Draft Regulation

Act respecting industrial accidents and occupational diseases
(chapter A-3.001)

Health services, adapted equipment and other costs

Notice is hereby given, in accordance with sections 10 and 11 of the Regulations Act (chapter R-18.1), that the Regulation respecting health services, adapted equipment and other costs, appearing below, may be made by the Commission des normes, de l'équité, de la santé et de la sécurité du travail and submitted to the Government for approval, in accordance with the first paragraph of section 455 of the Act respecting industrial accidents and occupational diseases (chapter A-3.001), on the expiry of 45 days following this publication.

The draft Regulation replaces the Regulation respecting medical aid (chapter A-3.001, r. 1) and the Regulation respecting hearing devices and audiology services (chapter A-3.001, r. 14.001). It determines the medicines and other pharmaceutical products, physical rehabilitation services, other health services, adapted equipment and other costs to which a worker who has suffered an employment injury is entitled under sections 189 and 198.1 of the Act respecting industrial accidents and occupational diseases, where required by the worker's condition as a result of the injury, and the cases in which and conditions on which health services, adapted equipment and other costs may be granted.

Further information may be obtained by contacting Mireille Huot, strategic advisor and executive assistant, Commission des normes, de l'équité, de la santé et de la sécurité du travail, 1600, avenue D'Estimauville, 6e étage, Québec (Québec) G1J 0H7; email: DGIR-bureaudedirection@cnesst.gouv.qc.ca.

Any person wishing to comment on the draft Regulation is requested to submit written comments within the 45-day period to Claude Beauchamp, Vice-President for compensation and work reintegration, Commission des normes, de l'équité, de la santé et de la sécurité du travail, 1600, avenue d'Estimauville, 7e étage, Québec (Québec) G1J 0H7; email: VPIRT-Bureau_VPIRT@cnesst.gouv.qc.ca.

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Acting Secretary General, Commission des normes, de l'équité, de la santé et de la sécurité du travail

Regulation respecting health services, adapted equipment and other costs

Act respecting industrial accidents and occupational diseases
(chapter A-3.001, s.189, pars. 3, 3.1 and 4, and s. 454, 1st par., subpars. 3.1, 3.2, 3.3 and 4.1, 2nd par.).

CHAPTER I
DEFINITIONS AND GENERAL

DIVISION I
DEFINITIONS

1. In this Regulation,

"account" means an invoice, a form prescribed by the Commission, a bill of fees, a payment transaction by electronic link or other technological support; (*compte*)

"health worker" means a natural person, other than a health professional, entered on the roll of a professional order governed by the Professional Code (chapter C-26) and referred to in this Regulation, including a holder of a psychotherapist's permit issued by the Ordre professionnel des psychologues du Québec; (*intervenant de la santé*)

"non-insured service" means a non-insured service under the Health Insurance Act (chapter A-29) and its regulations; (*service non assuré*)

"professional service" means an act performed by a health worker, other than care and treatment; (*service professionnel*)

"session" means a visit, with or without an appointment, to a health worker by a worker who has suffered an employment injury to receive care or treatment or to obtain an initial evaluation, including home care and professional services in accordance with the rate per session listed in Schedule I; (*séance*)

"supplier" means a person or an enterprise that directly or indirectly provides a worker with goods or services provided for in this Regulation and that must, to do so, comply with Chapter VIII.1 of the Act, including a health worker and a health professional. (*fournisseur*)

DIVISION II
GENERAL

2. This Regulation determines the medicines and other pharmaceutical products, physical rehabilitation services, other health services, adapted equipment and other costs to which a worker who has suffered an employment

injury is entitled under sections 189 and 198.1 of the Act respecting industrial accidents and occupational diseases (chapter A-3.001), where required by the worker's condition as a result of the injury, and the cases in which and the conditions on which the health services, adapted equipment and other costs may be granted.

3. Subject to provisions to the contrary, the Commission pays the cost of the health services, adapted equipment and other costs determined in this Regulation to the supplier that provided them to the worker or the enterprise within which the supplier works that is also a supplier, if the following conditions are met:

(1) they were received in Québec, in accordance with the conditions and amounts set out in this Regulation;

(2) they were prescribed, where provided for in this Regulation, by the health professional in charge of the worker before they were received or before the expenditures for them were made.

Unless otherwise provided, the amounts include the supplier's travel expenses and the supplies and ancillary costs related to the health services, adapted equipment or other costs.

The health worker or the health professional must keep the prescription in the worker's record.

4. The Commission assumes the cost of the health services, adapted equipment and other costs determined in this Regulation in accordance with the amounts and rates applicable at the time they are provided to the worker.

DIVISION III
CLAIM

5. Every claim submitted to the Commission concerning health services, adapted equipment or other costs must comply with the following conditions:

(1) it must be made by the supplier having provided the health services, adapted equipment or other costs, or the enterprise within which the supplier works that is also a supplier;

(2) it must be accompanied by the health worker's recommendation, where applicable, and by vouchers detailing their cost;

(3) it is made using an account.

6. The account related to fees or costs for a good or service must be sent by the supplier having provided the health services, adapted equipment or other costs, or the enterprise within which the supplier works that is also a supplier, to the Commission within 180 days following the date of provision of the good or service, or the performance of the act related to another cost, except that related to a fee or cost for medicines, other pharmaceutical products and cannabis.

In the case of a report required under this Regulation, the 180-day period provided for in the first paragraph begins to run from the date on which the report becomes exigible.

7. The supplier must indicate on the accounts the authorized supplier number assigned by the Commission in accordance with Chapter VIII.1 of the Act.

8. Despite section 7, where more than one health worker or health professional practise their profession as a group on the same premises, they must indicate the following on their accounts:

(1) the authorized supplier number assigned by the Commission to the group;

(2) the authorized supplier number assigned by the Commission to the health worker or health professional having provided the health services or adapted equipment and other costs.

The health workers or health professionals must send to the Commission, in writing, the name of the person designated to receive payment and the address where the payment must be made. They must also inform the Commission of any change in such information.

9. Where a worker has recourse to the services of a non-participating professional within the meaning of the Health Insurance Act (chapter A-29) and pays the professional services related to the employment injury directly to that professional, the worker must submit a claim to the Commission along with the account of the health professional, any voucher and proof of payment of the account, within 180 days following the date of provision of the services.

The Commission reimburses the worker for the cost of the professional services referred to in the first paragraph in accordance with the Act and on the conditions and rates set out in this Regulation.

DIVISION IV
BORDER REGION AND OUTSIDE QUÉBEC

10. If the employment injury occurs in a border region of Québec, the Commission assumes the cost of the following, provided that the Commission had first given authorization to the worker:

(1) the cost of the health services, adapted equipment and other costs received or incurred outside Québec and described in this Regulation, including supplies and ancillary costs related thereto, up to the amounts provided for in the Regulation;

(2) the cost of care and treatment received in a hospital centre and the services of health professionals, dentists, optometrists, pharmacists or specialized nurse practitioners received outside Québec, including, where applicable, the cost of supplies and ancillary costs related thereto, on the basis of what similar care, treatment and services would cost under a public hospital insurance or health insurance plan in force in Québec.

For the purposes of this section, "border region" means a part of the territory of Québec comprised within 80 km of any point along the border with Ontario, New Brunswick or Newfoundland and Labrador.

11. Despite section 3, where a worker sustains an employment injury outside Québec, the Commission assumes the actual cost of the health services described in this Regulation, received outside Québec, including the supplies and ancillary costs related thereto, on presentation of vouchers and of a health professional's attestation as to necessity.

The Commission also assumes the cost of the adapted equipment and other costs, received or incurred outside Québec by such a worker, up to the amounts and on the conditions set out in Chapter III.

Despite the second paragraph, the Commission assumes the actual cost of the professional services listed in Schedule VI, received outside Québec by such a worker, on presentation of vouchers and of a health professional's attestation as to necessity.

CHAPTER II
HEALTH SERVICES

DIVISION I
MEDICINES AND OTHER PHARMACEUTICAL PRODUCTS

§1. Medicines

12. For the purposes of this subdivision, "medicines" means the substances authorized by Health Canada to which a drug identification number (DIN) has been assigned.

13. The medicines to which a worker is entitled are generic or biosimilar medicines.

Despite the first paragraph, the worker is entitled to innovative or reference biologic medicines in any of the following situations:

(1) no generic or biosimilar medicine is available on the market;

(2) the health professional in charge of the worker requests, on the prescription, that the medicine prescribed not be substituted by a generic or biosimilar medicine.

14. The Commission assumes the cost of the medicines provided for in this subdivision where they are prescribed by the health professional in charge of the worker and are related to the employment injury.

§2. Other pharmaceutical products

15. For the purposes of this subdivision,

"extemporaneous preparations" means compounded medicines prepared in a pharmacy to produce a targeted therapy specific to a patient according to a specific pharmaceutical form and dosage; (*préparations magistrales*)

"foods for special dietary use" means dietary products intended for medical purposes to meet specific nutritional needs related to the employment injury; (*aliments à usage diététique spécial*)

"medical instruments and pharmaceutical supplies" means

(1) devices used to administer medicines;

(2) oscillating positive expiratory pressure devices used to clear the respiratory tract;

(3) devices for monitoring a pharmaceutical treatment and their accessories;

(4) sanitary, personal hygiene or wound care products;

(5) hot water bottles or hot compresses;

(6) viscosupplements;

(7) artificial tears; and

(8) any other similar product; (*instruments médicaux et fournitures pharmaceutiques*)

"natural health products" means vitamins, minerals and any other product authorized by Health Canada and given a natural product number (NPN), except homeopathic medicines (DIN-HM). (*produits de santé naturels*)

16. The other pharmaceutical products to which a worker is entitled are

(1) foods for special dietary use;

(2) extemporaneous preparations;

(3) natural health products; and

(4) medical instruments and pharmaceutical supplies.

17. The Commission assumes the actual cost of the other pharmaceutical products provided for in this subdivision where they are prescribed by the health professional in charge of the worker and are related to the employment injury.

DIVISION II
OTHER HEALTH SERVICES

18. The other health services to which a worker is entitled under this Division are

(1) care, treatment and professional services provided for in this Division and in Schedule I to this Regulation;

(2) the non-insured health services provided for in this Division; and

(3) cannabis for medical purposes.

19. The Commission assumes the cost of the other health services provided for in this Division where they are prescribed by the health professional in charge of the worker and on the conditions set out in this Division.

§1. Care, treatment and professional services

General rules

20. A worker is entitled to the care, treatment and professional services listed in Schedule I, in accordance with the amounts set out in the Schedule, if they are provided personally by a health worker.

The amounts for acupuncture, chiropractic, podiatric, speech therapy, psychological, psychotherapeutic and neuropsychologic care and treatment, home chiropractic care and treatment and home nursing care are revalorized according to the rules set out in sections 118 and 120 to 122 of the Act and by multiplying the amount to be revalorized by the average of the revalorization rates of the 6 preceding years. The revalorization rate of each year is equal to the ratio between the Consumer Price Index of the current year and that of the preceding year.

21. The first session with a health worker, even for an initial evaluation, is paid in accordance with the amounts listed in Schedule I, or the amounts for a care or treatment session if no specific rate is provided for therein.

No other amount is payable by the Commission for an initial evaluation where the evaluation goes beyond the first session with a health worker.

22. An amount provided for care or treatment includes, in addition to what is provided for in the second paragraph of section 3, the cost of x-rays.

Special rules for home care

23. The Commission assumes the cost of the sessions for nursing care and chiropractic and physiotherapy treatment provided in the home by a health worker at the rates listed to that effect in Schedule I on the following conditions:

(1) the health professional in charge of the worker observes that it is impossible for the worker to leave the home because of the employment injury;

(2) the health professional in charge of the worker previously prescribed such home care.

Special rules for physiotherapy and occupational therapy

24. For physiotherapy or occupational therapy care or treatment, the Commission assumes the cost thereof up to a maximum of 1 care or treatment session per day

and 3 care or treatment sessions per week, subject to a prescription to the contrary from the health professional in charge of the worker.

25. Where an initial evaluation goes beyond the first session, and care or treatment is also provided at the same time, the initial evaluation must neither hinder the care or treatment, nor reduce the quality or duration thereof.

26. The Commission assumes the cost of a care or treatment session provided for in the worker's personal care or treatment program established on the basis of the worker's specific needs, even if the worker receives the care and treatment simultaneously with other persons.

27. A physiotherapist, a physiotherapy technologist or an occupational therapist must keep a register indicating, for each session,

(1) the date of the professional act performed;

(2) a description of the professional act performed, namely, the initial evaluation or care or treatment; and

(3) the name of the health worker who performed the professional act.

The worker must sign the register at each session.

The register must be kept in the record kept by the health worker for a minimum period of 5 years from the date on which the record is closed. The register must be put at the disposal of the Commission, on request.

