PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

ACC TREATMENT PROVIDER HANDBOOK

This is a living document and will be updated as required

Contents

While ACC has endeavoured to see that it is correct, the legal information contained in this document is a summary only. For any legal purpose, see the applicable legislation and regulations.

1. Overview

Welcome

ACC's role and our partnership with you

ACC's role is to ensure that people in New Zealand receive the rehabilitation they need to return to work or everyday life after injury.

Of course this isn't a role that we perform alone, but one that we carry out in partnership with you, and other health professionals who provide treatment and rehabilitation services.

It is your expertise and dedication that are the main drivers of your patients' recovery. However, the funding and support available through ACC play an integral role in creating successful rehabilitation outcomes. Our partnership is therefore an important one, and it is vital to the wellbeing of the clients we serve.

This Handbook has been created to help us work together as effectively as possible in this partnership. It gives you a thorough overview of what ACC is, how it works and, most importantly, the processes that need to be followed to ensure we work together in the best interests of our clients.

The Handbook covers everything from your responsibilities as an ACC-registered treatment provider to details about how to lodge claims, order ACC resources and invoice us for your services. It also talks about the important of our clients' right to privacy and your role to play in this.

If you're not familiar with any of the terms used in the Handbook, please refer to the Glossary. You can also get more information by calling one of our toll free enquiry numbers or sending us an email (you'll find contact details on p4) or visiting our website at www.acc.co.nz.

I trust you will find the Handbook both helpful and easy to use, and I wish you well as we begin this important partnership together.

Yours sincerely

Scott Pickering
Chief Executive
ACC

ACC on the map

KEY

Branches
- Manage high-complexity claims

Service Centres
- Receive all claims
- Register claims
- Assess claims for cover (or stream to the appropriate unit)
- Manage accidental death, hearing loss, and dental claims
- Assess requests for lump sum/ independence allowance, ancillary services, aids and appliances
- Process claim-related invoices to service providers
- Provide additional support functions (eg Provider Helpline, provider registration)

Short-Term Claim Centres
- Manage low-complexity claims

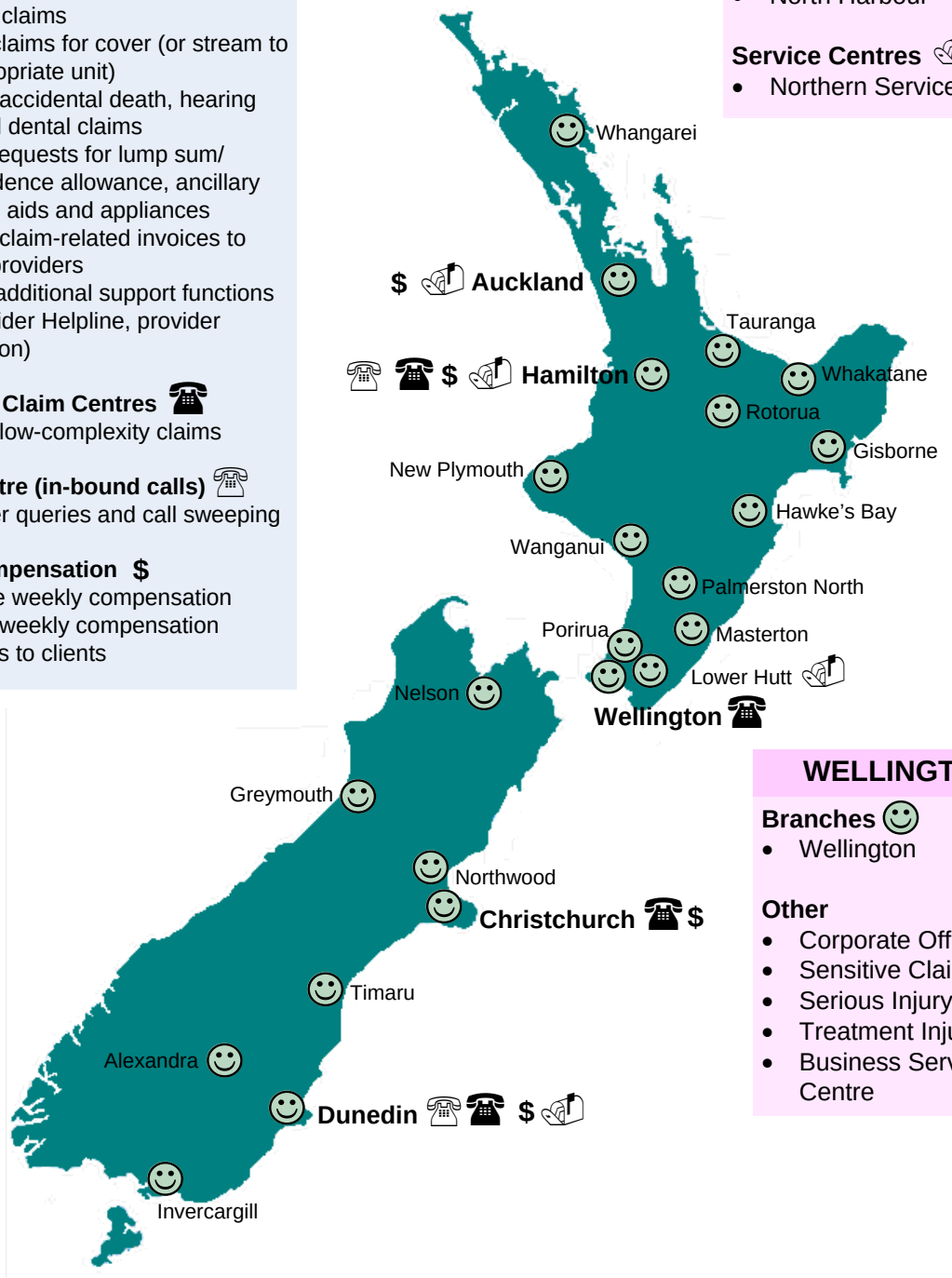
Inquiry Centre (in-bound calls)
- Customer queries and call sweeping

