

Excerpt from Memo re COVID Vaccine Considerations, February 2021

Forecast volume for TI claims

It is very difficult to forecast likely Treatment Injury claims from COVID vaccines.

If we apply the previous claim rates for influenza vaccine, this suggests a possible claim rate of 2 per 100,000 vaccinations. Therefore, with an estimated 10 million COVID vaccination doses provided, a potential 200-450 additional claims could be incurred to the treatment injury account. Based on previous claim history, 96% of these would be med fees only claims. However, the influenza vaccine claim rate may not be comparable to COVID vaccine claim rate.

It is possible claim rates could be higher due to increased public scrutiny and social media e.g. inflammation occurring around the injection site that would have been previously ignored, could mean more people seek medical advice. In addition, some people who normally do not choose to vaccinate due to concerns of adverse effects based on their health status may be more likely to have this vaccine.

The total incidence of adverse effects could be forecast as below, however not all adverse events will result in a claim (e.g. this includes mild symptoms such as dizziness, fatigue, headaches). Also note, our current decline rate is 50% for vaccine related TIs, however this may not be applicable to COVID vaccine.

Note the CDC has classified any adverse event as 'Rare'.

As an indicator of the scale of potential impact on customers, we've applied the US CDC adverse reactions from the Pfizer vaccine (Jan 21) to the proposed rollout phases:

	Phase 1	Phase 2	Phase 3
Anaphylaxis (0.0011%)	2	17	43
Adverse effect (0.2%)	425	3000	7800

Note there is no information available about possible long-term effects of these vaccines.

At this stage actuarial services do not consider we need to forecast an OCL impact. We will continue to engage with finance and actuarial as further forecasts are refined to estimate any claims costs impact.

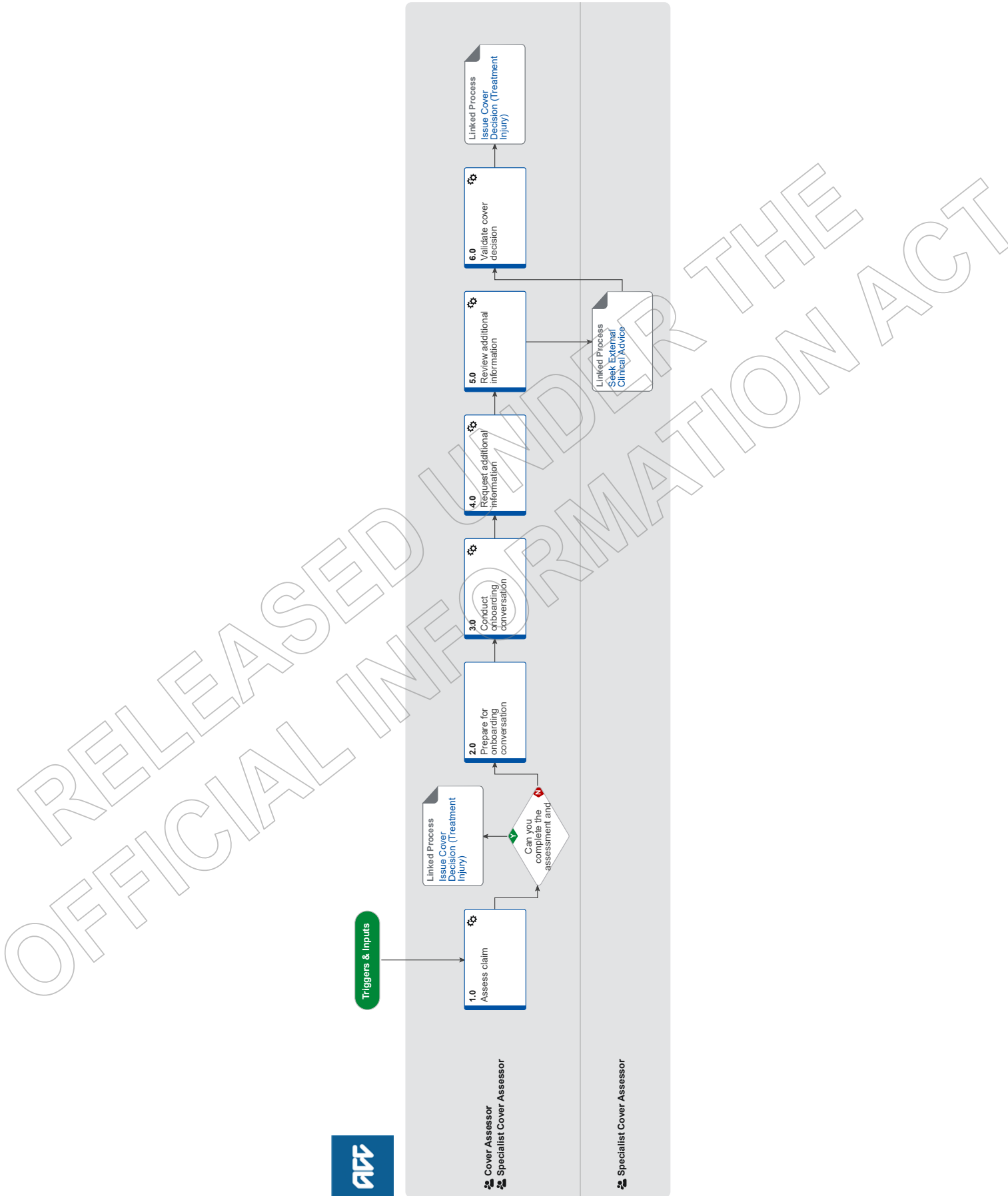
Operations have indicated that they are likely to be able to resource up fairly easily for the portion of claims that are simple decisions, however the more complex claims that require further information gathering, applying of judgement and that require technical or clinical advice will take some lead in time to set up and resource for. Further planning will be required with the Cover Assessment teams.