28. A physiotherapist, a physiotherapy technologist or an occupational therapist must send to the Commission a first account whose form and content must comply with the form in Schedule III or, if sent using another technological medium, complying with that authorized by the Commission, within 7 days following the first session. They must also use that account form or an authorized technological medium to claim an amount for care or treatment.

The account form is available on the Commission's website.

29. At the request of the Commission, a physiotherapist, a physiotherapy technologist or an occupational therapist must provide a report whose form and content must comply with the form in Schedule IV or, if sent using another technological medium, complying with that authorized by the Commission.

The report form is available on the Commission's website.

The report must be sent to the Commission and the health professional in charge of the worker within 15 days following the date of the Commission's request.

Where the worker is followed exclusively by a physiotherapy technologist, a physiotherapist or the health professional in charge of the worker must send a report to the Commission after 25 treatment sessions and, subsequently, every 12 treatment sessions.

Where the report is sent by a physiotherapist, it must comply with the form in Schedule IV.

30. A report is payable by the Commission only if it is made on the form in Schedule IV or, if sent using another technological medium, complying with that authorized by the Commission, and is complete.

31. Except in case of superior force, where a report is not filed within the time limit provided for in the third paragraph of section 29, the Commission withholds payment of the accounts for the care and treatment sessions provided after the deadline for filing the report, until it is sent to the Commission.

When the report is filed, the Commission pays the accounts for the care and treatment sessions whose payment was withheld.

32. The following occupational therapy services are not health services:

(1) services provided as part of a rehabilitation measure consisting of furnishing professional psychosocial services;

(2) services provided as part of a rehabilitation measure consisting of the adaptation of the residence;

(3) services provided as part of a rehabilitation measure consisting of the adaptation of a principal vehicle;

(4) services provided as part of a rehabilitation measure consisting of the adaptation of recreational equipment;

(5) services provided as part of a rehabilitation measure consisting of specialized interdisciplinary rehabilitation services;

(6) services provided as part of a rehabilitation measure consisting of a refresher program and a vocational training program that may include a skills acquisition training period;

(7) services provided as part of a rehabilitation measure consisting of the adaptation of a work station;

(8) services provided as part of a rehabilitation measure consisting of the evaluation and development of functional aptitudes;

(9) services provided as part of a rehabilitation measure to develop the worker's capacity to gradually resume the tasks involved in his employment.

33. Subject to a prescription to the contrary from the health professional in charge of the worker concerning the date on which treatment begins, the Commission assumes only the cost of the occupational therapy sessions held from the sixth week following the date of the employment injury and if the employment injury is not consolidated on that date. The same conditions apply for an initial evaluation.

Despite the first paragraph, the Commission assumes the cost of sessions held before that date, if the prescription of the health professional in charge of the worker pertains to one or more of the following injuries:

(1) a hand or wrist injury;

(2) a complex regional pain syndrome, regardless of the site of the injury;

(3) nerve damage to the upper limbs;

(4) a burn, regardless of the site of the injury.

Special rules for psychology, psychotherapy and neuropsychology

34. The Commission assumes the cost of psychological, psychotherapeutic and neuropsychological care provided by a psychologist entered on the roll of the Ordre professionnel des psychologues du Québec and the cost of psychotherapeutic care provided by the holder of a psychotherapist's permit.

The Commission assumes the cost of the reports required in this subdivision.

35. The Commission assumes the cost of psychological, psychotherapeutic and neuropsychological care in accordance with the amount in Schedule I where the Commission and the health professional in charge of the worker have received, for the worker, an evaluation report and, if treatment is provided, a progress report, where required, and a final treatment report.

A progress report must be prepared starting from 6 hours of treatment, but not more than every 12 hours of treatment or every 3 months, at the choice of the health worker.

Where the treatment ends before a progress report is to be completed, only a final treatment report must be sent to the Commission.

The reports must be sent within 15 days following the date of the last meeting giving rise to the report.

36. The reports referred to in section 35 must contain the information in Schedule V and be signed by a psychologist or by the holder of a psychotherapist's permit who provided the care.

37. The hourly rate listed in Schedule I for psychological, psychotherapeutic and neuropsychological care applies for the payment of the reports required under section 35, up to the following limits:

(*a*) evaluation report:

i. psychology and psychotherapy: 2 hours;

ii. neuropsychology: 8 hours;

(*b*) progress report: 1 hour;

(*c*) final report: 2 hours.

The reports are payable when they are sent to the Commission.

§2. Non-insured services

General rules

38. In this subdivision,

"medical imaging laboratory" means the legal person that makes available radiological services rendered by radiologists attached to the medical imaging laboratory, and that is operated by a physician who holds a specialist's certificate in diagnostic radiology issued by the Collège des médecins du Québec and who holds the permits and authorizations required under the Act respecting medical laboratories and organ and tissue conservation (chapter L-0.2); (*laboratoire d'imagerie médicale*)

"professional component" means the fees of a health professional for a medical act; (*composante professionnelle*)

"technical component" means the costs other that the professional component when providing a non-insured service, including the salary of the staff other than a health professional, devices, instruments and surgical trays. (*composante technique*)

39. The non-insured health services to which a worker is entitled under this subdivision are

(1) computer tomography services, also called axial tomography, CAT-scan, CT-scan or scan, and magnetic resonance imaging services provided elsewhere than in an institution which operates a hospital centre within the meaning of the Act respecting health services and social services (chapter S-4.2);

(2) ultrasound services provided in a private institution within the meaning of that Act by a physician other than a radiologist;

(3) surgeries;

(4) services rendered by a dentist;

(5) services rendered by an optometrist;

(6) medico-administrative services rendered by a dentist or an optometrist; and

(7) any other non-insured service.

40. The Commission assumes the cost of non-insured health services provided for in this subdivision, if they are provided personally by a health professional, are related to the worker's employment injury and on the conditions set out in this subdivision.

Special rules for computer tomography and magnetic resonance imaging services

41. The Commission assumes the cost of computer tomography and magnetic resonance imaging services if the following conditions are met:

(1) they are provided by a radiologist attached to a medical imaging laboratory;

(2) they are not provided in an institution which operates a hospital centre within the meaning of the Act respecting health services and social services (chapter S-4.2);

(3) the Commission has authorized the provision of the services following an authorization application made by the health professional on the form prescribed for that purpose and available on the Commission's website, which form must include in particular

(*a*) the date, description and detailed cost of the services and examinations; and

(*b*) the medical prescription of the health professional in charge of the worker requesting the services and examinations, including the diagnosis or diagnoses for which the services and examinations are required.

42. The health professional must provide the computer tomography and magnetic resonance imaging services within 10 working days after the health professional has received the authorization from the Commission provided for in paragraph 3 of section 41.

The medical imaging laboratory to which the health professional providing the services is attached must notify the Commission, as soon as the request is received, of its inability, where applicable, to take charge of a worker within the prescribed time.

All the computer tomography and magnetic resonance imaging services indicated in the medical prescription and authorized by the Commission must be rendered on the same day.

When the diagnoses for which the examinations are required pertain to different anatomical regions situated at the body's extremities, a maximum of 2 examinations per day is permitted.

43. Every claim to the Commission concerning computer tomography and magnetic resonance imaging services must be submitted by the medical imaging laboratory, which claim must in particular include

(1) the date, description of the service rendered and the type of examination performed;

(2) the prescription of the health professional in charge of the worker requiring the service and examination;

(3) the worker's name, address, record number;

(4) the name of the physician having provided the service;

(5) the amount of the technical component of the service provided, detailed with the code of the Ministère de la Santé et des Services sociaux; and

(6) the amount of the professional component of the service provided, detailed with the code of the Régie de l'assurance maladie du Québec.

(a) Computer tomography services

44. The Commission assumes the cost of the technical component and the professional component for the computer tomography services provided to a worker for the performance of the examinations required by the health professional in charge of the worker, according to the terms set out in this subdivision.

45. The Commission assumes the cost of the professional component for the computer tomography services provided to a worker for the performance of the examinations required by the health professional in charge of the worker in accordance with the rate provided for in the diagnostic radiology section of the Manuel de facturation des médecins spécialistes of the Régie de l'assurance maladie du Québec. The document is available on the Commission's website.

46. The Commission assumes the cost of the technical component for the computer tomography services provided to a worker for the performance of the examinations required by the health professional in charge of the worker in accordance with the following amounts:

(1) $200 for a simple examination performed on the same day;

(2) $200 per different anatomical region examined as part of multiple examinations performed on the same day;

(3) for an examination on multiple sections of the spine:

(*a*) $200 for 1 section;

(*b*) $288 for 2 sections;

(*c*) $332 for 3 sections.

The amounts include the cost of the contrast agents administered during the examinations.

47. When an arthrography is required by the health professional in charge of the worker, the Commission assumes, in addition to the cost of the computer tomography services provided to the worker in accordance with sections 45 and 46, the cost of the technical component and the professional component of such an arthrography provided to the worker in accordance with the following amounts:

(1) for the professional component, the rate prescribed in the Manuel de facturation des médecins spécialistes of the Régie de l'assurance maladie du Québec for the appropriate code;

(2) for the technical component, the rates for general radiology in schedule 1 to circular 03.01.42.19 entitled "Tarifs pour les services rendus en externe, prix de journée pour la courte et la longue durée ainsi que prix de journée pour la réadaptation, les nouveau-nés et les services aux jeunes" of the Ministère de la Santé et des Services sociaux, and according to the list of unit values of circular 03.04.01.01 (schedule G) of the Ministère de la Santé et des Services sociaux.

The documents are available on the Commission's website.

48. For the purposes of this subdivision, a simple examination is required where the diagnosis for which the examination is requested, as indicated in the medical prescription of the health professional in charge of the worker, pertains to only one of the following anatomical regions:

(*a*) head, including the brain and the skull;

(*b*) neck;

(*c*) thorax;

(*d*) abdomen;

(*e*) pelvis, including the sacroiliac articulations;

(*f*) extremities (shoulders, hips, lower limbs, upper limbs);

(*g*) spine (1 section, 2 sections, 3 sections), including the lumbosacral joint.

A simple examination is also required when the diagnosis for which the examination is requested, as indicated in the medical prescription of the health professional in charge of the worker, pertains to a combination of the following anatomical regions:

(*a*) shoulder – shoulder blade;

(*b*) shoulder – arm;

(*c*) arm – elbow;

(*d*) elbow – forearm;

(*e*) forearm – wrist;

(*f*) hand – fingers and thumb;

(*g*) pelvis – sacrum;

(*h*) pelvis – a hip;

(*i*) hip – femur;

(*j*) femur – knee;

(*k*) knee – leg;

(*l*) leg – ankle;

(*m*) ankle – hindfoot.

49. For the purposes of this subdivision, multiple examinations are required where the diagnoses for which the examinations are requested, as indicated in the medical prescription of the health professional in charge of the worker, pertain to different anatomical regions.

For the purposes of this section, the following regions are different anatomical regions:

(*a*) hand – wrist, provided that there is a complete examination of the hand and a complete examination of the wrist and the phalanges are included in the examination;

(*b*) shoulder – neck;

(*c*) right shoulder – left shoulder;

(*d*) shoulder – trapezius;

(*e*) neck – head;

(*f*) head –cervical spine;

(*g*) ankle – forefoot;

(*h*) shoulder – elbow;

(*i*) shoulder – wrist.

(b) Magnetic resonance imaging services

50. The Commission assumes the cost of the technical component and the professional component for the magnetic resonance imaging services provided to a worker for the performance of the examinations required by the health professional in charge of the worker, according to the terms set out in this subdivision.

The Commission does not assume any cost other than the cost provided for in the first paragraph for the provision of magnetic resonance imaging services.

51. The Commission assumes the cost of the professional component for the magnetic resonance imaging services provided to a worker for the performance of each examination required by the health professional in charge of the worker in accordance with the rate in the diagnostic radiology section of the Manuel de facturation des médecins spécialistes of the Régie de l'assurance maladie du Québec. The document is available on the Commission's website.

52. The Commission assumes the cost of the technical component for the magnetic resonance imaging services provided to a worker for the performance of each examination required by the health professional in charge of the worker in accordance with the following amounts:

(1) $543.60 for a simple examination performed on the same day;

(2) $543.60 per different anatomical region examined as part of multiple examinations performed on the same day;

(3) for an examination pertaining to multiple sections of the spine:

(*a*) $543.60 for 1 section;

(*b*) $785.20 for 2 sections;

(*c*) $906.00 for 3 sections.

The amounts include the cost of the contrast agents administered during the examinations.

