Nova Scotia
Physiotherapy
Association

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Mr. David McCarron
Superintendent of Insurance, Province of Nova Scotia
P.O. Box 2271
Halifax, NS B3J 3C8

Nova Scotia Auto Insurance Review - Nova Scotia Physiotherapy Association

The Nova Scotia Physiotherapy Association (NSPA) is the professional voice for physiotherapists across the province, representing clinicians who work in community-based clinics, hospitals, rehabilitation centres, and interdisciplinary health teams. Our members provide first-line assessment, rehabilitation, and recovery support for thousands of Nova Scotians each year, including a significant proportion of individuals injured in motor vehicle collisions.

Because physiotherapists are often the first health professional to see patients after an accident—and frequently the provider who follows them throughout their entire recovery—we have a unique vantage point on how the current auto insurance system impacts access to care, patient outcomes, and clinical workflow. Our insights come from the collective experience of front-line clinicians who navigate Section B benefits daily, support patients through the Diagnostic and Treatment Protocols, and manage the administrative processes required by insurers.

The NSPA is participating in this review to share evidence-informed, patient-centred perspectives that reflect what is working well, where avoidable barriers persist, and what changes could meaningfully improve recovery timelines while reducing pressure on the broader health system. We have drawn from patterns that our members encounter regularly in clinical practice, collected through survey, as well as insights from relevant rehabilitation literature, to provide recommendations to improve the current auto-insurance system.

We welcome the opportunity to collaborate with researchers and policymakers to modernize the system in a way that strengthens patient access, supports provider autonomy, and promotes transparent, efficient claims processes.

We have included supplementary documents, including themes derived from a *2025 member survey regarding MVA Diagnostic and Treatment Protocols*, as well as *Fee Information for Physiotherapy Services* provided by itracks. We have referenced these documents throughout the following responses but the full documents may provide additional context as needed.

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Overview

The insights shared by NS Physiotherapists reflect a consistent and evidence-aligned message: while many aspects of the current MVA system function well for straightforward cases, structural barriers delay care, increase administrative burden, and undermine timely recovery for more complex or vulnerable patients.

The NSPA recommends the following changes to current practices, to allow for improved patient outcomes;

1. Enforce timely payment (30-day maximum) and enable EFT across all insurers.
2. Update fee schedules to reflect current market rates.
3. Remove mandatory physician referral for out-of-protocol care and allied health services—PTs are autonomous practitioners and can determine appropriate care.
4. Improve insurer communication standards, including escalation pathways and continuity when adjusters change.
5. Strengthen patient choice—insurers should not direct or pressure patients.
6. Reduce administrative burden on providers (e.g., streamline NS-02 requirements).

Patient Understanding of Auto insurance benefits

Patients have a limited understanding of auto insurance Section B coverage, what the Diagnostic and Treatment Protocols mean, and what steps are required to initiate care.

Common misunderstandings include

- which therapies are covered,
- additional coverage (e.g. TENS, specialized pillows, heating pads, etc.)
- what is covered “in-protocol” vs “out-of-protocol” (e.g. concussion),
- the need for physician notes,
- whether they have the right to choose their provider (or must attend insurer-preferred clinics),
- how to initiate care,
- whether or not they need insurer approval before starting treatment,
- time-limits that may apply (i.e. 90-day limit post injury for assessment).

Some groups are more likely to experience confusion, such as rural residents, newcomers, younger drivers. If patients seek legal advice they may have additional

knowledge, otherwise physiotherapists are left to explain coverage to patients. This can impact time available to deliver rehabilitation services that will ultimately help patients recover.

The lack of clarity of Section B coverage can lead to delays in patients seeking care. Based on our membership survey, physiotherapists observe delayed initiation of treatment increases risk of chronic pain & prolonged disability. Research demonstrates timely access to care leads to shorter recovery times and improved outcomes.[1,2,3] Early versus delayed physiotherapy is associated with fewer physician visits, decreased cost, as well as decreased frequency of opioid prescriptions, advanced imaging, and surgeries.[1,2] Early physiotherapy is also associated with reduced pain, improved function, and lower risk of long-term problems when compared with delayed or "wait-and-see" approaches.[3]

Injury Needs & Recovery Pathways

Typical MVA-related injuries include the following: whiplash associated disorders (WAD I, WAD II, WAD III), muscle strains, joint sprains, concussions or head trauma, nerve-related injuries (radiculopathy, neuropraxia), headaches and TMJ dysfunction. Some patients are impacted by more serious injuries including fractures and spinal cord injuries.