We expect to be asked for data on COVID vaccine related treatment injury claims. We are working with the Ministry of Health on relevant data capture (e.g. brand of vaccine) to enable this reporting.

Excerpt from Policy Governance Committee paper, 26 May 2021

- 5.5 While it is difficult to predict the impact that the COVID-19 vaccination will have on ACC's treatment injury rates, a high level indication is that there is potential for approximately 200-450 additional claims to be attributed to the treatment injury account from an estimated 10 million COVID vaccination doses provided. This forecast is based on ACC's previous vaccination injury rates and evidence that COVID-19 vaccinations have a 0.011% chance of anaphylaxis and a 0.2% chance of adverse reaction (of which not all would be covered by ACC).³ However, current lodgement rates of COVID-19 vaccination injuries suggests the additional number of claims will be higher, and we do not know yet if ACC would decline COVID-19 vaccination treatment injuries at the same rate as other vaccination-related injuries.
- 5.6 The costs associated to COVID-19 vaccination claims are also hard to estimate because we do not know how expensive COVID-19 vaccination related claims would be. However, based on ACC's expenditure on other vaccination related claims covering an additional 450 claims may equate to approximately \$500,000 cash costs per year.

RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To assess information on a claim and decide whether it meets the criteria for cover for a treatment injury.

Background

This process was developed to allow a consistent framework for Cover Assessors and Specialist Cover Assessors to investigate all claims requesting cover under Treatment Injury legislation. This process ensures consistency across the organisation in the steps required for this to take place.

Owner **s 9(2)(a)**

Expert **s 9(2)(a)**

Procedure

1.0 Assess claim

Cover Assessor, Specialist Cover Assessor

- a** Consider Risk of Harm questions.

 Risk of Harm Guidance 1.0.pdf

NOTE What if I believe there is a risk of harm?

The risk of harm data will be entered when you update the Treatment injury tab in Eos and will be processed via the Create Report for Risk of Harm Review Group process linked below.

However, if at any time during the cover assessment process you believe there is an imminent risk of harm to the public and you believe you cannot wait until the cover decision is made, then send an email to clinicalquality@acc.co.nz outlining your reasons why you believe there is an imminent risk of harm to the public.

 **PROCESS** Create Report for Risk of Harm Review Group

- b** Review the client's claim and party record, including the ACC45, ACC2152 (if on file), all clinical documents and all open tasks on the claim.

NOTE What if there is a request for treatment on the claim, ACC18, ARTP, weekly compensation request or other requests i.e. dental treatment, hearing aids, prosthesis and district nursing care?

1. Ensure that an ENT05 Cover decision pending letter is sent out to the client. This letter advises the client that as cover is yet to be determined, we are not able to consider an application for entitlement, unless cover is awarded on their claim. Ensure that you forward date the task associated with the request to the legislative date on the claim.

2. Create 'Follow-up cover' task and add in the description [Complex claim, please assess].

3. Set priority on the task as 'high' if:

- a) the client requires a critical decision,
- b) the client needs more than a week off work,
- c) there is an ARTP on file,
- d) the claim is on the complex list,
- e) we determine the client needs some sort of other urgent assistance

4. Change the target date of the task to the lodgment date

5. Transfer 'Follow-up cover' task to TIC-Case Ownership."

- c** Generate ACC2184 Cover decision tool if required.

NOTE When is ACC 2184 is required?

ACC 2184 is required if ANY or ALL of these criteria apply:

- It is a complex claim
- A detailed timeline of the events is required
- Any tier 3 internal or external opinion is required

If the claim does not meet the above criteria use the below template and place into a contact on Eos.

ACCEPT or DECLINE (delete one) - (state the injury being accepted)

DATE OF INJURY:

ACC 45

ACC 2152

BACKGROUND

ANALYSIS

ADVICE

RESEARCH

d Confirm this is a newly lodged claim.

NOTE What if the claim is a re-assessment and the information is not new?

- If there is no new information on file, and we did not re-open the claim, add a contact to note this. Call the client to advise. This process ends.
- If there is no new information on file, and we re-opened the claim, go to 'Issue Cover Decision' process.

PROCESS Issue Cover Decision (Treatment Injury)

NOTE What if the claim is a re-assessment and the information is new?

1) If there is new information on file which would warrant re-assessment, and the claim was initially lodged under the Treatment Injury legislation (claim lodged with ACC after 1 July 2005), continue with this process - Assess Claim for Cover - Treatment Injury.