53. When an arthrography is required by the health professional in charge of the worker, the Commission assumes, in addition to the cost for the magnetic resonance imaging services provided to the worker in accordance with sections 51 and 52, the cost of the technical component and the professional component of such an arthrography provided to the worker in accordance with the following amounts:

(1) for the professional component, the rate in the Manuel de facturation des médecins spécialistes of the Régie de l'assurance maladie du Québec for the appropriate code;

(2) for the technical component, the rates for general radiology in schedule 1 to the circular (03.01.42.19) entitled "Tarifs pour les services rendus en externe, prix de journée pour la courte et la longue durée ainsi que prix de journée pour la réadaptation, les nouveau-nés et les services aux jeunes" of the Ministère de la Santé et des Services sociaux, and according to the list of unit values of circular 03.04.01.01 (schedule G) of the Ministère de la Santé et des Services sociaux.

The documents are available on the Commission's website.

54. For the purposes of this subdivision, a simple examination is required where the diagnosis for which the examination is requested, as indicated in the medical prescription of the health professional in charge of the worker, pertains to only one of the following anatomical regions:

(*a*) head, including the brain and skull;

(*b*) neck;

(*c*) thorax;

(*d*) abdomen;

(*e*) pelvis, including the sacrum-iliac articulations;

(*f*) extremities (shoulders, hips, lower limbs, upper limbs);

(*g*) spine (1 section, 2 sections, 3 sections), including the lumbosacral joint.

Multiple examinations are required where the diagnoses for which the examinations are required, as indicated in the medical prescription of the health professional in charge of the worker, pertain to different anatomical regions among those identified in the first paragraph.

Specific rules for ultrasound services

55. The Commission assumes the cost of

(1) diagnostic ultrasound services; and

(2) ultrasound guidance services.

56. The Commission assumes the cost of the ultrasound services provided for in this subdivision provided to a worker if the following conditions are met:

(1) they are provided by a physician other than a radiologist;

(2) they are provided in a private institution within the meaning of section 99 of the Act respecting health services and social services (chapter S-4.2);

(3) in the case of ultrasound guidance services, the ultrasound services are used as guidance during an injection;

(4) the Commission authorized the services following an application by the health professional.

(a) Diagnostic ultrasound services

57. The Commission assumes the cost of diagnostic ultrasound services in accordance with the rate for radiologists in the diagnostic radiology section of the Manuel de facturation des médecins spécialistes, Services de laboratoire en établissement, of the Régie de l'assurance maladie du Québec, excluding digitization fees (R-9). The document is available on the Commission's website.

58. The Commission assumes the cost of diagnostic ultrasound services up to 1 examination per day per worker.

Despite the first paragraph, the Commission assumes the cost of diagnostic ultrasound services up to 2 examinations per day per worker in the situations described in the Manuel de facturation des médecins spécialistes, Services de laboratoire en établissement, of the Régie de l'assurance maladie du Québec. The document is available on the Commission's website.

(b) Ultrasound guidance services

59. The Commission assumes the cost of ultrasound guidance services in accordance with the rate for surface ultrasound - miscellaneous in the diagnostic radiology section of the Manuel de facturation des médecins spécialistes, Services de laboratoire en établissement, of the Régie de l'assurance maladie du Québec, excluding digitization fees (R-9). The document is available on the Commission's website.

Special rules for non-insured surgeries

60. The Commission assumes the cost of a non-insured surgery provided to a worker if the following conditions are met:

(1) it is required as a result of the employment injury;

(2) the Commission authorized the surgery following an application by the health professional.

In addition to the conditions set out in the first paragraph, it assumes the cost of a surgery where any of the following conditions are met, as the case may be:

(1) for cosmetic surgery, the worker's employment injury causes functional interference or psychological harm;

(2) for a surgery required medically, it is recognized scientifically.

61. The Commission assumes the cost of a non-insured surgery provided for in this subdivision in accordance with the following amounts:

(1) for the professional component, the rates in the billing manuals of the Régie de l'assurance maladie du Québec for the same type of services as those rendered by the health professional who performed the surgery;

(2) for the technical component, the rate for day surgery provided for in the agreement entered into between the Commission and the Minister of Health and Social Services in accordance with section 195 of the Act respecting industrial accidents and occupational diseases (schedule 1 Tarifs – Services rendus en externe);

(3) the actual cost of implants and prostheses that may be integrated into the human body during the surgery, where applicable.

The documents are available on the Commission's website.

Special rules for non-insured services rendered by a dentist

62. The Commission assumes the cost of non-insured services rendered by a dentist to a worker, including laboratory costs, if the following conditions are met:

(1) they are required, in terms of dentistry, by the worker's condition as a result of the employment injury;

(2) they are provided by a dentist;

(3) the Commission authorized the provision of the services following an authorization application by the health professional.

Subparagraph 3 of the first paragraph does not apply to non-insured services rendered by a dentist provided in an emergency.

63. The Commission assumes the cost of non-insured services rendered by a dentist provided for in this subdivision up to the amounts in the list of rates of the Association des chirurgiens-dentistes du Québec and that of the Fédération des dentistes spécialistes du Québec in force on 31 January 2025.

The documents are available on the Commission's website.

The amounts provided for in those documents are, where required, revalorized annually according to the variation between the amounts of the year concerned and those of the preceding year applied by the professional associations mentioned in the first paragraph, up to the rate of revalorization applicable according to the rules set out in sections 119 to 122 of the Act. A list of the amounts is available on the Commission's website.

Special rules for non-insured services rendered by an optometrist

64. The Commission assumes the cost of non-insured services rendered by an optometrist to a worker if the following conditions are met:

(1) they are required, in terms of optometry, by the worker's condition as a result of the employment injury;

(2) they are provided by an optometrist.

65. The Commission assumes the cost of non-insured services rendered by an optometrist provided for in this subdivision up to the amounts in the list of rates of the Association des optométristes du Québec in force on 31 January 2025.

The document is available on the Commission's website.

The amounts provided for in the document are, where required, revalorized annually according to the variation between the amounts of the year concerned and those of the preceding year applied by the professional association mentioned in the first paragraph, up to the rate of revalorization applicable according to the rules set out in sections 119 to 122 of the Act. A list of the amounts is available on the Commission's website.

Special rules for medico-administrative services rendered by a dentist or an optometrist

66. For the purposes of this subdivision, "medico-administrative services" means the services for completing the documents required by the Commission for the management of a worker's record, including in particular certain medical evaluations and report drafting.

67. The Commission assumes the cost of the medico-administrative services provided by a dentist or an optometrist in accordance with the amounts provided for those services in the Manuel de facturation des médecins of the Régie de l'assurance maladie du Québec. The document is available on the Commission's website.

Special rules for other non-insured services

68. The Commission assumes the cost of any other non-insured service provided to a worker, if the following conditions are met:

(1) it is required, medically, by the worker's condition as a result of the employment injury;

(2) the health professional in charge of the worker provides, with the prescription, a scientific and medical demonstration of the effectiveness of the service for the worker;

(3) the Commission authorized the provision of the service following an application by the health professional in charge of the worker.

69. The Commission assumes the cost of any other non-insured service provided for in this subdivision in accordance with the rate applicable for a comparable service covered by the Régie de l'assurance maladie du Québec under of the Health Insurance Act (chapter A-29), the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) or a regulation made under those Acts.

§3. Cannabis for medical purposes

70. The Commission assumes the cost of cannabis for medical purposes up to a limit equal to 3 grams per day of dried cannabis, if the following conditions are met:

(1) it is prescribed by the health professional in charge of the worker;

(2) it is related to the employment injury;

(3) the cannabis is consumed by ingestion or by transdermal absorption.

Despite subparagraph 3 of the first paragraph, the Commission assumes exceptionally the cost of cannabis for medical purposes that is consumed by inhalation where that type of consumption is justified by the health professional in charge of the worker because of the worker's condition.

71. The Commission assumes the costs of delivery of cannabis for medical purposes up to an amount of $20 per delivery.

72. Every claim to the Commission concerning cannabis for medical purposes must be submitted on the form prescribed and available on the Commission's website.

DIVISION III
PHYSICAL REHABILITATION SERVICES

§1. General rules

73. Physical rehabilitation services to which a worker is entitled to remove or lessen a worker's physical handicap and, where applicable, to enable a worker to develop residual capacity are

(1) home inhalation therapy;

(2) dominance transfer; and

(3) graded motor imagery.

Physiotherapy and occupational therapy care and treatment as well as home nursing care and physiotherapy treatment provided for in Division II also constitute physical rehabilitation services to which the worker is entitled where the objective is that provided for in the first paragraph.

74. The Commission assumes the cost of the physical rehabilitation services provided for in the first paragraph of section 73 where they are prescribed by the health professional in charge of the worker.

The Commission assumes the cost of the physical rehabilitation services provided for in the second paragraph of section 73 on the same conditions as those set out in Division II.

§2. Special rules for home inhalation therapy

75. The Commission assumes the cost of the home inhalation therapy care by a health worker up to $168.60 for a session of 60 minutes, according to the frequency determined by the health professional in charge of the worker.

76. During the first session, the inhalation therapist providing the home care must provide an evaluation report. The inhalation therapist must also provide a progress report at the Commission's request.

The reports referred to in the first paragraph must be sent to the Commission on the prescribed form or, if sent using another technological medium, complying with that authorized by the Commission.

The report form is available on the Commission's website.

The report must be sent to the Commission and to the health professional in charge of the worker within 15 days following the date of the first session or the request by the Commission, as the case may be.

77. Except in case of superior force, where a report required under this subdivision is not filed within the time limit provided for in the fourth paragraph of section 76, the Commission withholds payment of the accounts for the care and treatment sessions provided after the deadline for filing the report, until it is sent to the Commission.

When the report is filed, the Commission pays the accounts for the care and treatment sessions whose payment was withheld.

78. A report required under this subdivision is payable by the Commission only if it is made on the prescribed form or, if sent using another technological medium, complying with that authorized by the Commission, and is complete.

79. The Commission assumes the cost of the reports required under this subdivision, in accordance with the rate for the professional services of occupational therapists and physiotherapists in Schedule I.

§3. Special rules for graded motor imagery and dominance transfer

80. The Commission assumes the cost of graded motor imagery and dominance transfer up to the following limits:

(1) for graded motor imagery, 1 session per week for a total of 12 weeks;

(2) for dominance transfer, 1 session per week for a total of 8 weeks.

The health professional in charge of the worker may extend the number of sessions provided for in the first paragraph for a maximum period of 4 weeks if the health professional considers that the time period contributes to the achievement of the objectives pursued for the worker.

The Commission assumes the cost of 1 session under this section at the same cost as that provided for occupational therapy in Schedule I.

81. The Commission assumes the cost of acquiring or leasing accessories required for graded motor imagery according to the terms set out in Schedule II.

CHAPTER III
ADAPTED EQUIPMENT AND OTHER COSTS

General rules

82. This Chapter applies subject to section 198.1 of the Act.

83. Adapted equipment and other costs to which a worker is entitled under this Regulation are

(1) prostheses and ortheses;

(2) technical aids; and

(3) extricating equipment and long distance calls.

84. The Commission assumes the cost of adapted equipment and other costs on the conditions set out in this Chapter and in Schedule II.

DIVISION I
PROSTHESES AND ORTHESES

85. In this Division,

"orthesis" means a device fitted to a human being and intended to ensure the proper functioning of one of the members or organs of the human being or to restore proper functioning, make up for the limitations or improve the physiological capacity of one of the members or organs that has ceased to function within the meaning of the Act respecting medical laboratories and organ and tissue conservation (chapter L-0.2) and required following an employment injury; (*orthèse*)

"prosthesis" means a device intended to replace the whole or part of an organ or a member of a human being within the meaning of the Act respecting medical laboratories and organ and tissue conservation (chapter L-0.2) and required following an employment injury. (*prothèse*)

86. The prostheses and orthoses to which a worker is entitled under this Division are

(1) hearing devices;

(2) visual orthoses;

(3) ocular prostheses;

(4) hairpieces;

(5) dental prostheses;

(6) trunk and lower and upper limb prostheses and orthoses;

(7) plantar orthoses; and

(8) orthopedic shoes.

87. The Commission assumes the cost of prostheses and orthoses provided for in this Division where they are prescribed by the health professional in charge of the worker and on the conditions set out in this Division.

88. The Commission does not assume the following costs:

(1) the cost of an extended warranty for a prosthesis or orthesis;

(2) the cost of replacing a prosthesis or orthesis that has been lost, destroyed or stolen or whose use was negligent or contrary to the manufacturer's recommendations.

§1. Rules on hearing devices

General rules

89. For the purposes of this subdivision,

"audiogram" means an audiogram performed by an audiologist as part of an audiological evaluation or by a health professional.

90. Every claim related to a hearing device must be accompanied by an audiogram performed less than 1 year before the date of acquisition of the device.