Weekly Compensation $
- Calculate weekly compensation
- Process weekly compensation payments to clients

AUCKLAND

Branches
- Auckland (Sale Street)
- Henderson
- Counties Manukau
- North Harbour

Service Centres
- Northern Service Centre

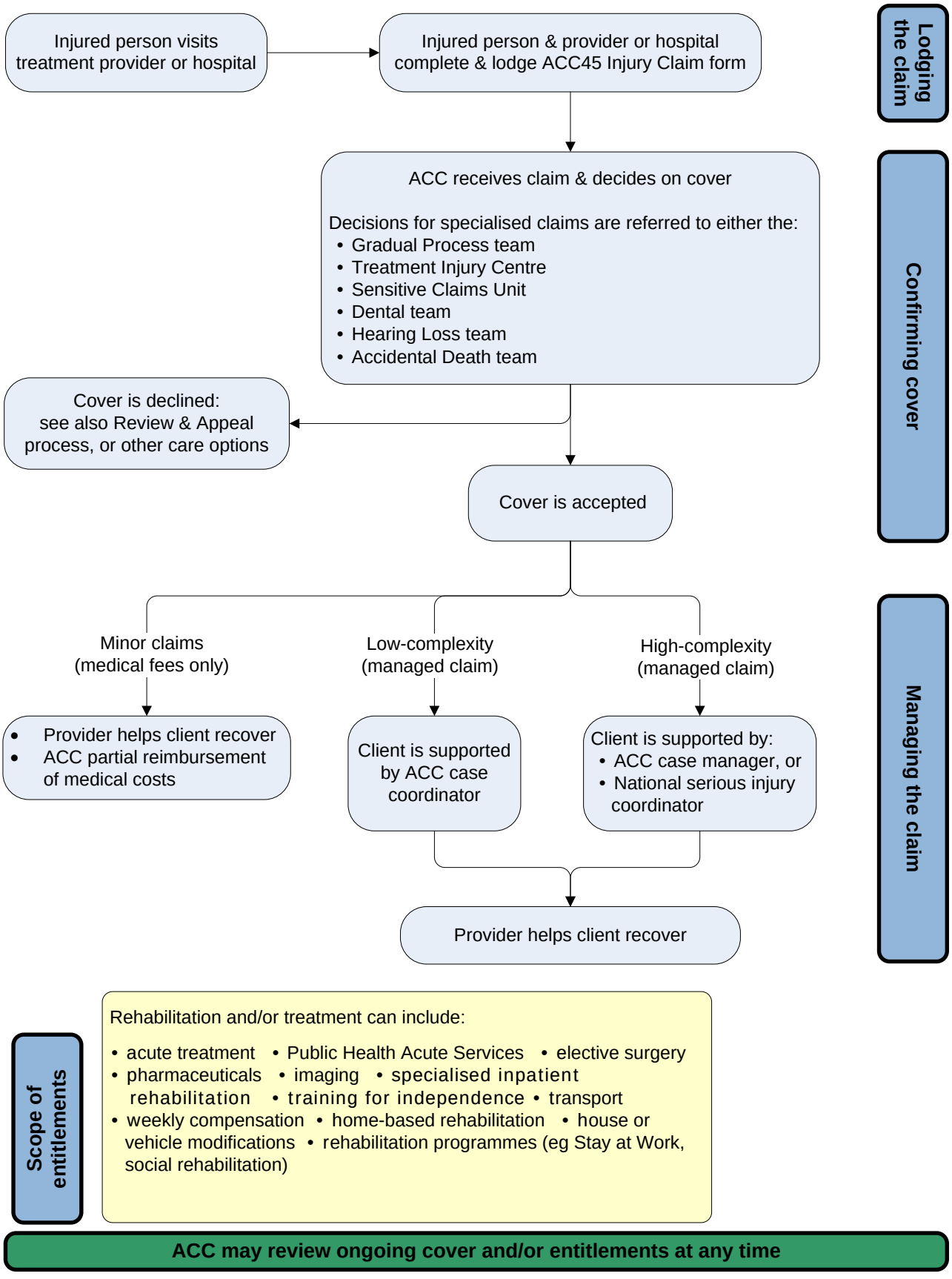


WELLINGTON

Branches
- Wellington

Other
- Corporate Office
- Sensitive Claims Unit
- Serious Injury Unit
- Treatment Injury Unit
- Business Service Centre

How ACC cover works at a glance



Key ACC contacts for treatment providers

Provider Contact Centre	Ph: 0800 222 070	Email: providerhelp@acc.co.nz
Client/Patient Contact Centre	Ph: 0800 101 996	
Urgent home help (fax numbers during ACC office hours)	Hamilton: 0800 222 891 Christchurch: 0800 222 359	Wellington: 0800 181 306 Dunedin: 0800 633 632
Provider Registration	Ph: 04 560 5211 Fax: 04 560 5213	Email: registrations@acc.co.nz Post: ACC, PO Box 30 823 Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994 option 1	Email: ebusinessinfo@acc.co.nz
Medical fees units for invoices, schedules, ACC32 treatment requests	For regions north of New Plymouth and Gisborne: Post to: ACC Northern Service Centre, PO Box 90 341, Victoria Street West, Auckland 1142 email: auckland.acc32@acc.co.nz	Fax: 09 354 8301
	For New Plymouth, Gisborne and all areas south Post to: ACC Dunedin Service Centre, PO Box 408, Dunedin 9054 email: dunedin.acc32@acc.co.nz	Fax: 0800 222 463