2) If there is new information on file which would warrant re-assessment, and the claim was initially lodged under the Medical Misadventure legislation (claim lodged with ACC prior to 1 July 2005), check if a personal injury was found during the initial investigation.

- If a personal injury WAS found during the initial investigation of the claim, re-assess the claim under the Medical Misadventure legislation. Refer to 'Cover criteria for medical misadventure Policy'.
- If a personal injury was NOT found, re-assess claim under the Treatment Injury legislation. Continue with this process.

If you are uncertain discuss the claim with a Specialist Cover Assessor, Practice Mentor or Technical Specialist.

Note, even though there are no timeframes on re-assessment, we must complete re-assessment in a timely manner.

Cover criteria for medical misadventure Policy

NOTE What if the claim is a duplicate?

Go to Identify and link duplicate claims.

PROCESS Identify and Link Duplicate Claims :: Treatment Injury

NOTE What if you identify the claim is consequential to another claim?

Refer to Consequential Injury Claims Policy

PROCESS Consequential Injury Claims Policy

NOTE What to do if claim was previously incorrectly accepted as PICBA?

If claim was previously accepted as PICBA in error, however, it was determined that this is a treatment injury claim and not a PICBA claim; transfer the claim to TIC - Admin Queue for triaging. In the confirm cover decision task - add the following description "claim accepted by system in error - please reassess this claim for Treatment Injury" and follow the Triage and Allocate Claim (Treatment Injury).

PROCESS Triage and Allocate Claim (Treatment Injury)

e Following an initial review of the claim, document your findings in Eos in a contact

NOTE What should be written in the contact?

Claim checked for PICBA, AE (accredited employer), consequential claims, reassessment, duplicate claims - nil found. No evidence of a mental injury on ACC45, ACC2152 or other lodging documents ie ACC18, ACC21.

If one of the above claim types is identified, document this clearly in the contact and if relevant the associated claim number.

f Determine whether the client has suffered a personal injury.

NOTE What if the client did not suffer a personal injury?

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

PROCESS Issue Cover Decision (Treatment Injury)

NOTE What if the claim is for a mental injury?

Asses whether there may be a physical injury that we can assess for cover (discuss this during the onboarding conversation):

- If there is a physical injury we can assess for cover, you will need to lodge a separate claim for the mental injury because of physical injury after completing the onboarding conversation (see activity 3(d)).
- The mental injury claim will be initially declined because of the specific legislative timeframes associated with the lodgement of a separate claim. Once you have approved or declined cover for physical injury, the mental injury claim will be re-opened to assess for cover either as MICPI (if physical injury is approved) or TIMI (if physical injury is declined).

Refer to the policy pages below for more information on mental injury policy and how to manage timeframes.

Mental Injury Because of a Physical Injury Policy

Statutory timeframes for mental injuries Policy

Treatment injury mental injury Policy

g Assess whether the personal injury occurred within the context of treatment. Refer to the 'Context of Treatment Policy'.

Context of Treatment Policy

NOTE What if the injury did not occur within the context of treatment?

Context of treatment refers to the registered profession of the health provider who gave, provided or directed the treatment either in New Zealand or overseas.

If the injury occurred within the context of accident, update the Treatment Injury tab to reflect PICBA status and ensure the fund code is not treatment injury. Then go to 'Assess Claim for Cover :: PICBA'. This process ends.

If the injury occurred within the context of work, eg work-related personal injury and work-related gradual personal injury, return the claim to the Hamilton Reg - Cover Assessment. This process ends.

PROCESS Assess Claim for Cover :: PICBA

NOTE What if the injury occurred as a result of treatment received overseas?

Any personal injury caused by treatment outside New Zealand is coverable Section 22(3) and (4), only if:

- the injured person is a New Zealand resident when they were treated, and
- the injury is suffered on or after 1 July 2005, and
- the treating practitioner is equivalent to a New Zealand Registered Health Professional (the 'equivalency standards'), and
- the injury is one they would get cover for in New Zealand

In simple terms there is cover for a Treatment Injury caused by treatment overseas but only for those who are ordinarily resident at the time of treatment.

- Context of treatment
- Cover Criteria for Treatment Injury Policy
- Request Clinical Records for Treatment Injury
- When to use an interpreter Policy
- Criteria for injury occurring outside New Zealand Policy

NOTE What if the treatment received overseas by a health provider who did not meet the equivalency standards?

If there is does not meet the equivalency test noted in Context of Treatment policy, then consider the claim under the PICBA cover criteria.

Assess claim for cover: PICBA

h Determine if there is a direct causal link between the treatment sought or received and the personal injury. Refer to 'Causal Link Policy'.

NOTE What if there is no direct causal link?

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

PROCESS Issue Cover Decision (Treatment Injury)

i Consider whether the injury was a necessary part or ordinary consequence of treatment. Refer to 'Necessary Part or Ordinary Consequence of Treatment Policy'.

Necessary Part or Ordinary Consequence of Treatment Policy

NOTE What is the injury was a necessary part or an ordinary consequence of the treatment?

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

PROCESS Issue Cover Decision (Treatment Injury)

j Check if any exclusions to cover apply. Refer to 'Treatment Injury Exclusions from Cover Policy'.

Treatment Injury Exclusions from Cover Policy

NOTE What if any exclusions to cover apply to the treatment injury claim?