91. The amounts for audiology services are revalorized according to the rules set out in sections 118 and 120 to 122 of the Act and by multiplying the amount to be revalorized by the average of the revalorization rates of the 6 preceding years. The revalorization rate of each year is equal to the ratio between the Consumer Price Index of the current year and that of the preceding year.

Professional services of hearing-aid acousticians

92. The Commission assumes the cost of the professional services in Schedule VI, in accordance with the amounts and the conditions set out in the Schedule, if they are provided personally by a health worker.

The Commission also assumes the cost of the professional services provided by a person other than a health worker to the extent provided in Schedule VI.

93. The amounts for the professional services of hearing-aid acousticians are revalorized according to the rules set out in sections 118 to 122 of the Act.

94. Subject to a prescription to the contrary from the health professional in charge of the worker, the Commission assumes, once every 30 months, the cost of an audiological evaluation listed in Schedule VI, in accordance with the amount set out in the Schedule and only if the evaluation is prescribed by a health professional.

The Commission also assumes the cost of an audioprosthetic evaluation, in accordance with the amount and the conditions set out in Schedule VI, where the worker has not had an audiological evaluation in the 12 months preceding the claim and more than 12 months have elapsed since the date of the services for the acquisition of the hearing device indicated in the form prescribed by the Commission.

The hearing-aid acoustician must keep the evaluation referred to in the second paragraph in the worker's record for a period of 5 years from the date on which the record is closed. The evaluation must be put at the disposal of the Commission, on request.

95. When the hearing-aid acoustician sends the audiological evaluation to the Commission using the form prescribed by the Commission for payment, the hearing-aid acoustician must also send a copy to the health professional in charge of the worker.

Special rules for hearing devices, accessories and other costs

96. For the purposes of this subdivision, the conditions and payment limits are established having regard to the date of acquisition of the hearing device indicated in the form prescribed by the Commission.

97. The Commission assumes, at the frequency determined in sections 104 to 110, the cost of acquiring a hearing device that is not a continuous wear hearing device, up to an amount of $700, if the hearing device is warranted for a minimum period of 2 years.

For the purposes of this subdivision, a hearing device covered by a program administered by the Régie de l'assurance maladie du Québec is deemed to be under warranty for that period.

98. The Commission assumes the cost of acquiring a continuous wear hearing device or a hearing device the amount of which exceeds $700 only where the Commission gave prior authorization for the acquisition.

The Commission authorizes the acquisition of such a hearing device if it has been demonstrated to the Commission that the worker's condition prevents the worker from operating or having adequately adjusted another type of hearing device.

To meet that condition, the worker must provide an attestation from a health professional holding a specialist's certificate relevant to the worker's condition.

The Commission assumes an amount up to $1,800 per year for each ear, but no other amount for goods and services relating to a continuous wear hearing device.

The Commission assumes an amount up to the manufacturer's cost for a hearing device other than the continuous wear hearing device referred to in the first paragraph, according to the frequency determined in sections 104 to 110 of this subdivision.

99. The Commission assumes, at the choice of the worker, the acquisition of a remote control or services for pairing the hearing devices to the worker's cellular telephone.

Where the worker chooses the remote control, the Commission assumes, at the frequency determined in sections 104 to 110 and up to an amount of $150, the cost of acquiring 1 remote control if it is covered by a warranty for a minimum period of 30 months.

Where the worker chooses the pairing of the hearing devices to the worker's cellular telephone, the Commission assumes the cost of the services for pairing the hearing devices to the cellular telephone in accordance with the amount and the conditions set out in Schedule VI.

For the purposes of this Regulation, a remote control covered by a program administered by the Régie de l'assurance maladie du Québec is deemed to be under warranty for that period.

100. Despite the first paragraph of section 98, the Commission assumes the cost of acquiring rechargeable prostheses up to an amount of $900 each, including the charger.

101. The Commission assumes the cost of replacing the charger of a rechargeable prosthesis, up to an amount of $200 where the 2-year warranty of the prosthesis is expired.

102. The Commission assumes the cost, up to an amount of $800, of acquiring a CROS or BiCROS system, including its programming at the time of acquisition, including the professional services of the hearing-aid acoustician, if the system is warranted for a minimum period of 2 years.

The Commission assumes the cost of acquiring such a system where it has been demonstrated to the Commission that the worker's condition is such that

(1) the particular anatomy of the worker's ear does not allow for the fitting of a hearing device;

(2) the worker is affected by recurring infections that preclude the fitting of a device; or

(3) the worker is totally deaf or has substantial discriminatory loss that precludes the fitting of a device in 1 ear.

To meet the condition, the worker must provide an attestation from the health professional in charge of the worker. The attestation must state that the wearing of a device is impossible in the worker's case and specify what the worker's condition is. In the case described in subparagraph 3 of the second paragraph, the worker may provide an audiological evaluation to that effect instead of an attestation.

For the purposes of this Regulation, a CROS or BiCROS system covered by a program administered by the Régie de l'assurance maladie du Québec is deemed to be under warranty for the 2-year period.

103. Where the Commission assumes the cost of a CROS or BiCROS system, it assumes the cost of acquiring 1 hearing device only.

Replacement and repair of hearing devices and their accessories

104. A worker may apply to the Commission to renew a hearing device the cost of which was assumed by the Commission if at least 5 years have elapsed since the date of acquisition of the hearing device indicated in the form prescribed by the Commission and the warranty for the hearing device has expired.

Where the health professional in charge of the worker has established the permanency of the worker's deafness, the worker must provide, with the application, an audiogram dating less than 1 year.

Where the worker is unable to obtain an audiogram within 90 days, the worker must be able to provide, at the Commission's request, an evaluation for audioprosthetic purposes, dating less than 1 year performed by a hearing-aid acoustician.

A worker who has a CROS or BiCROS system at the time the hearing device is renewed is also entitled to have the system renewed.

105. Despite section 104, where a repair has been performed in the 4th year of the acquisition of the hearing device, the renewal period is extended for a maximum period of 12 months or where 72 months will have elapsed from the date of acquisition.

The extension of the renewal period applies to both hearing devices in the case of a binaural device.

106. Despite section 88, the Commission assumes, on the conditions set out in this Regulation, the cost of the adjustment, maintenance and repair of a device acquired by a worker to replace a device described in the second paragraph of that section if the device is compatible with the original device for which the Commission assumed the cost, where applicable.

In such a case, the worker must provide the Commission with a voucher containing

(1) proof of acquisition of the device;

(2) the date of acquisition; and

(3) information on the make and model of the device.

A hearing device acquired by the worker is deemed to be covered by a warranty for a period of 2 years from the date of acquisition.

107. The Commission assumes the cost of replacing a hearing device before the expiry of the time limit referred to in section 104 where the Commission authorized the acquisition and any of the following conditions is met:

(1) the worker's auditory condition shows a new sensorineural hearing loss of at least 20 dB HL at not fewer than 2 frequencies between 500 Hz and 4,000 Hz in the same ear since the audiogram and the device cannot be adjusted to account for the hearing loss;

(2) the worker has a new medical condition preventing the use of the hearing device, even with a remote control;

(3) the hearing device has become so deteriorated that it can no longer be used, repaired or cleaned, including because of the worker's acidic perspiration, excess toxic fumes or pollution, such as dust, to which the device is exposed;

(4) subject to section 113 of the Act, the device was unintentionally and accidentally damaged.

In the case provided for in subparagraph 1 of the first paragraph, a written explanation from a hearing-aid acoustician of the reasons justifying that the device may not be adjusted to the worker's auditory condition and an attestation from a health professional or an audiological evaluation indicating the worker's hearing loss must be provided to the Commission.

In the case provided for in subparagraph 2 of the first paragraph, an attestation from a health professional specifying the condition that prevents the worker from using the hearing device must be provided to the Commission.

In the case provided for in subparagraph 3 of the first paragraph, a written document from the hearing-aid acoustician describing the state of deterioration of the device and explaining the reason for the deterioration must be provided to the Commission. A hearing-aid acoustician must keep the result of the electroacoustic analysis and provide it to the Commission on request.

In the case provided for in subparagraph 4 of the first paragraph, the worker must provide a written explanation of the circumstances in which the device was damaged and the hearing-aid acoustician must provide a written document showing that the manufacturer is unable to repair the device.

If 2 hearing devices must be replaced in the cases described in subparagraphs 1, 3 and 4 of the first paragraph, a written document from a hearing-aid acoustician

or a hearing device manufacturer setting forth the reasons substantiating the necessity of replacing both devices must be provided to the Commission.

The application must be made on the form prescribed by the Commission. The form is available on the Commission's website.

108. The Commission assumes cost of renewing a remote control for a hearing device if the control has been used in accordance with the manufacturer's recommendations, the remote control's warranty has expired and if a written document from a hearing-aid acoustician substantiating that it cannot be repaired is provided to the Commission.

The Commission also assumes the renewal cost when the worker's hearing device has been renewed in accordance with section 104.

109. The Commission assumes the cost of having a hearing device, including the replacement of the battery of a rechargeable prosthesis, or a CROS or BiCROS system repaired by its manufacturer up to an amount of $125 where the warranty period has expired or the breakage is not covered by a warranty and once done, the repair will be covered by a warranty for a minimum period of 1 year.

110. The Commission assumes the cost of having a remote control for a hearing device repaired by the manufacturer if the following conditions are met:

(1) the remote control is used in accordance with the manufacturer's recommendations;

(2) the cost of the repair does not exceed 80% of its replacement cost;

(3) the warranty period for the remote control has expired;

(4) the breakage is not already covered by a warranty;

(5) the repair is covered by a warranty for a minimum period of 30 month.

Other costs relating to hearing devices

111. The Commission assumes the maintenance costs and the cost of acquiring other accessories, up to the amounts and on the conditions set out in Schedule VII.

112. The Commission assumes the cost of services to have a hearing device remade by the manufacturer up to an amount of $175 where the warranty period has expired and the work is covered by a warranty for a minimum period of 1 year.

113. In the case of temporary bilateral deafness, the Commission assumes the cost of acquiring a tinnitus masker up to an amount of $80.

For the purposes of this section, a hearing device that has a feature or program allowing tinnitus to be masked does not constitute a tinnitus masker.

The costs under the first paragraph are not payable by the Commission for the adjustment of such a feature or program when a hearing device is adjusted or fitted.

§2. Rules relating to visual ortheses

114. For the purposes of this subdivision, "visual orthesis" means eyeglasses, including the frame and corrective lenses, and contact lenses.

115. The Commission assumes the cost of acquiring a visual orthesis according to the appropriate and most economic means and on the conditions set out in this subdivision.

116. Where the worker's condition may only be corrected by the wearing of contact lenses, the Commission assumes the cost of acquiring contact lenses and the cost of acquiring solutions for the care of the lenses.

117. Where the correction of the worker's condition does not absolutely require the wearing of contact lenses, but the worker chooses the contact lenses instead of eyeglasses, the Commission assumes the cost corresponding to the cost of acquiring eyeglasses.

The Commission does not assume, in that case, the cost of acquiring solutions for the care of contact lenses.

118. The Commission assumes the cost of acquiring eyeglasses, including the frame and corrective lenses, up to the following amounts:

(1) for the frame, the amount provided for in section 113 of the Act;

(2) for the corrective lenses, the amount in the list of rates of the Association des optométristes du Québec in force on 31 January 2025. The document is available on the Commission's website.

The amounts provided for in the document referred to in subparagraph 2 of the first paragraph are, where required, revalorized every 5 years according to the variation between the amounts of the year concerned and those of the preceding list applied by the professional association mentioned in subparagraph 2 of the first paragraph, up to the rate of revalorization applicable according to the rules set out in sections 119 to 122 of the Act, with the necessary modifications. A list of the amounts is available on the Commission's website.

119. The Commission assumes, where authorized by the Commission, the cost of renewing a worker's visual orthesis the acquisition cost of which was assumed by the Commission according to the following frequency:

(1) every 2 years from the date of the initial acquisition, for eyeglasses;

(2) according to the worker's needs, for the contact lenses required to correct the worker's condition and for the solutions for the care of the lenses.

Despite subparagraph 1 of the first paragraph, when the eyeglasses are repaired or replaced in accordance with section 120, the 2-year period runs from the repair or replacement date, as the case may be.

120. The Commission assumes the cost of repairing the worker's visual orthesis the acquisition cost of which was assumed by the Commission, up to 80% of its initial acquisition cost.

Where it exceeds that cost, the Commission assumes the cost of replacing the worker's visual orthesis before the expiry of the term provided for in section 119.

§3. Rules relating to ocular prostheses

121. The Commission assumes the cost of acquiring an ocular prosthesis required as a result of a partial or total loss of a worker's eye or eyes caused by the employment injury on the conditions set out in this subdivision.

122. The Commission assumes the cost of renewing an ocular prosthesis every 5 years. The time period is calculated from the date of acquisition of the prosthesis, its repair or replacement, as the case may be.