Members highlighted significant psychological and psychosocial impacts on patients, including, but not limited to: anxiety and driving-related fear, stress related to insurance navigation, sleep disturbance, and emotional distress. They noted that patient anxiety and distress become more prevalent when recovery is prolonged.

Functional impacts can include: reduced mobility/strength, difficulty returning to work duties, fatigue, sleep disturbances, and decreased tolerance for daily activities.

Rehabilitation needs and recovery outcomes are highly individualized and depend on injury severity, complexity, and number of injuries, with more severe or multiple injuries requiring greater rehabilitation resources and longer recovery trajectories.[4] Demographic and baseline health factors (e.g., age, prior physical functioning) also predict return to work and functional outcomes.[4,5] In addition, non-medical factors such as psychosocial profiles (fear, confidence, coping), social support, and

legal/compensation context have been shown to independently influence rehabilitation outcomes and overall recovery.[4,5,6]

Access to care

Access to care is highly variable, but some patients do not receive the type or duration of care that aligns with their clinical needs.

Key factors that can limit access to appropriate care include, but are not limited to:

- Insurance and Funding constraints
  - Rigid visit limits in protocol do not reflect the complexity of many cases.
  - Delayed approval processes can interrupt continuity of care.
  - Time limited benefits: 4-year restriction on rehabilitation services.
- Administrative and System Barriers
  - Out-of-protocol services (incl. OT, counselling, massage, kinesiology) often require physician notes and insurer approval, causing multi-week delays.
- Geographic and Workforce Barriers
  - Limited availability of practitioners (incl. physiotherapists, physicians & specialists) in rural or remote areas.
  - Transportation challenges, particularly for individuals with functional limitations or without reliable access to vehicles.
- Socioeconomic Factors
  - Out-of-pocket costs, including co-payments, travel expenses, or unpaid time off work, may limit attendance or duration of care.
  - Individuals with lower income or precarious employment may prioritize work or caregiving responsibilities over rehabilitation.
  - Language barriers and limited health literacy can impede understanding of treatment plans or system navigation.

Return-to-work (RTW)

Expectations, from patients, providers, employers, and insurers, around RTW strongly influences patient recovery. When a patient believes they will return to work they are more likely to engage actively in treatment and fear-avoidance behaviors decrease. If a patient expects long-term disability or for work to worsen their condition then there can be an increase in pain catastrophizing, recovery timelines and risk for chronic pain.[7]

Physiotherapists provide education and reassurance within rehabilitation programs to assure patients that they can safely move and how to build tolerance to activities, including work.

Administrative Processes & Approvals

Delays in administrative processes are one of the most significant barriers identified by NSPA members. For injuries falling outside simple soft tissue or WAD (e.g., complex injury, concussion, chronic pain, mental/psychological sequelae), insurers may require more extensive documentation or justification, which increases administrative burden for providers and may lead to friction or delays. Due to prolonged reimbursement timelines, some rehabilitation providers are unable to accept direct billing from auto insurers. Upfront payment requirements can therefore restrict access to care, especially for patients with limited financial resources.

Treatment outside of protocol requires insurer approval and a note from a physician prior to initiating care. It can take weeks to months for patients to access care through their family physician, and some patients do not have their own family physician. There can also be delays in receiving approval from insurers for treatment plans. Members report that adjusters may take weeks or months to review submissions and that the impact of this is compounded when claims are transferred between staff (due to turnover, vacation, etc.). This creates lost treatment time for patients and may shorten their approved treatment block (i.e. requests for treatment blocks are approved with delayed start dates, cutting into the treatment window).

When it comes to documentation requirements, the current NS-2 Forms are relatively straightforward. Only a small number of members report issues with the paperwork itself. The largest administrative burden is related to chasing down payments from adjusters for services rendered. Smaller clinics and sole practitioners are disproportionately affected due to limited administrative capacity. The requirement to monitor treatment counts for accurate invoicing introduces significant administrative complexity, especially when a patient accesses different services at multiple clinics. Removing the change of fees at visits 4 (WAD I) and 8 (WAD II) would help decrease administrative load on clinics and practitioners.

