric condition by using the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Treatment protocols

- 5 (1) When treating a patient with an injury listed in section 3 or 4, a health care practitioner must educate the patient with respect to, at a minimum, the following matters:
 - (a) if applicable, the desirability of an early return

- (i) to the activities the patient could perform before the injury, and
 - (ii) to the patient's employment, occupation or profession or the patient's training or education in a program or course;
 - (b) an estimate of the probable length of time that symptoms will last;
 - (c) the usual course of recovery;
 - (d) the probable factors that are responsible for the symptoms the patient may be experiencing;
 - (e) appropriate self-management and pain management strategies.
- (2) When treating a pain syndrome and a psychological or psychiatric condition, a health care practitioner must identify comorbid conditions, if applicable.