Despite the first paragraph, the Commission may assume the cost of replacing an ocular prosthesis before the expiry of the term where the replacement is required after a modification of the worker's eye and is recommended by an ophtalmologist.

123. The Commission assumes the cost of repairing the ocular prosthesis, up to 80% of the cost of the initial acquisition.

Where it exceeds that cost, the Commission assumes the cost of replacing the worker's ocular prosthesis before the expiry of the term provided for in section 122.

The Commission also assumes the cost of any adjustment of an ocular prosthesis.

124. The Commission assumes the cost of acquiring, adjusting, repairing, renewing and replacing an ocular prosthesis up to the amounts set out in the list of rates of ocularists in force on 31 January 2025.

The document is available on the Commission's website.

The amounts provided for in the document are, where required, revalorized annually according to the variation between the amounts of the year concerned and those of the preceding year applied by ocularists, up to the rate of revalorization applicable according to the rules set out in sections 119 to 122 of the Act. A list of the amounts is available on the Commission's website.

§4. Rules relating to hairpieces

125. For the purposes of this subdivision, a hairpiece includes in particular a custom hair volumizer.

126. The Commission assumes the cost of acquiring a hairpiece and the cost of acquiring specialized products required for the care of the hairpiece when it is necessary to mask or compensate a worker's major hair loss caused by the employment injury and on the conditions set out in this subdivision.

127. The Commission assumes the cost of renewing the hairpiece and specialized products required for its care up to once per calendar year.

128. The Commission assumes the cost of repairing the worker's hairpiece, up to 80% of the cost of the initial acquisition.

Where it exceeds that cost, the Commission assumes the cost of replacing the worker's hairpiece despite the annual limit provided for in section 127.

The Commission also assumes the cost of any adjustment of a hairpiece.

129. The Commission assumes the actual cost of acquiring, adjusting, maintaining, repairing, replacing and renewing a hairpiece and specialized products required for the care of the hairpiece.

§5. Rules relating to dental prostheses

130. The Commission assumes the cost of acquiring a fixed or removable dental prosthesis, if the following conditions are met:

(1) the fixed or removable prosthesis is required as a result of the worker's condition resulting from the worker's employment injury;

(2) it is provided by a dentist or a denturologist;

(3) the Commission authorized the purchase of the prosthesis following an authorization application.

131. Where a dentist deems that the worker's condition requires a fixed prosthesis, the dentist must submit to the Commission a treatment plan and a cost estimate in order to obtain an authorization.

132. The Commission assumes the renewal cost of a dental prosthesis on the same conditions every 8 years. The period is calculated from the date of acquisition of the dental prosthesis, its repair or replacement.

Despite the first paragraph, the Commission may assume the replacement of a dental prosthesis before the expiry of the term where the worker provides a prescription from the dentist or a recommendation of a denturologist establishing the need for such a replacement.

133. The Commission assumes the cost of repairing a worker's dental prosthesis, up to 80% of the initial acquisition cost.

Where it exceeds that cost, the Commission assumes the replacement cost of the worker's dental prosthesis before the expiry of the renewal period provided for in section 132.

134. The Commission assumes the cost of acquiring, repairing, replacing and renewing a dental prosthesis up to the rates set out in the list of rates of the Association des denturologistes, of the Association des chirurgiens-dentistes du Québec and of the Fédération des dentistes spécialistes du Québec in force on 31 January 2025. The rates include the denturologist or dentist fees and laboratory costs. The latter may not be higher than 50% of the denturologist or dentist fees.

The documents are available on the Commission's website.

The amounts provided for in the documents are, where required, revalorized annually according to the variation between the amounts of the year concerned and those of the preceding year applied by the professional associations mentioned in the first paragraph, up to the rate of revalorization applicable according to the rules set out in sections 119 to 122 of the Act. A list of the amounts is available on the Commission's website.

§6. Rules relating to trunk and lower and upper limbs prostheses and ortheses

135. The Commission assumes the cost of acquiring a prosthesis or orthesis for the trunk and limbs covered by a program administered by the Régie de l'assurance maladie du Québec under the Health Insurance Act (chapter A-29) or the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) if the following conditions are met:

(1) the health professional in charge of the worker prescribes such a prosthesis or orthesis and indicates the diagnosis for which it was prescribed;

(2) it is provided by

(*a*) a laboratory holding a permit issued by the Minister of Health and Social Services in accordance with the Act respecting medical laboratories and organ and tissue conservation (chapter L-0.2);

(*b*) a public rehabilitation institution; or

(*c*) a supplier recognized by the Commission, where it is not established in Québec.

136. When a prosthesis or orthesis for the trunk and limbs required by a worker as a result of an employment injury is not covered by a program administered by the Régie de l'assurance maladie du Québec under the Health Insurance Act (chapter A-29) or the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5), the Commission assumes the cost of acquiring the prosthesis or orthesis if the following conditions are met:

(1) the health professional in charge of the worker prescribes such a prosthesis or orthesis and indicates the diagnosis for which it was prescribed;

(2) it is provided by

(*a*) a laboratory holding a permit issued by the Minister of Health and Social Services in accordance with the Act respecting medical laboratories and organ and tissue conservation (chapter L-0.2);

(*b*) a public rehabilitation institution; or

(*c*) a supplier recognized by the Commission, where it is not established in Québec;

(3) it must be accompanied bv a warranty comparable to the program administered by the Régie de l'assurance maladie du Québec and its life must be comparable to that of a prosthesis or orthesis of the program;

(4) it is not a prototype;

(5) the Commission authorized the acquisition following an authorization application by the supplier, including in particular,

(*a*) where the authorization application concerns an orthesis, a justification of its usefulness by demonstrating that the ortheses included in the program do not meet the worker's need and a demonstration that the probable life and the warranty of the orthesis are comparable to that provided for in the program; and

(*b*) where the authorization application concerns a prosthesis, a report provided by a public rehabilitation centre justifying the need of a prosthesis other than the prosthesis covered by a program administered by the Régie de l'assurance maladie du Québec, which must contain in particular

i. an evaluation of the worker's needs and the objective sought by the device;

ii. an indication of the options, including a comparison between the prosthesis being considered and the prosthesis covered by a program administered by the Régie de l'assurance maladie du Québec; and

iii. substantiation that the prosthesis being considered better meets the worker's needs.

The acquisition cost includes

(1) the adjustment of the prosthesis or orthesis during the fitting;

(2) the components and optional supplements;

(3) fittings during the manufacturing up to the installation of the prosthesis or the orthesis; and

(4) fittings and repairs during the warranty period of the prosthesis or orthesis.

The Commission assumes the cost of acquiring such a prosthesis or orthesis in accordance with the rate prescribed in the program administered by the Régie de l'assurance maladie for an equivalent prosthesis or orthesis or the actual cost if the prosthesis or orthesis is not included in the rates.

137. Where the cost of acquiring an orthesis for the trunk and limbs that is not covered by a program administered by the Régie de l'assurance maladie du Québec under the Health Insurance Act (chapter A-29) or the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) is greater than $300 and is not custom-made, the Commission may request a second tender from the worker.

138. The Commission assumes the cost of a subsequent adjustment of a prosthesis or orthesis for the trunk and limbs when recommended by the health professional in charge of the worker or by a health worker qualified to make such a recommendation, in accordance with the rates provided for the manpower and material used in the program administered by the Régie de l'assurance maladie du Québec under the Health Insurance Act (chapter A-29) or the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5).

Where such an adjustment is not covered by the program, the Commission assumes the actual cost of the adjustment.

139. The Commission assumes the cost of a repair or fitting of a prosthesis or orthesis for the trunk and limbs or one of its components where the warranty has expired, in accordance with the rates provided for the manpower and material used in the program administered by the Régie de l'assurance maladie du Québec or the actual cost if they are not included in the rates, up to 80% of the acquisition cost.

140. The Commission assumes the cost of renewing a prosthesis for the trunk and limbs for an identical model, where the minimum duration period provided for in the Regulation respecting devices which compensate for a physical deficiency and are insured under the Health Insurance Act (chapter A-29, r. 4) is reached and where prescribed by the health professional in charge of the worker.

The period provided for in the first paragraph is calculated from the date of acquisition of the prosthesis.

141. The Commission assumes the cost of renewing an orthesis for the trunk and limbs, according to the minimum duration period provided for in the Regulation respecting devices which compensate for a physical deficiency and are insured under the Health Insurance Act (chapter A-29, r. 4), where prescribed by the health professional in charge of the worker.

The period provided for in the first paragraph is calculated from the date of acquisition of the orthesis.

142. The Commission assumes the cost of replacing a prosthesis or orthesis for the trunk and limbs before the expiry of the minimum duration period provided for in sections 140 and 141 in any of the following situations:

(1) the worker's condition undergoes a significant change, the change is attested by a prescription of the health professional in charge of the worker indicating the nature of the change and the supplier of the prosthesis or orthesis is unable to adapt it to compensate for the change;

(2) the prosthesis or orthesis shows signs of premature wear that may not be repaired;

(3) the cost of repairing the prosthesis or orthesis exceeds 80% of its initial acquisition cost.

§7. Rules relating to plantar ortheses

143. For the purposes of this subdivision, "plantar orthesis" means a custom inner sole inserted in the shoes to improve the condition of a lower limb by compensating a posture or support deficiency while protecting the limb.

144. The Commission assumes the cost of acquiring a pair of plantar ortheses, up to an amount of $526.50, if the following conditions are met:

(1) the health professional in charge of the worker prescribes such plantar ortheses and indicates the diagnosis for which they are required;

(2) the Commission authorized the acquisition following an application by the supplier on the form prescribed for that purpose and available on the Commission's website.

145. The Commission may assume the cost of acquiring a second pair of plantar ortheses for the worker, up to the amount provided for in section 144, where the worker is employed and the work environment so requires.

146. The Commission assumes, every 2 years, the cost of renewing a pair of plantar ortheses, up to the amount provided for in section 144 if the following conditions are met:

(1) the health professional in charge of the worker prescribes such plantar ortheses and indicates the diagnosis for which they are required;

(2) the orthesist produces a biomechanical assessment;

(3) the Commission authorized the renewal following an application by the supplier on the form prescribed for that purpose and available on the Commission's website.

When the employment injury is consolidated and the health professional in charge of the worker determines that there is a permanent need, the Commission continues to assume the renewal cost, every 2 years, without it being necessary to submit a new prescription.

147. The Commission assumes the cost of replacing the worker's pair of plantar ortheses before the expiry of the renewal period provided for in section 146 in any of the following situations:

(1) the health professional in charge of the worker observes, on a prescription, a change in the worker's condition;

(2) the worker's pair of plantar ortheses no longer meets its functions and the cost of its repair or adjustment exceeds 80% of its initial acquisition cost.

It assumes the replacement cost if the following conditions are met:

(1) in the case of a change in the worker's condition, a prescription of the health professional in charge of the worker attests the change;

(2) the Commission authorized the replacement following an application by the supplier on the form prescribed for that purpose and available on the Commission's website.

148. The Commission assumes the cost of repairing or adjusting a pair of plantar ortheses, up to 80% of its initial acquisition cost.

Where it exceeds that cost, the Commission assumes the cost of replacing the worker's pair of plantar ortheses before the expiry of the renewal period provided for in section 146.

149. Every claim to the Commission concerning plantar ortheses must be submitted on the form prescribed and available on the Commission's website.

150. Where the worker's shoes cannot accommodate the plantar ortheses, the Commission assumes the cost of acquiring only one pair of mass-produced shoes that may accommodate them. The Commission does not assume the cost of renewing those shoes.

§8. Rules relating to orthopedic shoes

151. For the purposes of this subdivision,

"orthopedic shoes" means shoes or their equivalent including boots, ankle boots, slippers or sandals that are manufactured, transformed or modified to preserve or restore the function of the worker's lower limb, to compensate for the worker's functional limitations or increase the worker's physiological capacity following an employment injury.

Orthopedic shoes are divided into 3 categories:

(1) custom or moulded shoes that are crafted to accommodate a very severe deformation of the feet or ankles and when no prefabricated shoe or boot may be transformed or modified to do so;

(2) prefabricated shoes that are designed to meet a special need as a result of a recognized employment injury or that are modified permanently to accommodate a handicap;

(3) transition shoes to meet the worker's temporary needs, as a result in particular of an injury to the foot, an operation or an edema.

The term "modification" means the permanent modifications made to shoes. The term does not apply to shoes that have undergone non-permanent modifications, including by inserting plantar ortheses or heel pieces.

152. The Commission assumes the cost of acquiring orthopedic shoes or the cost of a modification to the worker's shoes if the following conditions are met:

(1) the health professional in charge of the worker prescribes such shoes or modifications and indicates the diagnosis for which they are required;

(2) the Commission authorized the acquisition or modification following an authorization application by the supplier on the form prescribed for that purpose and available on the Commission's website.