Stationery Order Line (forms and brochures) Dental Stationery	Ph: 0800 802 444 Ph: 0800 226 440	
Sensitive Claims Unit (sexual assault)	Ph: 0800 735 566 option 1	
Health Procurement (for health service contracts only)	Ph: 0800 400 503	
Fraud Helpline	Ph: 0800 372 830	Post: ACC, PO Box 1426 Wellington 6140
ACC website	www.acc.co.nz	
My local ACC contact	Name: Fax:	Ph: Email:

2. How the scheme works & working with us

About the ACC scheme

How the ACC scheme works

The ACC scheme provides comprehensive, 24-hour, no-fault cover and entitlements for all New Zealand citizens, residents and temporary visitors who sustain certain types of personal injury in New Zealand, generally those resulting from accidents. The Scheme is mandated by law, in particular by the Accident Compensation Act 2001 (AC Act 2001).

ACC is responsible for:

- helping to prevent the circumstances that lead to injuries at work, at home, at play, on the road and elsewhere
- providing cover for personal injuries, no matter who is at fault
- reducing the physical, emotional and social impacts of people's injuries by funding timely treatment and rehabilitation that gets them back to work or independence as safely and quickly as possible
- minimising personal financial loss by paying a contribution to treatment costs, paying lump sum compensation and providing weekly compensation to injured people who can't work because of their injuries.