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

PROCESS Issue Cover Decision (Treatment Injury)

k Ensure that you are closing the relevant tasks for the information or work that you have completed on the claim. An example would be if you have assessed and completed the work associated with an 'Alert you have mail' task, 'NGCM - Medical Notes Received', or other task type that is NOT a master claim task (Confirm Cover Decision) or other legislative task

l Review the knowledge articles for the particular treatment by going to the page below (search under 'Knowledge for Cover Assessors'), if applicable.


Next Generation Case Management landing page

m Updating Eos with relevant information

NOTE What do you document in the 'contacts/task' following/during assessment of the claim?

As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

 Causal Link Policy

 **Can you complete the assessment and issue cover decision?**

Cover Assessor, Specialist Cover Assessor

YES... **PROCESS** Issue Cover Decision (Treatment Injury)

NO... Continue

2.0 Prepare for onboarding conversation


Cover Assessor, Specialist Cover Assessor

NOTE What if you're a Cover Assessor and you think you cannot complete the assessment because it's a complex claim?

Go to Activity 4.0 in 'Triage and Allocate Claim (Treatment Injury)' process.

PROCESS Triage and Allocate Claim (Treatment Injury)

- a** Determine what consent is necessary to collect medical and other records: ACC45, verbal consent, ACC6300 Authority to collect medical and other records, or ACC163 Authority to collect information about a deceased person.

 NG GUIDELINES Obtain Verbal or Written Authority

NOTE When is a ACC6300 required?

An ACC6300 is required to request notes after 12 months of a claim being lodged, or when a provider has indicated that they will not provide notes based on the ACC45 consent and/or verbal consent.

- Verbal consent can be obtained during the onboarding conversation
- If you think you cannot rely on the verbal consent and the ACC45, as we need a significant amount of information from several providers, or we require external clinical advice - send the ACC6300 form to the client after conducting the onboarding conversation

NOTE What if the client is deceased?

- If the client is deceased contact the lodging provider to obtain contact details for the NOK (next of kin)
- Contact the NOK to determine if there is an executor of the estate, if there is an executor of the estate, obtain the relevant consent documents regarding this (copy of the will showing the named executor and send an ACC163, confirm with the executor of the estate that they wish to continue with the claim investigation
- If there is no executor of the estate, discuss with the Privacy team on Ext. 46464 that there is no executor of the estate and confirm that it is appropriate to then utilize the NOK as the authority on the claim
- Despite the multiple attempt (maximum 2 attempts) to contact the NOK or executor of the estate (EOE) (without success) - please issue the appropriate decision after discussing this with your Team Leader. However, do not send the decision (unless address is verified in last 2 months - though check with your Team Leader or Privacy Team) and in contacts add "unable to contact the NOK or executor of estate - decision not sent".
- If you receive the call after decision is issued, please confirm the authority with NOK or EOE, re-open the claim if it required or asked by the NOK/EOE and reassess the claim accordingly.
- If a client dies during the investigation of their claim, ensure that this is reflected in the party record by altering the 'Profile' tab and the 'Deceased Status' data field

NOTE What if verbal consent is appropriate?

In Skype, during the call with the client, play the pre-recorded consent message:

1. Select "Invite More People" in the top right hand corner of the active call window
2. Enter the extension for the Verbal Consent Recording: 50013 and press OK
3. You will appear in a Conference with the Verbal Consent Recording and the Client
4. Once the consent recording has finished playing, it will automatically leave the phone conference

Then verbally confirm that the client agrees, and note this down in a contact.

Refer to the process below for more information.

PROCESS Obtain Client Authority to Collect Information

NOTE What if you need to request consent to lodge a mental injury claim?

- obtain client's consent.
- inform the client they will receive a declined decision regarding the mental injury claim.
- advise we will reopen the claim to investigate once we have made a decision on their physical injury.

- b** Determine if the client requires an Authority to Act (ATA)

NOTE What if the client requires an Authority to Act?

Refer to the process below prior to conducting the onboarding conversation.

PROCESS Obtain Authority to Act (ATA)

- c** Determine what clinical information is required to make cover decision. Communicate the requirements to the client during the onboarding conversation.

NOTE When should you request ACC2152?

The ACC2152 can be beneficial when filled out by the provider who gave the treatment or a provider who has given subsequent treatment on the injury with a similar qualification and/or scope of practice. Consider if ACC2152 would be helpful. If not, request clinical records.

NOTE What if you require an audiology assessment?

- Check with the client whether they have already undergone audiometry assessment during the onboarding conversation, ACC will not require a client to undergo a further test if the audiometry has been undertaken in the last three months.
- If the client hasn't completed this assessment, let them know during the onboarding conversation that we will send the letter and purchase order for them to complete the assessment. Advise the client that they will need to organise an appointment with the most convenient audiometry provider, who will send the report directly to ACC. Advise them that ACC will fund this.

- d** Determine if the client can provide the additional information. Collect this information during the onboarding conversation.

- e** Check if the client has any existing language or cultural needs.

NOTE What if the client does have language or cultural needs?

To find resources to support a client with language and cultural needs, refer to the following documents.