153. Where a modification may be made directly on a worker's shoes to meet the worker's needs without having to provide the worker with prefabricated shoes with special features, the Commission assumes exclusively the cost of the modification.

Where the modification may not be made to the worker's shoes, the Commission assumes the cost of acquiring only one pair of mass-produced shoes meeting the worker's needs.

154. The Commission requires from the worker a second tender where the cost of acquiring prefabricated shoes with special features is $300 or more.

It requires from the worker a second tender where the cost of acquiring custom or moulded shoes is $1,500 or more.

155. Unless notice to the contrary is given by the health professional in charge of the worker, the Commission assumes the cost of acquiring custom or moulded shoes and prefabricated shoes with special features, up to a maximum, for a calendar year, of

(1) 3 pairs for a worker who is employed; and

(2) 2 pairs for a worker who is unemployed or retired.

Unless notice to the contrary is given by the health professional in charge of the worker, the Commission assumes the cost of acquiring only 1 pair of transition shoes.

156. Unless notice to the contrary is given by the health professional in charge of the worker, the Commission assumes the cost of a modification to the worker's shoes, up to a maximum, for a calendar year, of

(1) 3 modifications to the pairs of shoes of a worker who is employed; and

(2) 2 modifications to the pairs of shoes of a worker who is unemployed or retired.

157. The Commission assumes, when it authorized it, the acquisition cost of shoe covers adapted to orthopedic shoes, up to a maximum of 1 pair per calendar year where it previously assumed the cost of moulded or custom shoes or an orthesis other than a plantar orthesis that slides into the shoe.

158. Every claim to the Commission concerning orthopedic shoes must be submitted on the form prescribed and available on the Commission's website.

159. The Commission assumes, according to the worker's need and where it authorized it, the cost of acquiring heel pieces, on prescription of the health professional in charge of the worker.

160. The Commission assumes, every year and until the consolidation of the worker's employment injury, the cost of renewing custom or moulded shoes and prefabricated shoes with special features or a modification to the worker's shoes if the following conditions are met:

(1) the health professional in charge of the worker confirms, by prescription, every 2 years, that such shoes or modifications are required;

(2) the Commission authorized the renewal following an application by the supplier on the form prescribed for that purpose and available on the Commission's website.

Where the employment injury is consolidated and the health professional in charge of the worker determines that there is a permanent need, the Commission continues to assume the renewal cost, every year, without it being necessary to submit a new prescription.

161. The Commission does not assume the cost of renewing transition shoes or mass-produced shoes.

162. The Commission assumes the cost of a modification to custom or moulded shoes and prefabricated shoes with special features, or the cost of acquiring orthopedic shoes of a category other than that held by the worker if the following conditions are met:

(1) the health professional in charge of the worker produces a new prescription modifying the findings of the initial prescription as a result of a change in the worker's condition, and indicating the diagnosis for which the modification or acquisition is required;

(2) the Commission authorized the modification or acquisition following an application by the supplier on the form prescribed for that purpose and available on the Commission's website.

Unless notice to the contrary is given by the health professional in charge of the worker, the Commission assumes the cost up to the maximum provided for in sections 155 and 156.

163. The Commission assumes the cost of repairing a worker's pair of orthopedic shoes, up to 80% of its initial acquisition cost.

Where it exceeds that cost, the Commission assumes the cost of replacing the worker's orthopedic shoes before the expiry of the renewal period provided for in section 160.

DIVISION II
RULES RELATING TO TECHNICAL AIDS

§1. General rules

164. The technical aids to which a worker is entitled under this Division are

(1) locomotive aids;

(2) assistive listening devices;

(3) daily life aids;

(4) therapeutic aids; and

(5) communication aids.

165. The Commission assumes the cost of leasing, acquiring and renewing a technical aid provided for in Schedule II and in this Division, on the conditions and in accordance with the amounts set out in the Schedule and in the Division, where the technical aid is used to treat the employment injury or it is required to compensate for a temporary or permanent functional disability resulting from the injury.

166. Despite section 165, where the Health Insurance Act (chapter A-29), the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5) or a regulation made under those Acts provides for a cost for purchasing or renewing a technical aid the features of which are identical to a technical aid provided for in this Regulation, the Commission assumes only the cost provided for in those Acts or regulations.

167. In the case of the acquisition or renewal of a technical aid the estimated cost of which is $300 or more, the worker must also provide the Commission with 2 estimates, except in the cases referred to in sections 166 and 186.

168. Every adjustment, acquisition or renewal of a technical aid the estimated cost of which is $150 or more must be authorized by the Commission except in the case of the adjustment, acquisition or renewal of an aid referred to in sections 166 and 186.

169. The Commission assumes the cost of adjusting, repairing or renewing a technical aid, except during the warranty period, insofar as the aid is used in accordance with the manufacturer's instructions.

170. Where the estimated cost of repairing a technical aid exceeds 80% of the renewal cost, the Commission assumes only the renewal cost.

§2. Special rules for locomotive aids

171. The Commission assumes the cost of acquiring and leasing the locomotive aids provided for in Schedule II, on the conditions set out in this subdivision.

172. For the foreseeable period of consolidation of the worker's employment injury, the Commission assumes the cost of leasing canes, crutches, walkers and their accessories, or the acquisition cost if it is less than the leasing cost.

173. The Commission assumes the cost of leasing a manually propelled wheelchair if the following conditions are met:

(1) the worker has a temporary disability;

(2) the wheelchair is prescribed by the health professional in charge of the worker.

It assumes the cost of leasing a motorized wheelchair where, in addition to the conditions set out in the first paragraph, the worker is unable to use his or her upper limbs to move the wheelchair or where the health professional in charge of the worker attests that it is contraindicated for the worker to use a manually propelled wheelchair.

174. The Commission assumes the cost of acquiring a manually propelled wheelchair if the following conditions are met:

(1) the worker has a permanent physical impairment;

(2) the wheelchair is prescribed by the health professional in charge of the worker or is recommended by an occupational therapist.

It assumes the cost of acquiring a motorized wheelchair where, in addition to the conditions set out in the first paragraph, the worker is unable to use his or her upper limbs to move the wheelchair or the health professional in charge of the worker attests that it is contraindicated for the worker to use a manually propelled wheelchair.

175. The Commission assumes the cost of acquiring a 3-wheel scooter or a 4-wheel scooter if the following conditions are met:

(1) the worker has a functional limitation related to the employment injury that seriously hinders the worker's locomotion capacity;

(2) the Commission has the certainty that the worker's physical impairment is permanent;

(3) the Commission has the certainty that the physical or mental consequences of the employment injury compromise the worker's social or vocational reintegration;

(4) the apparatus is intended for a permanent use for the worker's regular activities;

(5) the worker does not own a motorized technical aid;

(6) a recommendation from an occupational therapist confirms that

(*a*) the worker's functional limitation related to the employment injury seriously hinders the worker's locomotion capacity;

(*b*) the worker is able to perform transfers independently;

(*c*) the worker has the judgment necessary to use the 3-wheel scooter or the 4-wheel scooter;

(*d*) the apparatus is required to render the worker independent in the worker's environment and residence; and

(*e*) the worker is unable to propel a manual wheelchair.

The Commission assumes the cost of the occupational therapist's evaluation required under this section in accordance with the rate in Schedule I for an initial evaluation in occupational therapy.

176. The cost of acquiring a 3-wheel scooter or a 4-wheel scooter includes the mandatory accessories according to the Ministère des Transports du Québec, namely reflectors, white headlights or red tail-lights, and triangular orange flags. The costs for insurance and storage are not assumed by the Commission.

§3. Special rules for assistive listening devices

177. The Commission assumes the cost of acquiring an assistive listening device covered by a program administered by the Régie de l'assurance maladie du Québec under the Health Insurance Act (chapter A-29) or the Act respecting the Régie de l'assurance maladie du Québec (chapter R-5), where an audiologist recommends it as part of an audiological evaluation to meet the worker's needs.

178. The Commission assumes the cost of acquiring one of the following assistive listening devices, according to the audiologist's recommendation:

(1) text transmission devices such as a television decoder or a TTY;

(2) sound transmission devices such as a personal amplifier or a television infrared system;

(3) environmental control systems such as a door monitor or a telephone monitor, an adapted smoke detector or alarm clock.

179. At the end of the 12-month warranty, the Commission assumes the following repair costs:

(1) the actual cost for the parts and time required by the manufacturer according to the repair;

(2) a maximum of 8 work shifts annually is payable to the hearing-aid acoustician in accordance with the tariff provided for in the Tariff for insured hearing aids and related services (chapter A-29, r. 8).

180. The Commission assumes the cost of replacing an assistive listening device where it becomes inefficient as a result of a change of the worker's auditory condition and an audiologist recommends it.

It also assumes the cost of replacing a stolen, lost or destroyed device after a period of 6 years from the acquisition date.

181. The Commission assumes the cost of repairing an assistive listening device where the estimate for the repair does not exceed 80% of its acquisition cost, if it exceeds that estimate or if the device cannot be repaired, the Commission assumes the renewal cost.

Where the assistive listening device has a life of 6 years, the Commission does not assume the cost of the repair if the estimate of the repair, added to the total cost of the repairs since the expiry of its life, exceeds 80% of the cost of acquiring the device.

182. At the choice of the worker, the Commission assumes, according to the solution that better meets the worker's needs, the cost of acquiring an assistive listening device for television or a connectivity accessory compatible with the device for watching television, when an audiologist recommends it as part of an audiological evaluation.

Where the worker chooses the connectivity accessory, the Commission assumes the cost of acquiring the accessory up to an amount of $200. The Commission also assumes, if it authorized it, the replacement cost after 3 years if the accessory cannot be repaired.

The Commission assumes the cost of replacing a connectivity accessory when it becomes inefficient as a result of a change in the worker's medical condition.

183. In the case of temporary bilateral deafness, the Commission assumes the cost of leasing

(1) telephone amplifiers; and

(2) audible warning devices.

§4. Special rules for daily life aids

184. The Commission assumes the cost of acquiring or leasing, in the case and on the conditions set out in Schedule II, of a daily life aid where

(*a*) it has been prescribed by the health professional in charge of the worker; or

(*b*) its use is recommended by an occupational therapist or a physiotherapist consulted by the worker following a prescription by the health professional in charge of the worker.

§5. Special rules for certain therapeutic aids

185. In addition to the therapeutic aids provided for in Schedule II, the Commission assumes the cost of the therapeutic aids provided for in this subdivision and on the conditions set out in the subdivision.

186. The Commission assumes the cost of a transcutaneous nerve stimulator having the following characteristics:

(1) 2 channels;

(2) direct current;

(3) biphasic square waves;

(4) variable frequencies adjustable from 2 to 80 cycles per second;

(5) impulses adjustable between 50 to 250 microseconds;

(6) frequency modulator.

187. The Commission assumes the cost of leasing a transcutaneous nerve stimulator only for the first 3 months of its use.

At the end of that period, the Commission assumes the cost of acquiring such a device, less the initial leasing cost, if the medical prescription for the use of the device is renewed.

The cost of leasing, acquiring or renewing a transcutaneous nerve stimulator includes the accessories required for its use.

The accessories are wires, batteries, battery charger and either electrodes, gel and hypoallergenic adhesive tape, or self-adhesive rigid or flexible electrodes, where the health professional in charge of the worker prescribes the use of such electrodes.

The cost of acquiring or renewing a transcutaneous nerve stimulator may not exceed $590 plus, where applicable, the cost of self-adhesive rigid or flexible electrodes, up to an amount of $400 for the first year.

188. The cost of renewing the accessories of a transcutaneous nerve stimulator is assumed by the Commission up to the amounts provided for in paragraphs 1 and 2 or, where the health professional in charge of the worker prescribes the use of self-adhesive rigid or flexible electrodes, paragraphs 2 and 3:

(1) $180 per year for all of the following accessories:

(*a*) 4 electrodes;

(*b*) gel;

(*c*) hypoallergenic adhesive tape;

(2) $120 per year for all of the following accessories:

(*a*) 2 pairs of wires;

(*b*) batteries and battery charger;

(3) $400 per year for self-adhesive rigid or flexible electrodes.

189. The Commission assumes the cost of acquiring adapted clothing, including in particular anti-UV clothing and accessories, compressive clothing, heated clothing and anti-vibration gloves, where authorized by the Commission.

190. The Commission assumes, where prescribed by the health professional in charge of the worker, the cost of renewing the following adapted clothing:

(1) heated clothing, including the accessories necessary for heating the clothing, every 2 years, where the worker retains a permanent impairment or permanent limitations. Where the worker is employed, the Commission assumes the cost of renewing an additional pair of heated gloves annually;

(2) anti-UV clothing, every year, up to scar maturity.