Where the system creates delays and friction:

- Slow insurer response times
  - Based on membership survey: Payments can often take longer than the legislated 30 days. Can be up to 60–120 days, with TD insurance being the company most frequently identified as problematic.
  - Some adjusters are responsive and communicate clearly - members report some positive experiences but these appear to be adjuster-dependent.
  - Communication lapses occur when adjusters go on leave or files change hands without notice.
- Misalignment of clinical judgment and administrative rules
  - Many insurers approve straightforward, in-protocol claims without issue.
  - Physiotherapy diagnoses or determinations of protocol status may be overridden by adjusters relying on physician notes, despite the fact that physiotherapists' clinical impressions align closely with those made by orthopaedic surgeons and expert physicians, and outperform generalist family physicians in diagnostic accuracy.[8]
- Steering patients to preferred provider clinics
  - Preferred providers can be very helpful if patients do not have existing practitioners and need quick access to care.
  - However, pressure to attend preferred clinics when this is not the case can erode patient choice, harm local clinics, and ignores existing therapeutic relationships.
  - Some insurance companies do not provide direct billing to clinics that are not preferred providers, creating unnecessary financial strain on patients.
  - Some insurers threaten not to reimburse travel/parking if patients choose to attend treatment at non-preferred clinics.

Adequacy of Benefits & Coverage Gaps

When injuries are straight forward (soft tissue, uncomplicated WAD I-II) then the 21 treatments allowed in current protocols can be sufficient; however, there are patients who require additional benefits beyond protocol. Additional care may be needed when there are comorbidities, multiple compounding injuries, and psychosocial factors that impact patient healing times. Because recovery depends on many factors, a "one-size-fits-all" protocol (i.e., a fixed short course of treatment) may not meet clinical needs for

all individuals. Allowing for clinical judgement and flexibility in treatment approaches is imperative for best patient outcomes.

The auto insurance system should facilitate timely access to physiotherapy and rehabilitative services for people injured in MVAs, without unnecessary delays or burdensome authorization processes, as early access as early intervention is associated with improved recovery outcomes and a reduced risk of long-term disability.[1,2,3] The current NS-2 protocol serves its purpose in providing faster access to care; however, things become more complicated once patients fall outside of protocol.

Multiple clinically appropriate services are difficult to access under current benefit structures. Mental health services and Occupational therapy are two services of note where patients can get access with a medical referral but wait times can be long, and are significantly worse for patients in rural areas. As well, the number of approved treatments makes it challenging for patients to access multi-disciplinary services, despite research being in support of collaborative care for improved function and return to work outcomes.[9]

Assistive devices and adjunct therapies, such as access to braces, TENs units, heating pads, and similar supports often requires physician authorization, delaying or preventing timely use. These services support rehabilitation and can accelerate healing times when used appropriately.

Fee Schedules & Billing

Current fee schedules are generally below the cost of care based on member survey responses and comparable fees.

The NSPA, in collaboration with our national body - the Canadian Physiotherapy Association – conducted a survey in 2023 to determine current market rates for physiotherapy services within each province and across the country. The following table has been extracted from that document. From November 2023 to June 2025, the Consumer Price Index (CPI) in Nova Scotia increased from 162.5 to 167.70, representing an inflation rate of 3.2% over that period.[10] Rates for 2025 have been adjusted by 3.2% to reflect the change.

Rate for Physiotherapy Assessment

Most clinics charge a rate for a physiotherapy assessment. The 85th percentile fees for a physiotherapy assessment have been reported below. The 2025 rates have been adjusted 3.2% based on the CPI index.

Physiotherapy Assessment

Physiotherapy Assessment Time	2024 85th Percentile Fee	2025 Fee (Adjusted for Inflation)
40-50 minutes	$115.00	$118.68
51-60 minutes	$120.00	$123.60
Over 60 minutes	$164.00	$169.25

Physiotherapy Treatment

Physiotherapy Treatment Time	2024 85th Percentile Fee	2025 Fee (Adjusted for Inflation)
10-20 minutes	$80.00	$82.56
21-30 minutes	$90.00	$92.88

MVA physiotherapy assessments generally take an hour or more, depending on the complexity of the patient. Current protocol rates for assessment are $115, sitting below the average rates in Nova Scotia.

The first few appointments within protocol sit at or near average rates; however, the changes in fees at 3/7 visits in the fee schedule is a significant concern. The skills, decisions and ethics of our members are focussed on providing the best outcomes for their patients and fees/financial considerations must not be part of treatment guidelines or clinical decisions. The significant reduction in fee for service at these time points is a major reason clinics opt out of treating Motor Vehicle patients. If fewer clinics provide services, this decreases access for Nova Scotians who need care.

The following table shows ICBC's pre-approved treatments during the first 12 weeks after an accident.[11] These rates allow significantly more treatments compared to the 21 treatments included within NS Protocols, which need to be shared between practitioners.