We've put together a Glossary that helps explain the terms we use in our policies and procedures for claims, treatment, and with providers.

Note: This handbook has been produced to assist you to work within the parameters of the Scheme and what you need to know about the legislation and regulations that govern what we're able to do. We haven't set out everything here and ask that, if in doubt and for legal purposes you refer to our governing legislation and regulations that apply.

ACC's governing legislation

The AC Act 2001 is ACC's governing legislation. It sets out what we are able to cover and that the help we provide clients is both appropriate and of the required quality.

ACC's policy requirements

ACC has a number of policies and procedures to ensure that we deliver the outcomes required by our legislation and provide appropriate treatment and rehabilitation for our clients.

These include:

- promoting current treatment protocols, guidelines and evidence-based practice
- encouraging providers to stay up to date with the latest developments in ACC policy
- requiring providers' clinical records to be of a standard acceptable to their relevant practitioner body and/or the HPCA Act
- promoting compliance with the 'Hauora Māori - Cultural Competency' clause in all provider contracts, when they work with Māori (see Services to Māori)

- promoting the Guidelines on Māori Cultural Competencies for Providers as a best-practice model when working with Māori
- monitoring appropriate outcomes for Māori
- monitoring health care services
- assessing provider claims, both random and targeted
- investigating any concerns about the need for treatments, or the appropriate number, length or quality of treatments
- taking legal action if dishonest claims are made
- recovering any funding for claims that are charged for inappropriately.

Legislative and policy requirements for providers

When we ask providers to assist in the treatment of clients we're guided by three things:

1. Legislation and policy.

2. Standards set by professional bodies.

3. Major health sector frameworks such as the Health Practitioners Competence Assurance Act 2003, (the HPCA Act). The HPCA Act protects the public's health and safety by ensuring the competence of health practitioners for the duration of their professional lives. Having one legislative framework allows for consistent procedures and terminology across the many professions now regulated by the HPCA Act.

For more information, see the HPCA Act online or the Ministry of Health commentary on the Act.

Your partnership with ACC

Your role in our partnership

We work with injured people and their families in an extended partnership with you, our treatment providers, other health sector professionals, employers and supporting groups.

Some of you will have occasional contact with patients who become ACC clients, while others of you may work with our clients daily. This handbook explains how to work with us, and the formal arrangements such as policies, processes and tools that govern the way we work and the help we can offer clients.

As a health services provider seeking funding to treat clients with ACC covered injuries, you'll have certain responsibilities. These include:

- complying with the ACC Act 2001, our polices and procedures, and your professional standards when treating and making claims for ACC clients
- providing our clients with clinical treatment that meets the requirements of best practice and the standard of your professional body
- providing treatment and advice that assist ACC clients to return to work and/or independence
- following the ACC Treatment Profiles. See the ACC Website
- maintaining appropriate clinical records. See Clinical records
- invoicing appropriately, including those providers who are registered with more than one professional body.

We encourage you to get to know us and to feel free to make personal contact with us locally, e.g. through your local Supplier Manager, or your local branch.