Where the worker's employment injury is consolidated, that the worker retains a permanent impairment and the health professional in charge of the worker determines that there is a permanent need, the Commission continues to assume the renewal cost provided for in the first paragraph without having to submit a new prescription.

191. The Commission assumes the cost of leasing or acquiring, according to the appropriate and most economic means, an osteogenesis stimulator where it is prescribed by the health professional in charge for healing that is delayed or stopped or a non-union exceeding a 3-month period.

§6. Special rules for communication aids

192. The Commission assumes the cost of acquiring a communication aid provided for in Schedule II to compensate for temporary or permanent language functional limitations if the following conditions are met:

(1) the worker has a prescription from the health professional in charge of the worker recommending a consultation in speech therapy;

(2) the use of such an aid is recommended by a speech therapist.

DIVISION III
OTHER COSTS

193. The other costs to which a worker is entitled under this Division are

(1) extricating equipment; and

(2) long distance calls.

The Commission assumes the costs provided for in the first paragraph, on the conditions and in accordance with the amounts indicated in this Division on presentation of vouchers detailing their cost.

194. The Commission assumes the cost of using extricating equipment where the worker's condition so requires because of an employment injury sustained outside the employer's establishment or away from a construction site.

The costs incurred for the use of extricating equipment are reimbursable, up to $646. Where the distance to be travelled is more than 50 km, the reimbursement is increased by a maximum of $2.00 per kilometre travelled to transport the extricating equipment to the site of the accident.

195. The Commission assumes the cost of long distance calls made by a worker admitted to and sheltered in an institution within the meaning of the Act respecting health services and social services (chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (chapter S-5), as a result of an employment injury, up to an amount of $53 per 30 days insofar as the worker is sheltered.

TRANSITIONAL AND FINAL PROVISIONS

196. This Regulation replaces the Regulation respecting medical aid (chapter A-3.001, r. 1) and the Regulation respecting hearing devices and audiology services (chapter A-3.001, r. 14.001). Those Regulations continue however to apply for the purposes of section 197.

197. The care, treatment, professional services, technical aids and hearing devices and audiology services provided before *(insert the date of coming into force of this Regulation)* are paid by the Commission in accordance with the rates applicable at the time they were provided.

198. Where the Commission accepted an application for the reimbursement of cannabis for medical purposes by a worker before (*insert the date of coming into force of this Regulation*), every new application for the reimbursement of cannabis for medical purposes submitted by the same worker for the same employment injury is excluded from the application of section 70, for as long as the prescription of the health professional in charge of the worker remains unchanged.

199. When this Regulation requires a prescription as condition, the Commission accepts any prescription made by the health professional in charge of the worker in connection with the employment injury before the date of coming into force of this Regulation.

Where such a prescription concerns a medicine, the worker is entitled, despite section 13 of this Regulation, to any medicine prescribed by the health professional in charge of the worker in connection with the employment injury up to the expiry of the renewals of the medicine on that prescription or not later than up to 1 year from the date of coming into force of this Regulation.

200. When this Regulation provides for a time period, the latter applies to existing situations, taking into account the time already elapsed.

If a new time period, that did not exist or was not applicable to a health service or adapted equipment and other costs in the Regulation respecting medical aid (chapter A-3.001, r. 1) or in the Regulation respecting hearing devices and audiology services (chapter A-3.001, r. 14 001), is introduced by this Regulation and begins with an event which in fact occurred before the coming into force of this Regulation, the period, if not already expired, runs from that coming into force.

201. When a physical rehabilitation measure has been granted to a worker and a professional services contract has been entered into between the Commission and a supplier with respect to the measure before *(insert the date of coming into force of this Regulation)*, the contract continues to have effect until it terminates.

202. This Regulation comes into force on 1 October 2025.

SCHEDULE I
CARE, TREATMENT AND PROFESSIONAL SERVICES PROVIDED BY HEALTH WORKERS

	Rate
1. Care and treatment:	
Acupuncture	
Acupuncture care provided by an acupuncturist, per session	$57.00
Chiropractic	
Chiropractic treatment, per session, including cost of x-rays	$43.00
Occupational therapy	
Treatment, per session	$53.50
Physiotherapy	
Treatment provided by a physiotherapist, per session	$53.50
Treatment provided by a physiotherapy technologist, per session	$47.00
Podiatry	
Per session	$57.00
Psychology	
Psychological, psychotherapeutic and neuropsychological care, hourly rate	$108.00
Home care	
Chiropractic treatment, per session	$65.00
Treatment by a physiotherapist, per session	$60.00
Treatment by a physiotherapy technologist, per session	$53.50
Nursing care, per session	$68.50
2. Professional services:	
Occupational therapy	
Initial evaluation	$85.00
Reports	$30.00
Speech therapy	
Per session	$85.00
Physiotherapy	
Reports	$30.00
Laboratory examinations	
The cost of the examinations is reimbursed according to the amounts provided for in the agreement made under section 195 of the Act.	

SCHEDULE II
TECHNICAL AIDS AND OTHER COSTS

TECHNICAL AIDS

1. Locomotive aids:

(1) canes, crutches, walkers and their accessories;

(2) manually propelled wheelchair;

(3) motorized wheelchair;

(4) 3-wheel scooter and 4-wheel scooter.

2. Daily life aids:

(1) Adapted objects:

The cost of acquiring aids for eating, dressing, personal hygiene care or household activities, made or modified for use by a worker who suffers an employment injury; such aids include jar openers, stocking-pullers, long-handled combs or brushes, buttoners or other similar objects;

(2) Transfer aids:

The cost of leasing, or acquiring when the needs are permanent, the following transfer aids:

(*a*) hydraulic, electrical or mechanical patient lifters;

(*b*) seat lifters for the bathtub;

(*c*) armchairs for the bath and shower;

(3) Bathroom apparatus:

(*a*) The cost of acquiring the following bathroom apparatus:

i. bedpans;

ii. urinals;

iii. elevated toilet seats;

iv. safety handles and grabs;

(*b*) The cost of leasing the following apparatus:

i. commodes and their accessories;

ii. shower chairs;

(4) Hospital beds and accessories:

The cost of leasing, or acquiring when the needs are permanent, a hospital bed and its accessories, namely, bedboards, a bed table, a bed cradle, a trapeze and a footstool.

The cost of leasing, or acquiring when the needs are permanent, an electrical hospital bed is assumed only when the worker has no-one to position the bed and the worker is capable of positioning an electric bed by himself or herself.

3. Therapeutic aids:

(1) The cost of acquiring epidural and intra-thalamic nerve stimulators;

(2) The cost of leasing or acquiring an oxygen concentrator;

(3) The cost of acquiring or leasing accessories for graded motor imagery.

An amount of $110.00 for leasing a set of mirrors and cards for the treatment period or, if leasing is not possible, a maximum amount of $154.00 for acquiring a set of mirrors and a maximum amount of $65.00 for acquiring cards;

The Commission may assume the cost of acquiring a mobile application for a mobile telephone or a tablet instead of leasing or acquiring cards.

4. Other therapeutic aids:

The cost of acquiring the following therapeutic aids:

(*a*) accessories for the prevention and treatment of bed sores such as a sheepskin, a mattress and a cushion, an elbow pad, a foot-drop splint, a heel pad and a donut;

(*b*) corsets, collars and splints;

(*c*) exercise equipment such as the following, used in the home as part of an active occupational therapy or physiotherapy program: exercise balls, a balloon, an elastic band, plasticine, a system of pulleys for shoulder ankylosis, weights for the wrist or ankle, a sandbag with a velcro fastener, a fixed resistance exercise apparatus, and a set of light weights under 5 kg;

(*d*) compressive clothing, where authorized by the Commission;

(*e*) lumbar belts and hernia bandages;

(*f*) cervical traction devices with dead weights;

(*g*) intrathecal pumps;

(*h*) orthopedic walking boots to eliminate the edema or heal a fracture.

The cost of leasing or acquiring the following aids according to the appropriate and most economic means:

(*a*) muscular nerve stimulators;

(*b*) continuous passive motion machines (C.P.M.).

5. Communication aids:

(1) the cost of acquiring

(*a*) imagers;

(*b*) communication boards; and

(*c*) any other technical communication aid on authorization by the Commission.

SCHEDULE III

PHYSIOTHERAPY OR OCCUPATIONAL THERAPY CARE AND TREATMENT ACCOUNT

CNESST

PHYSIOTHERAPY AND OCCUPATIONAL THERAPY CARE OR TREATMENT ACCOUNT

Occupational health and safety

☐ Physiotherapy ☐ Occupational therapy Worker's file No.

Identification of the worker

Surname (as shown on birth certificate)	First name	Health insurance No.
Postal code	Date of original event (Y Y Y Y M M D D)	Date of recurrence, relapse or aggravation (Y Y Y Y M M D D)

Health professional

Health professional in charge of the worker	Permit No.
Name of the clinic (or health institution)	Date of the prescription (Y Y Y Y M M D D)

1. Diagnosis

2. Diagnosis requiring consultation in occupational therapy before the 6th week from the date of the event?
   ☐ Yes ☐ No

3. Consultation in occupational therapy before the 6th week from the date of the event indicated by the health professional in charge?
   ☐ Yes ☐ No

4. More than 3 treatments per week indicated by the health professional in charge ?
   ☐ Yes ☐ No

Information on the supplier

Name of the clinic (or health institution)		Supplier No.
5 Transfer from clinic (or health institution) ☐ Yes ☐ No	Telephone	Fax

6 **Indicate the care and treatment or services rendered by using the appropriate codes available on the Website of the CNESST.**

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Specify the date of the last treatment or last absence if it is the cause of the end of the treatment — Date of the end of treatment (Y Y Y Y M M D D)

Health worker

Name of the member of the professional order who made the initial evaluation	Member No.
Signature	Date (Y Y Y Y M M D D)
Name of the member of the professional order who provided treatment	Member No.
Signature	Date (Y Y Y Y M M D D)
Name of the member of the professional order who provided treatment	Member No.
Signature	Date (Y Y Y Y M M D D)

5055-A (2017-05)

SCHEDULE IV
PHYSIOTHERAPY AND OCCUPATIONAL THERAPY REPORTS

CNESST

PHYSIOTHERAPY REPORT
Occupational health and safety

1 Date of request for report Y Y Y Y M M D D Worker's file No.

Identification of the worker

Surname (as shown on birth certificate)	First name	Date of original event
		Y Y Y Y M M D D
Profession or trade practised at the time of event	Postal code	Date of recurrence, relapse or aggravation
		Y Y Y Y M M D D
2 Diagnosis	Left-handed ☐ Right-handed ☐ Sex F ☐ M ☐	Health insurance No.

Health professional

Health professional in charge of the worker	Permit No.	Date of the prescription
		Y Y Y Y M M D D
Name of the clinic (or health institution)		Telephone

Information on the supplier

Name of the clinic (or health institution)			Supplier No.
Date of initial evaluation Y Y Y Y M M D D	Number of treatments provided to this day:	Telephone	Fax
Name of the member of the Ordre professionnel de la physiothérapie du Québec who completed the report			Member No.

3 Subjective data (worker's perceptions)

Intensity of the pain felt: at rest _____ /10 in movement _____ /10 by palpation _____ /10
Positions or movements affected:

According to the worker, are daily activities impeded by the employment injury? ☐ Yes ☐ No ☐ N/A
If yes, describe.

According to the worker, are work activities impeded by the employment injury? ☐ Yes ☐ No ☐ N/A
If yes, describe.

Worker's perception of his or her return to work as before the injury:

Worker's perception of his or her evolution: Improvement _____ % Stable ☐ Deterioration _____ %

Other data

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4 Objective clinical data (examination). Fill out both sections: **Initial condition** and **Current condition**.

Initial condition (or at the time of last report sent to the CNESST)	**Current condition**
Date of examination Y Y Y Y M M D D	Date of examination Y Y Y Y M M D D
Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)	Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)

5 Functional data and Ordre professionnel de la physiothérapie du Québec member's opinion.
Fill out both sections: **Initial condition** and **Current condition**.

6 Initial condition (or at the time of last report sent to the CNESST)	**Current condition**
Date of examination Y Y Y Y M M D D	Date of examination Y Y Y Y M M D D
Minutes **Hours**	**Minutes** **Hours**
Standing: _____ _____ N/A	Standing: _____ _____ N/A
Sitting: _____ _____ N/A	Sitting: _____ _____ N/A
Crouching: _____ _____ N/A	Crouching: _____ _____ N/A
Kneeling: _____ _____ N/A	Kneeling: _____ _____ N/A
Walking: _____ _____ N/A	Walking: _____ _____ N/A
Stairs: 5 à 10 steps +10 steps N/A	Stairs: 5 à 10 steps +10 steps N/A
Pushing: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A	Pushing: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A
Pulling: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A	Pulling: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A
Grip strength: _____ kg N/A	Grip strength: _____ kg N/A
Handling: _____ N/A	Handling: _____ N/A
Lifting loads: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A	Lifting loads: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A
Moving loads: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A	Moving loads: 0-5 kg 5-15 kg 15-25 kg +25 kg N/A
Other functional data:	Other functional data:

Observations (presence of mixed signals, sensitivity, balance, etc.)