Type of health care provider	Number of approved treatments	Standard treatment fees covered by ICBC*	Minimum treatment times**
Physiotherapist	25	$95	20 minutes
Chiropractor	25	$75	15 minutes
Registered massage therapist	12	$105	45 minutes
Kinesiologist	12	$94	45 minutes
Psychologist	12	$241	50 minutes
Counsellor	12	$157	50 minutes
Acupuncturist	12	$113	20 minutes

Impacts of inflation, staffing shortages, and equipment costs on fees

There are many increased costs associated with running a business in general, as well as specific costs associated with providing physiotherapy services. General inflation has increased clinic rent and utilities, medical and office supplies as well as administrative overhead (i.e., software, compliance, billing). There have been significant staffing shortages post-pandemic that have led to higher wages to recruit and retain physiotherapists and increased use of locums or contract staff. The rates for rehabilitation services within NS-2 protocols have fallen well behind compared to 2013 rates. This has resulted in reduced profit margins, pressure to shorten visit times, and increased reliance on group therapy or assistants. For these reasons some therapists and clinics have opted out of treating MVA patients altogether because it is not sustainable for their livelihood.

Changes in the table below would represent rate changes based off inflation rates alone compared to the 2013 and 2024 NS-2 Protocol fees for physiotherapy services.

	2013 Protocol Fees	Inflation Rate from 2013 to Nov 2025 (+34.84%)	2024 Protocol Fees	Inflation Rate from 2024 to Nov 2025 (+2.67%)
Initial Assessment	$100	$134.84	$115	$118.07
WAD I/ Gr I Sprain/Strain Rx 1-3	$75	$101.13	$86	$88.30
WAD I/ Gr I Sprain/Strain Rx 6-10	$45	$60.68	$52	$53.39
WAD II/ Gr II sprain/Strain Rx 1-7	$75	$101.13	$86	$88.30
WAD II/ Gr II sprain/Strain Rx 8-21	$45	$60.68	$52	$53.39

* Jan 2013 CPI = 125.4[12], May 2024 CPI = 164.7[13], November 2025 = 169.1[14]

Provider Autonomy & Scope of Practice

Physiotherapists are autonomous regulated health professionals with defined competencies in assessment, diagnosis, treatment planning, and outcome evaluation. Restrictions that do not reflect this scope may undermine quality of care and place unnecessary administrative burdens on both providers and patients.

Current protocols can impose restrictions that interfere with physiotherapists' ability to exercise independent clinical judgment. Requirements for external approval, prescriptive treatment limits, or non-clinical decision-making by insurers can delay appropriate care and disrupt continuity of treatment. These constraints may prevent clinicians from responding promptly to changes in a patient's condition or from applying best practices supported by clinical guidelines and professional standards. Members have noted that experienced therapists may have the clinical confidence to advocate for a patient's continued treatment, while a new graduate may not.

Having physician approval for continued treatment is an unnecessary cost on the public health system, a barrier to patient access and a source of frustration for physiotherapists. Members note that it undermines their professional

opinions/recommendations, frustrates clients (particularly those without a family physician), and is an unnecessary strain on health resources.

Expanding Approval Authority to Reduce Delays

The NSPA supports the expansion of approval authority to qualified regulated health professionals within their respective scopes of practice in all areas of healthcare, including rehabilitation following automobile accidents. Allowing appropriate professionals to authorize and adjust treatment plans could significantly reduce delays in care, particularly in the early stages of recovery when timely intervention is most effective.

Expanded approval authority, to appropriate professionals such as physiotherapists and nurse practitioners, would:

- Improve patient access to care and reduce wait times
- Decrease reliance on physician visits for administrative approvals
- Reduce system inefficiencies and associated costs
- Support collaborative, team-based care models

This applies particularly for cases that fall outside of protocol.

Areas Where Physician Oversight Remains Essential

The NSPA recognizes that physician oversight remains essential in specific circumstances, including:

- Management of complex conditions (e.g., spinal cord injuries, fractures with complications, neurological deficits outside the scope of physiotherapy management)
- Cases involving significant medical comorbidities
- Prescription of medications
- Surgical decision-making and post-operative medical management

Physiotherapists routinely collaborate with physicians and other healthcare providers and are trained in determining when referral and consultation is required.

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System Coordination & First-Payor Rules

Challenges coordinating among payors (i.e. auto insurers, private plans, and public health care) include confusion among patients and administrative burden on providers, causing limitations in accessing care. Providers must coordinate between insurers to ensure correct payment, often duplicating documentation and chasing approvals. These challenges typically occur if a patient is outside of protocol.