- NG GUIDELINES Supporting the Diverse Needs of our Clients
- When to use an interpreter Policy
- Working with an interpreter process
- ezispeak - phone interpreting service for ACC

3.0 Conduct onboarding conversation

Cover Assessor, Specialist Cover Assessor

- a** Contact the client or person acting on the client's behalf by their preferred method of communication. There must be an Authority to Act (ATA) on file if contacting someone other than the client.

NOTE How many contact attempts should be made?

Claim lodged with ONLY ACC45 which does not fulfill complex claim criteria for direct allocation to Specialist Cover Assessor.

- Two attempts to contact client by phone, on different days/times, if unsuccessful send T173.
- Request clinical notes from lodging provider
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

Claim lodged with ACC45 and ACC2152 or additional clinical notes

- Two attempts to contact client by phone, on different days/times, if unsuccessful send T173.
- If we have been provided with sufficient information as to who provided the treatment on the lodging documents, it would be reasonable at this stage to request the clinical notes from those providers.
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

NOTE What if you are unable to contact the client after making the above contact attempts?

Go to Activity 3.0 Update necessary records within the Issue Treatment injury cover decision process and decline the claim.

PROCESS Issue Cover Decision (Treatment Injury)

- b** Follow the 'TI Onboarding conversation' guide.

TI Onboarding conversation

- c** In Eos, upload the completed onboarding conversation to the 'Documents' tab.

NOTE What if you identify the client's condition is rapidly deteriorating?

- In Eos, in 'General' tab, tick Triage indicator.
- In Eos, in 'Confirm cover decision' task, update the description to note [Critical decision is required - client's condition is rapidly deteriorating].

NOTE What if the client has not given consent to continue to investigate the claim during the Onboarding conversation?

If the client does not give consent to continue the investigation, document this in Eos and proceed to Issue Cover Decision (Treatment Injury) procedure.

PROCESS Issue Cover Decision (Treatment Injury)

NOTE What if a client mentions self-harm or suicide?

Refer to NG GUIDELINES Managing Threat of Self-harm Calls for guidance.

NG GUIDELINES Managing Threat of Self-harm Calls

NOTE What if the employer is a registered AEP participant and the client's injury is related to work?

If the client mentions their employer and you identify the employer is a registered AEP participant, advise the client their claim will be managed by their employer's Third Party Administrator and someone will be in touch with them soon.

If you need to verify this, contact the TPA admin team using the hunt line: ext 45394. Or alternatively use the relevant emails below:

Work claims: insurerliaison@acc.co.nz

Non work claims: TPAsupport@acc.co.nz

Follow the process link to 'Transition Claim to an Accredited Employer'.

NB: Clients are not able to opt out of AEP managed for work related claims, only for non-work related claims.

This process ends here.

PROCESS Transfer Claim to Accredited Employer (AE) or Third-Party Administrator (TPA) Service

Accredited Employer List

Participating Accredited Employers (Non-work claims only)

d Complete outstanding actions.

NOTE What if you need to lodge an additional claim for mental injury?

After the client onboarding conversation where you have obtained consent from the client to lodge this claim

- generate and fill out the Referral for New Claim Lodgement
- email the complete form to hamilton.registration@acc.co.nz (ensure you specify the date of lodgement is the date ACC received the claim, not the day you first spoke with the client).

Referral for New Claim Lodgement

4.0 Request additional information

Cover Assessor, Specialist Cover Assessor

a Follow the appropriate process below for requesting additional information.

NOTE What if you require additional information because cover decision is being reviewed?

If the cover decision is being reviewed and the claim is in actioned cases department, go to 'Re-open claim' process. Recovery Administrators can only support additional information requests if the claim is 'active'.

PROCESS Re-open claim

NOTE What if you require clinical records/report or ACC2152?

If you require an ACC 2152 from the relevant provider go to Request Clinical Records process step

PROCESS Request Clinical Records for Treatment Injury

NOTE What do I need to consider when writing questions to a provider?

Refer to the 'Clinical questions guide'.

Clinical questions guide

NOTE What if you require internal clinical, medical or technical guidance including hotline or written?

Please go to 'Seek Internal Guidance' process.

PROCESS Seek Internal Guidance

NOTE What if you require external clinical advice?

Go to 'Request External Clinical Advice (ECA) Report' process.

PROCESS Seek External Clinical Advice

NOTE What if you require an archived physical claim file?

Go to 'Retrieve Archived Physical Claim Files' process.

PROCESS Retrieve Archived Physical Claim Files

NOTE What if an Audiology (audiometry - percentage of hearing loss) assessment is required?

Upload onto clients claim an ACC 612 Audiometric Report for Hearing Loss (this is the document that the client is required to take to their assessment with the Audiologist of their choice).

Create a 'Send Letter' task (this will be auto routed to Recovery Administration Team to send)


- Select 'create and send letter'
- Enter code and name of letter 'HLS14 Audiologist Test letter'
- Select your method of delivery
- Copy the information below and place into the additional comments section of the task or into the description box (the Recovery Administrator will follow these instructions to create the purchase order and letter:
 - Choose 'HL01' for entitlement code and rehabilitation action - hearing loss, click search
 - Under 'entitlement in purchase order' add '1.00' for Quantity approved and frequency as 'quarter' and create purchase order and save
 - For the purchase method choose 'Claimant Reimbursement'
 - Generate 'HLS14 Audiologist Test' letter and send to client
 - Please send attached document ACC612 with the HLS14 Audiologist Test letter
 - Please send task 'PRC HL: Review Claim & Check for Duplicate Claims' back to task creator advising 'Hearing assessment letter sent to client' edit target date for 20 working days.