Have you discussed return to work arrangements with the worker? Yes No
If yes, specify. If not, why?

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Functional data and Ordre professionnel de la physiothérapie du Québec member's opinion (cont'd)

Describe the evolution of the **obstacles** to the return to work, if applicable (physical condition or personal and environmental factors or others).

Describe the evolution of the **levers** for the return to work, if applicable (physical condition or personal and environmental factors or others).

7 Treatment plan

Active conditions:

Passive conditions:

8 Worker's condition

Improvement _____ % Stable ☐ Deterioration _____ %

Do you recommend the end of treatment? ☐ Yes ☐ No

If **yes**, what is the real or planned date of the end of treatment? Y Y Y Y M M D D

What are the residual difficulties? ☐ N/A

If **no**, how many additional treatments are you planning?
Planned frequency of treatments: _____ / week Other:
What are the functional objectives pursued by the additional treatments?

Comments / Recommendations

Signature of the member of the Ordre professionnel de la physiothérapie du Québec who completed the report Date Y Y Y Y M M D D

5053-A (2017-05)

CNESST

OCCUPATIONAL THERAPY REPORT

Occupational health and safety

1 Date of request for report | Worker's file No.

Identification of the worker

Surname (as shown on birth certificate)	First name	Date of original event
Profession or trade practised at the time of event	Postal code	Date of recurrence, relapse or aggravation
2 Diagnosis	Left-handed / Right-handed; Sex F M	Health insurance No.

Health professional

Health professional in charge of the worker	Permit No.	Date of the prescription
Name of the clinic (or health institution)		Telephone

Information on the supplier

Name of the clinic (or health institution)			Supplier No.
Date of initial evaluation	Number of treatments provided to this day:	Telephone	Fax
Name of the member of the Ordre professionnel des ergothérapeutes du Québec who completed the report			Member No.

3 Subjective data (worker's perceptions)

Intensity of the pain felt: at rest _____ /10 in movement _____ /10 by palpation _____ /10

Positions or movements affected:

According to the worker, are daily activities impeded by the employment injury? ☐ Yes ☐ No ☐ N/A

If yes, describe.

According to the worker, are work activities impeded by the employment injury? ☐ Yes ☐ No ☐ N/A

If yes, describe.

Worker's perception of his or her return to work as before the injury:

Worker's perception of his or her evolution: Improvement ____ % Stable ☐ Deterioration ____ %

Other data

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4 Objective clinical data (examination). Fill out both sections: **Initial condition** and **Current condition**.

Initial condition (or at the time of last report sent to the CNESST) Date of examination Y Y Y Y M M D D	**Current condition** Date of examination Y Y Y Y M M D D
Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)	Objective clinical data (neurologic, signs, joint mobility, muscular force, muscular endurance, œdema, atrophy, etc.)

5 Functional data and occupational therapist's opinion. Fill out both sections: **Initial condition** and **Current condition**.

6 Initial condition (or at the time of last report sent to the CNESST) Date of examination Y Y Y Y M M D D	**Current condition** Date of examination Y Y Y Y M M D D
Minutes ____ **Hours** ____ ☐ N/A — Standing:	**Minutes** ____ **Hours** ____ ☐ N/A — Standing:
Sitting:	Sitting:
Crouching:	Crouching:
Kneeling:	Kneeling:
Walking:	Walking:
Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A	Stairs: ☐ 5 à 10 steps ☐ +10 steps ☐ N/A
Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A	Pushing: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A
Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A	Pulling: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A
Grip strength: ____ kg N/A ☐	Grip strength: ____ kg N/A ☐
Handling: ____ ☐ N/A	Handling: ____ ☐ N/A
Lifting loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A	Lifting loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A
Moving loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A	Moving loads: ☐ 0-5 kg ☐ 5-15 kg ☐ 15-25 kg ☐ +25 kg ☐ N/A
Other functional data:	Other functional data:

Observations (presence of mixed signals, sensitivity, balance, etc.)

Participation of worker during evaluation (cooperation, interest, effort, regularity). Specify:

Analysis of interactions between personal, environmental and work factors that pose **obstacles** to the return to work, if applicable.

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Functional data and occupational therapist's opinion. (cont'd)

Analysis of interactions between personal, environmental and work factors that constitute **levers** for the return to work, if applicable.

Opinion of occupational therapist on the return to work and on the performance of daily activities. Specify:

Have you discussed return to work arrangements with the worker? ☐ Yes ☐ No
If yes, specify. If not, why?

7 Treatment plan

Active conditions:

Passive conditions:

8 Worker's condition

Improvement _____ % Stable ☐ Deterioration _____ %

Do you recommend the end of treatment? ☐ Yes ☐ No

If **yes**, what is the real or planned date of the end of treatment? Y Y Y Y M M D D

What are the residual difficulties? ☐ N/A

If **no**, how many additional treatments are you planning?
Planned frequency of treatments: _____ / week Other:
What are the functional objectives pursued by the additional treatments?

Comments / Recommendations

Signature of the member of the OEQ who completed the report Date Y Y Y Y M M D D

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SCHEDULE V

CONTENT OF PSYCHOLOGY, PSYCHOTHERAPY AND NEUROPSYCHOLOGY REPORTS

1. An evaluation report, a progress report and a final treatment report must contain

(1) the worker's name, health insurance number, telephone number and address, and the Commission's record number;

(2) the psychologist's name and permit number, the telephone number and services supplier number or, where applicable, the group number;

(3) the signature of the psychologist who administered the care and the date of the signature;

(4) the name of the health professional in charge of the worker and the number of the health professional's permit to practise;

(5) the date of the employment injury and, where applicable, the date of any relapse, reoccurrence or aggravation; and

(6) the diagnosis by the health professional in charge of the worker giving rise to the referral or, where applicable, the reason for the referral.

2. An evaluation report must also contain

(1) the dates of the evaluation meetings;

(2) the history of the case and the relevant antecedents that may have an impact on the treatment plan;

(3) the factors intrinsic and extrinsic to the employment injury that could have an impact on the worker's psychological and social functioning and the return to work;

(4) the worker's perception of his or her situation in relation to the employment injury and capacity to return to work;

(5) the problems associated with the employment injury and their impact on the return to work;

(6) the nature, dates and frequency of the activities carried out, including, where applicable, the tests carried out;

(7) an analysis of all the data and observations and, where applicable, of the tests carried out;

(8) the findings of the evaluation and the recommendations;

(9) in the case of a neuropsychological evaluation,

i. the observations on the worker's behaviour during the meetings and when taking the tests, and the evaluation of the worker's behaviour in the following areas: cognitive, motor, somesthetic, affective, personality and perception;

ii. the identification and results of the validity scales used to corroborate the results of the tests taken;

iii. the correlation between the results of the tests referred to in subparagraph i and those of the validity scales; and

(10) in the case of treatment, an individualized treatment plan containing, among other things,

i. the clinical approach and the therapeutic methods being considered;

ii. the objectives sought by the treatment;

iii. the therapeutic activities to be implemented in relation to the objectives sought;

iv. the participation expected from the worker with respect to the means and activities for attaining the objectives;

v. the means and progress indicators used to measure progress made under the individualized treatment plan for each of the objectives sought;

vi. the prognosis regarding the attainment of results;

vii. the date set for the beginning of treatment;

viii. the number and frequency of the meetings scheduled.

3. A progress report must contain, in addition to the information required by section 1,

(1) the dates of the meetings for each period of treatment;

(2) a reminder of the objectives sought by the treatment;

(3) the therapeutic activities implemented in relation to the objectives sought;

(4) the evaluation of the worker's progress in relation to each of the objectives sought taking into account progress indicators;

(5) the worker's perception of his or her progress in relation to each of the objectives sought;

(6) where applicable, the changes to be made to the individualized treatment plan and the recommendations; and

(7) the number and frequency of the meetings scheduled.

4. A final treatment report must contain, in addition to the information required by section 1,

(1) the dates of the meetings since the previous report;

(2) the problems associated with the employment injury identified in the initial evaluation;

(3) the therapeutic activities implemented in relation to the objectives sought;

(4) the worker's perception in relation to the attainment of each of the objectives;

(5) an analysis and an evaluation of the results in relation to each of the objectives sought taking into account progress indicators and including the intrinsic and extrinsic factors having contributed to or hindered the attainment of the objectives; and

(6) the grounds for terminating treatment.

5. Subject to the acts a psychotherapist is authorized to perform under his or her permit, sections 1 to 4 apply, with the necessary modifications, to the holder of a psychotherapist's permit.

SCHEDULE VI

PROFESSIONAL SERVICES RELATING TO SUBDIVISION I OF DIVISION I OF CHAPTER III CONCERNING HEARING DEVICES

Audiology	
Audiological evaluation	$102.50
Hearing-aid acoustician	
Audio prosthetics evaluation Maximum of 2 evaluations per 5-year period, per worker	$68.46
Professional services provided in the first year after the purchase of a hearing device, per device	$822.36
Programming for pairing the hearing devices with the worker's cellular telephone.	$20.00
Maximum of 2 times during the life of the hearing devices	
Reprogramming by a hearing-aid acoustician following repair of a CROS -BiCROS system	$93.95
Remake, payable once per year if more than 1 year has elapsed since purchase of the device	$97.36
Repair, payable once per year per device if more than 1 year has elapsed since purchase of the device	$97.36
Professional services provided in the first year after purchase of a hearing device, where provided by a hearing-aid acoustician other than the acoustician having supplied the device, owing to the worker's change of place of residence	$62.28
Professional services provided for fitting if the worker dies before the device is supplied	$133.87
The costs of adjusting a hearing device are reimbursable up to an amount of $181.14 per year per device per worker. The costs cover the following, payable up to the following amounts:	
Cleaning of a hearing device, payable if more than 12 months have elapsed since purchase of the device and not payable if the cleaning is done at the time of a remake or repair or within 30 days thereafter The cleaning may be done by a person under the supervision of the hearing-aid acoustician.	$24.34
Electroacoustic analysis, payable if more than 12 months have elapsed since purchase of the device and not payable if the analysis is done at the time of a remake or repair or within 30 days thereafter	$40.16
Reprogramming, payable if more than 12 months have elapsed since purchase of the device and not payable if done at the time of a remake or repair or within 30 days thereafter	$30.42

Insertion gain, payable only if more than 12 months have elapsed since purchase of the device and not payable if the insertion gain is provided at the time of a remake or repair or within 30 days thereafter	$36.50
Impression taking once per year	$28.55
The costs of repairing or replacing a hearing device accessory are reimbursable up to a total annual amount of $195.	
The repairs may be done by a person under the supervision of the hearing-aid acoustician.	
The repair costs consist of the following, including the related products and professional services, and are payable up to the following amounts:	
Conduction tube without speaker (slim tube) for open-fit hearing devices	$5.00
Earmolds for conduction tube without speaker (dome receiver) for open-fit hearing devices	$5.00
Earmolds for conduction tube with speaker (RITE dome) for open-fit hearing devices	$5.00
Microphone protection covers	$5.00
Cerumen guard (pack)	$10.00
Conduction tube with speaker (RITE receiver) for open-fit hearing devices	$75.00
Other replacement parts such as battery holders, covers, etc.	$5.00
Custom earmold for behind-the-ear hearing device, maximum price	$45.00

SCHEDULE VII

COST OF GOODS FOR THE MAINTENANCE OF A HEARING DEVICE

The costs for the maintenance of a hearing device are reimbursable up to a total annual amount of $110 per worker.

The maintenance costs consist of the following, and are payable up to the following amounts:

	Unit rate
Telephone ear pad, per pad	$10.00
Insertion cream, for a minimum 15 ml format	$10.00
Cleansing tablets, pack of 20 tablets	$10.00
Dehumidifier	$15.00
Cleaner, for a minimum 60 ml format	$15.00
Soothing anti-itch cream, for a minimum 15 ml format	$15.00
Other accessories for hearing device maintenance:	
Earmold blower	**Unit rate**
Earmold blower, once per 5 years per worker	$15.00
Batteries:	**Unit rate**
Zinc air batteries, per hearing device, maximum of 100 batteries per year	$1.00
Remote control battery, maximum of 1 battery per year	$5.00
Zinc air batteries for a CROS-BiCROS system, maximum of 100 batteries per year	$1.00

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