Supplier Managers – key contacts

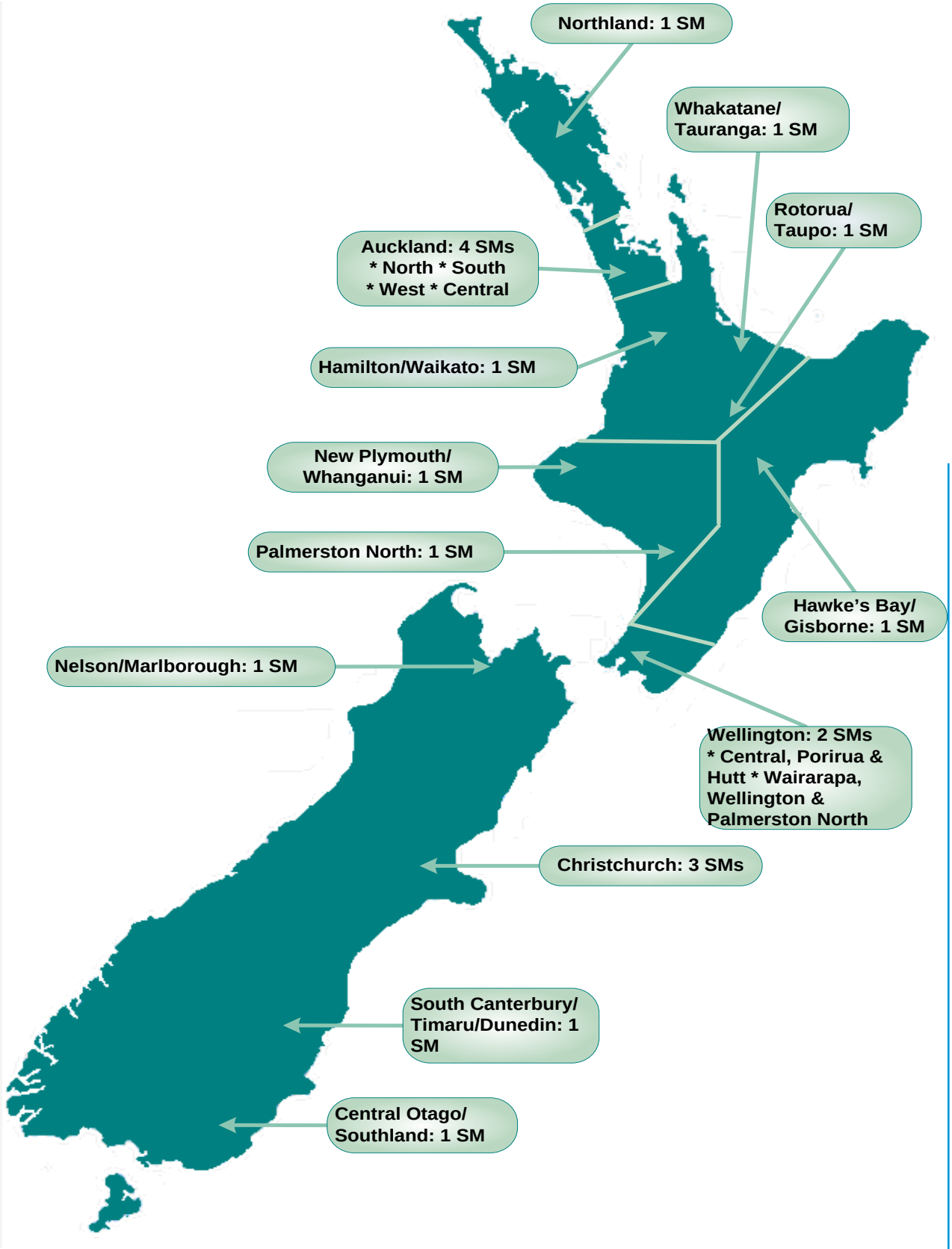
Supplier Managers work in the community with our contracted and non-contracted suppliers in the following ways:

- providing education and support to treatment providers
- helping treatment providers work within ACC's policies and processes
- managing performance as well as relationships.

You'll find where our Supplier Managers are located on the map on the next page.

Supplier Managers on the map

For more information about Supplier Managers see Supplier Managers Contact Details



What ACC covers

Treatment cover

ACC receives about 1.8 million claims a year for personal injuries including mental injuries. See also, Rehabilitation and treatment entitlements and the full Treatment cover section.

The most common injuries we cover are caused by:

- accidents at work, at home or on the road
- work-related gradual processes, diseases or infections
- treatment injuries
- sexual assault or abuse.

Advice on cover criteria

If you're unsure about advising patients on possible ACC cover, phone the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz. Alternatively, ask your patient to get in touch through the Client/Patient helpline on **0800 101 996** or by emailing claims@acc.co.nz.

Personal injuries

Personal injuries cover:

physical injuries (including fatal injuries) which typically include:

- wounds
- lacerations
- sprains
- strains
- fractures
- amputations
- dislocations
- some dental injuries

work-related gradual process injuries, diseases or infections, which cover a range of physical deteriorations caused over time by work or the work environment, e.g.:

- asbestosis
- work-related hearing loss

treatment injuries, i.e. physical injuries sustained while receiving treatment from registered health practitioners.