Attach the ACC612 document to the task

- Select 'document' tab
- Select 'link'
- Select 'clear' in the associated documents date range
- Select ACC612 Audiometric Report for Hearing Loss
- Select 'OK'

NOTE What if a face to face Otolaryngologist/ENT assessment for a hearing loss claim is required?

1. Check that you have all of the client's audiometry records on file, including one performed in the last three months. If you do not have this on file, please request using the note above named 'What if an audiology assessment is required?' Ensure that the client is made aware that they will be receiving this letter and that they will need to organise an appointment (ACC will fund this appointment).
2. If you have all of the relevant clinical notes related to the condition that the client is requesting cover for and clinical notes regarding the treatment event or events that have resulted in the injury. (ie Radiation is the treatment cause, you will need all radiation fields and radiation dose summaries. If medication ie gentamycin is the cause, you will need all medication charts and biochemistry results of serum peak and trough levels).
3. Create a memorandum utilising Ear Nose and Throat Memorandum template below.' Ensure that the memorandum is included in the document group.
4. Perform privacy checks on documents.
5. Create a referral-specific document group with today's date and name it 'ENT assessment'
6. Add the necessary documents and include the ENT memorandum in the document group
7. Complete privacy checks. Refer to 'NG Supporting Information Inbound and Outbound Document Checks'.
8. Generate an 'Organise Internal referral' task (under the Specialist Cover Assessor name or creator)
9. Edit the 'Complete internal referral' subtask to state 'Face ENT assessment required, please send document group labelled ENT Assessment with the referral'.
10. Send the 'Complete internal referral' sub-task to 'hearing loss claims' department queue.

 ENT memorandum.docx

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if a mental injury assessment is required?

- 1) Ensure you have requested sufficient clinical notes of current state of alleged causes of injury to support assessment.
- 2) If this is a treatment injury mental injury (TIMI), upload to the claim a memorandum to request a psychiatric review (this document will provide a summary of the claim, relevant legislation and have particular questions for the psychiatrist to answer). If a sensitive claim is on file ensure you specify this in the memorandum.
- 3) If a sensitive claim is on file ensure you specify this in the memorandum.
- 4) Create a referral-specific document group with today's date and name it 'Mental injury assessment'
- 5) Add the necessary documents - if this is for mental injury ensure you review the clients party record for any other claims relating to mental injury or pain disorder and include this information
- 6) Add any specific questions that need to be included in the body of the letter
- 7) Complete privacy checks. Refer to 'NG Supporting Information Inbound and Outbound Document Checks'.
- 8) Discuss with your team leader regarding the next steps

Refer to the Psychiatric assessment memorandum example below for guidance on how this should be completed, and use the template below.


 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Psychiatric assessment memorandum template

 Psychiatric assessment memorandum example

NOTE What if a face to face (other) specialist medical assessment is required?

Go to 'Arrange Medical Case Review (MCR) Assessment' process.

 **PROCESS** Arrange Medical Case Review (MCR) Assessment

- b** Determine if the timeframe to make cover decision needs to be extended. Refer to the policy below.

 How to manage legislative timeframes Policy

NOTE What if you need to advise of extension or request extension agreement?

Go to 'Extend Cover Decision Timeframe' process.

 **PROCESS** Extend Cover Decision Timeframe

c Updating Eos with relevant information

NOTE What do you document in the 'contacts' following/during assessment of the claim?

As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

5.0 Review additional information

Cover Assessor, Specialist Cover Assessor

a Review new information to make a cover decision.

NOTE What if you need more information?

Go back to activity 4.0 Request additional information.

NOTE How do you review the ENT assessment?

Refer to the guide below.

 Review ENT assessment

NOTE What should you do with the open task associated with the information that you have reviewed?

Ensure that you are closing the relevant tasks for the information or work that you have completed on the claim. An example would be if you have assessed and completed the work associated with an 'Alert you have mail' task, 'NGCM - Medical Notes Received', or other task type that is NOT a master claim task (Confirm Cover Decision) or other legislative task

NOTE What are the next steps following a mental injury assessment (once the client has undergone an independent psychiatric review?)

Proceed to 4.0, a, Request Additional Information, note 5 - What if you require written internal clinical, medical or technical guidance (Tier 3). Complete a referral for Psychology - TIMI.

b In Eos, update the 'Medical' tab and 'Treatment Injury' tab based on the new information received.

NOTE What if you need to extend the timeframe up to 9 months (extension request)?

Go to 'Extend Cover Decision Timeframe' process.

 **PROCESS** Extend Cover Decision Timeframe

NOTE What if the client has not responded to you or not returned the extension letter to ACC agreeing to extend timeframes?

Follow up with the client via a phone call with two attempts, two different days and times. If consent to continue to investigate is not received ACC is to issue a decision 5 business days prior to legislative decision due date. Go to the process below.