The current system of using private insurance as first-payor for outside of protocol penalizes our most injured patients. Although this may not be the majority of patients, it is a burden on those significantly injured who may have other financial challenges and significant stressors. For those who suffer with chronic pain or those who sustain other injuries unrelated to the MVA, their benefits of private insurance are no longer available to them when they need it. It is a common issue that prevents proper access to care and management of health concerns for which such insurance is intended. These patients may discontinue treatments or shift to accessing care from the public health system. Other provinces, like Ontario, have already changed protocols to require motor vehicle insurance to pay for related injuries.

Members report circumstances where insurance companies refuse to pay for assessments they were referred because it was determined that the patient was not within protocol. If there are delays in processing and decision-making, it may impact a clinic's ability to bill the clients' private health plan.

Shifting auto insurers to first-payor

Directly billing auto insurers could reduce confusion for patients and eliminate the need for them to coordinate between private health and auto coverage. It would decrease the possible financial burden on patients for the co-pay not covered by their private insurance, which can be a significant barrier to care. From a provider perspective, it would reduce administrative work and streamline processes. Reducing these burdens allows practitioners to focus their session time on rehabilitation instead of explaining within and outside of protocol differences.

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Equity & Barriers for Specific Groups

Socio-economically disadvantaged patients, seniors, newcomers to Nova Scotia, non-English speakers, or those with limited transportation may face additional barriers in understanding benefits, navigating paperwork, attending frequent sessions, or accessing services, particularly if required to travel long distances or pay for rehabilitation services up front. Factors that can add to confusion include complexity of insurer processes, inconsistent communication, lack of awareness about patient rights, and pressure from adjusters to use preferred clinics.

- Rural residents: Limited access to clinics, especially for specialized services (e.g., mental-health support, occupational therapy, TMJ treatment), increases travel time and cost, delaying care.
- Low-income patients: Upfront payment requirements for out-of-protocol treatment create financial barriers, particularly when coverage is unclear or delayed.
- Newcomers and non-English speakers: Language barriers and unfamiliarity with insurance processes can delay or reduce access to care as patients are unaware of the scope of their coverage.

Without adequate support these populations are at risk of under-treatment and long-term disability.

Suggestions to improve equitable access

- Improve care navigation and case management
    - Provide independent coordinators not employed by insurers to assist patients with provider referrals, appointment scheduling, and benefit navigation.
- Increase access in underserved and rural areas
    - Expand virtual care and telerehabilitation options.
    - Offer travel support (beyond paying for mileage) or mobile rehab services.
    - Incentivize provider participation in underserved regions.
- Strengthen patient education and access to information
    - Provide clear, accessible information (in multiple languages/formats) to patients about what benefits they have and how to access them.
    - Provide resources to insurers and providers to share with patients to ensure consistency of information received.

Recommendations for Improvement

The NSPA recommends the following to improve inefficiencies that currently delay care, increase provider burden, and negatively affect patient recovery:

Legislative or regulatory changes

- Enforce timely payment standards (e.g., a maximum 30-day payment requirement) and mandate electronic funds transfer (EFT) capability across all auto insurers.
- Update and regularly index fee schedules to reflect current market rates and cost-of-care realities.
- Remove mandatory physician referral requirements for out-of-protocol care and allied health services, recognizing physiotherapists as autonomous practitioners able to determine appropriate care.
- Strengthen patient choice protections, prohibiting insurer direction, steering, or pressure toward specific providers.

Administrative or procedural

- Improve insurer communication standards, including:
    - Clear escalation pathways
    - Timely responses
    - Continuity of claims handling when adjusters change
- Reduce administrative burden on providers, including streamlining documentation and reporting requirements (e.g., simplifying NS-2 processes).

Additional recommendations

- Implementation of a website comparable to ICBC[15] – this would help with patient understanding and alignment between practitioners and insurers.

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Conclusion

The insights shared by NS Physiotherapists reflect a consistent and evidence-aligned message: while many aspects of the current MVA system function well for straightforward cases, structural barriers continue to delay care, increase administrative burden, and undermine timely recovery for more complex or vulnerable patients.

Physiotherapists are committed to delivering safe, effective, and timely care, and the system functions best when their clinical expertise is trusted and administrative pathways support—not hinder—treatment. Improving clarity, strengthening provider autonomy, enforcing reasonable timelines, and modernizing benefit structures would collectively create a more responsive, patient-centred auto insurance system.

The NSPA appreciates the opportunity to contribute to this review and stands ready to collaborate on next steps, including supporting communication with providers, refining implementation strategies, and helping ensure that any system changes lead to better outcomes for injured Nova Scotians.

Sincerely,

Tara Moore, PT
Nova Scotia Physiotherapy Association
President

Patricia Connors
Nova Scotia Physiotherapy Association
Chief Executive Officer

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