 **PROCESS** Issue Cover Decision (Treatment Injury)

NOTE What if you are notified that the client has died during the investigation of the claim?

- If the client is deceased contact the lodging provider to obtain contact details for the NOK (next of kin)
- Contact the NOK to determine if there is an executor of the estate, if there is an executor of the estate, obtain the relevant consent documents regarding this (copy of the will showing the named executor and send an ACC163, confirm with the executor of the estate that they wish to continue with the claim investigation
- If there is no executor of the estate, discuss with the Privacy team on Ext. 46464 that there is no executor of the estate and confirm that it is appropriate to then utilise the NOK as the authority on the claim
- If a client dies during the investigation of their claim, ensure that this is reflected in the party record by altering the 'Profile' tab and the 'Deceased Status' data field

NOTE What if you're a Cover Assessor and think the claim should be assessed by a Specialist Cover Assessor or the claim might require External Clinical Advice?

- discuss the claim with a Practice Mentor first to agree on which role is best suited to continue with assessment.
- if the claim needs to be transferred to a Specialist Cover Assessor, go to the note 'What if it is a complex claim?' at step 4.0e in 'Triage and Allocate Claim (Treatment Injury)' process.

 **PROCESS** Triage and Allocate Claim (Treatment Injury)


c Updating Eos with relevant information

 **PROCESS** **Seek External Clinical Advice**
Specialist Cover Assessor

6.0 Validate cover decision

Cover Assessor, Specialist Cover Assessor

a Review 'Claim validation framework guide'.

 Claim validation framework guide

b Answer the questions in 'Claim validation framework guide.'

NOTE What if you're unsure of the decision?

- Contact a Specialist Cover Assessor, or Practice Mentor to help validate your decision.
- In Eos, in 'Contacts' tab, add a contact to note who is validating your claim and what your pre-validation decision is.

If you're still unsure of your decision, go to 'Seek Internal Guidance' process.

 **PROCESS** Seek Internal Guidance

 **PROCESS** **Issue Cover Decision (Treatment Injury)**
Cover Assessor, Specialist Cover Assessor

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COVID-19 related Claims – November 2021

Key Messages for claimants/ enquires in relation to COVID-19 claims

- We identified a variety of issues with claims being lodged due to COVID-19. Depending on the individual circumstances and situation, some claimants might be eligible to entitlements under the Scheme even though COVID-19 in most cases is not considered an accident or personal injury.
- We are also aware that a large volume of claims have been lodged for a variety of different reason, some of which are for:
 - General cover – adverse reactions to the vaccination
 - Treatment injury – severe adverse reactions to the vaccination
 - Treatment Injury – failure to provide medical treatment and someone is found deceased in MIQ or home isolation
 - Work related Mental Injury – stress at work or loss of employment due to vaccination status
 - Work related gradual process - Medical staff
 - Fatal – someone has died after contracting COVID-19

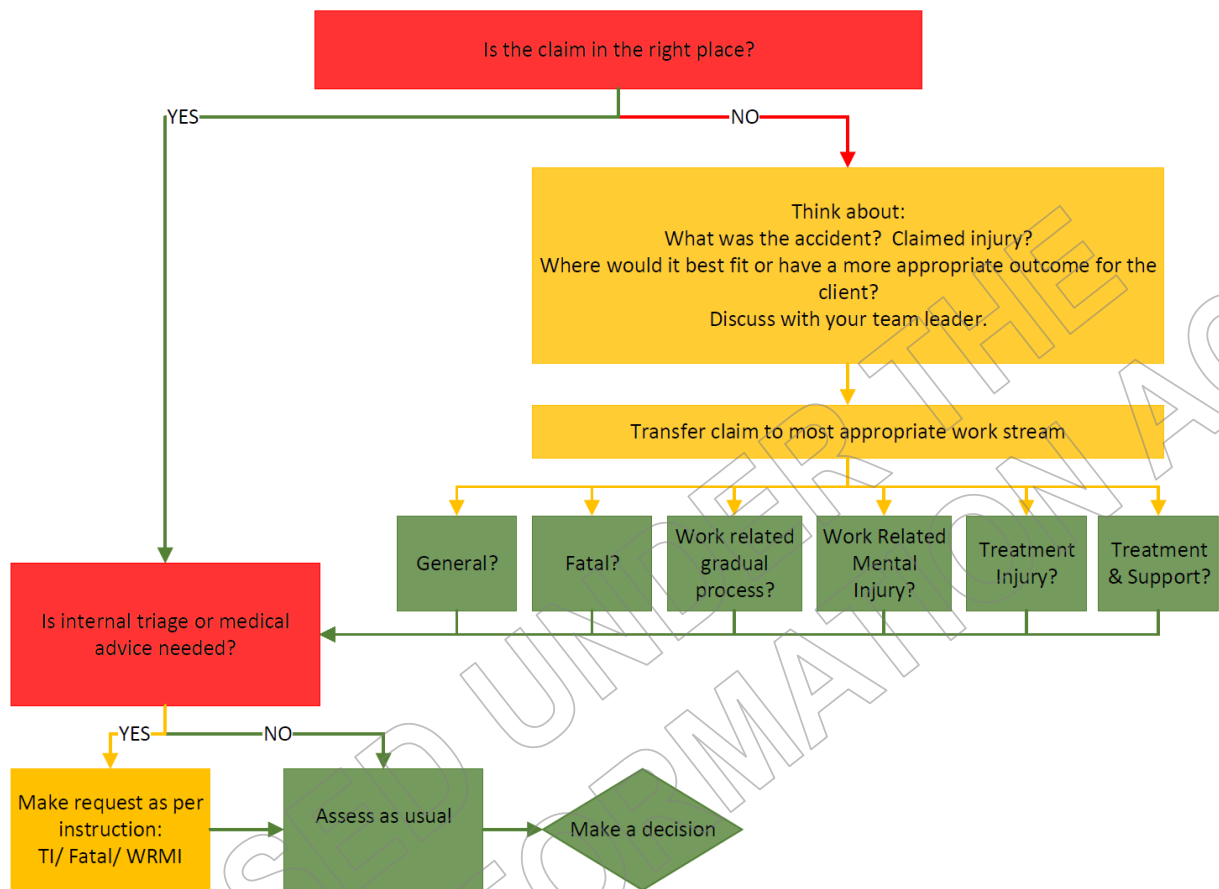
What’s happening/what support is available:

Support and advice is available to help you decide if a claim is in the right place and to assess a claim.

Issues:	Solution
Huge volume of vaccination claims being made – general and TI claims	This has been discussed with: Customer engagement/business partner Clinical oversight & engagement Health Sector partnerships <ul style="list-style-type: none"> - Communications are going out in the next provider e -newsletters via NZMA, GPNZ, Rural GP Network and RNZCGP, reminding general practitioners of what does not meet TI criteria for vaccinations. - ACC Website information update Hopefully reducing number of unnecessary claims
Thinking laterally about where various COVID claim should have been/should be placed or transferred – is the claim in the right place?	If it is a straightforward claim and is in the right place– assess and usual and issue decision. E.g. Anaphylactic reaction to the vaccine requiring medical treatment. If you notice that a claim might be in the wrong place and might be better suited (or might have a more appropriate outcome for the client), discuss transferring this with your team leader. Things to think about: <ul style="list-style-type: none"> • Does it meet cover criteria/ policy? • Could the claim meet criteria/policy in another area? • Is COVID the claimed issue or a side issue?

	<ul style="list-style-type: none"> • Was the personal Injury a necessary part or ordinary consequence of treatment? • Was the personal injury caused by a failure to provide treatment or to provide treatment in a timely manner? • Is the person deceased? • Did the personal injury occur during the course of work? • Was there a single, sudden event that caused the mental injury? • Can the event reasonably have caused the mental injury? <p>Refer to the flowchart below</p>
<p>Internal Clinical advice for COVID vaccination TI claims that are not straightforward</p>	<p>§ 9(2)(a) (Medical Advisor) is leading this. Email requests sent to § 9(2)(a) with subject line: COVID VACCINE REACTIONS TREATMENT INJURY</p> <p>MA group consists of:</p> <ul style="list-style-type: none"> § 9(2)(a) – Medical Advisor § 9(2)(a) – Medical Advisor § 9(2)(a) – Medical Advisor § 9(2)(a) – Medical Advisor § 9(2)(a) – Medical Advisor
<p>Internal Clinical advice for fatal COVID claims - Potential failure to provide medical treatment or failure to provide treatment in a timely manner</p>	<p>Any request for MA about a failure claim can be sent to § 9(2)(a) and § 9(2)(a) (not just COVID).</p> <p>Email requests sent to § 9(2)(a) and § 9(2)(a) with subject line: COVID Fatal – Potential failure claim</p> <p>MA group consists of:</p> <ul style="list-style-type: none"> § 9(2)(a) – Medical Advisor § 9(2)(a) – Medical Advisor
<p>WRMI claims -Internal triage</p>	<p>Engagement & Performance have contacted GP who has sent in multiple claims on the same day to discuss the legislative criteria for WRMI.</p> <p>Process has been set up to gain initial information from the client then info reviewed by a group and 'triaged' for assessment/decline.</p> <p>Process:</p> <ol style="list-style-type: none"> 1. Dedicated person to track these claims § 9(2)(a) 2. Cover assessor (or dedicated person) to request the additional information about the event and MI using MI questionnaire 3. When this information is received and a list of claims is compiled (when we have around 5-7 claims) – § 9(2)(a) will send an email through to triage group with the subject line: WRMI- COVID claim triage 4. The triage group will then meet and review the information and indicate next steps <p>The triage group consists of:</p> <ul style="list-style-type: none"> § 9(2)(a) CSL § 9(2)(a) - Legal § 9(2)(a) – Clinical Advice Manager § 9(2)(a) – Operational Policy § 9(2)(a) Principal Advisor § 9(2)(a) – Principal Advisor

Think about – Is the claim in the Right Place?



When to seek Clinical Advice – Links to Internal and external advice:

You can seek clinical advice when you need help to determine cover regarding a failure, standard of care, appropriateness of the chosen treatment pathway, identification of a physical injury, causation and determining what contribution patient specific factors (or underlying health conditions) had in the development of an injury.

Out of scope