Mental injuries

Cover for a mental injury is provided if it was caused by:

- a physical injury
- a specific event in the workplace
- sexual assault or abuse.

Mental injuries caused by physical injuries

This is a category of mental injury that is always connected to an original ACC-covered physical injury claim. If a person suffers a covered mental injury arising out of a physical injury then it gets treated as a single claim, rather than separate claims.

Mental injuries caused by witnessing a traumatic event at work

This category of mental injury came into effect on 1 October 2008. It refers to an event that was directly experienced by a person who was in close physical proximity to the event. That means they need to have experienced the event by seeing or hearing it.

Mental injuries caused by sexual assault or abuse

Mental injuries arising from this type of criminal offence are called sensitive claims. For more information see Schedule 3 of the AC Act 2001 or the Glossary.

Mental injury is a complex area and can sometimes be difficult to determine cover. Decisions are made in each case on the basis of diagnosis and evidence provided by a psychiatrist or psychologist in their report to us. In order to receive cover, the information provided in the report needs to prove that their patient's physical injury, the traumatic event at work or the sexual assault or abuse was a direct and significant cause of the mental injury.

For more details about the assessments used to determine treatment options for mental injuries, see Mental injuries, sensitive claims and counselling.

What ACC is unable to cover

ACC is not able to cover:

- injuries to teeth arising from their natural use, e.g. biting a boiled sweet
- cardio-vascular or cerebro-vascular disease, unless they are a result of treatment injuries or work injuries involving effort that is 'abnormally applied' or 'excessively intense'
- gradual process injuries that are not caused wholly or substantially by work-related gradual processes, diseases or infections
- personal injuries caused wholly or substantially by the ageing process (if medical opinion confirms that the injuries would not have happened without the ageing process)
- personal injuries caused by illness
- the emotional effects of injuries such as hurt feelings, stress or loss of enjoyment, unless they result from a mental injury
- injuries caused by coughing or sneezing, or other internal forces

Situations where we're unable to provide some entitlements

In some cases a person's injury will be covered, but we're unable to provide some entitlements, e.g. in some instances of self harm or criminal disentitlement (see the Glossary). If you are treating a patient with a claim of this nature, please encourage them to contact the helpline as soon as possible by phone on **0800 101 996**.

Who ACC covers

Three categories of people covered by ACC:

- all New Zealanders, 24 hours a day, whether or not they are earning an income
- New Zealanders who are injured overseas (with certain criteria)
- visitors to New Zealand (with certain criteria).

Code of Claimants' Rights

All ACC claims are managed under the Code of ACC Claimants' Rights. These rights are covered in the pamphlet ACC2393 Working together to resolve issues.

The pamphlet explains what clients can do if they are unhappy with the service they receive and outlines what they can expect from ACC in their dealings with us.

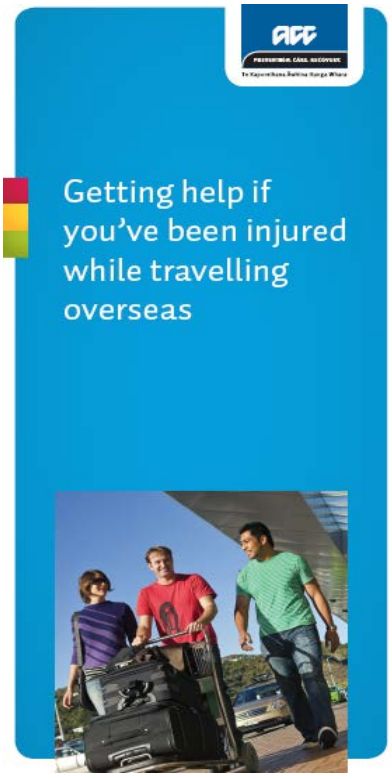
For more information see Code of Claimants Rights: respect, culture, and values.

Cover for Kiwis injured overseas

New Zealanders may also be able to receive support back in New Zealand if they were injured overseas. They just need to meet ACC's 'ordinarily resident' criteria.

Eligible New Zealanders may also receive payment for overseas treatment if they suffered work-related personal injuries overseas. ACC isn't able, however, to reimburse New Zealand providers for treatment given overseas (e.g. when accompanying sports tours). Providers can only receive payment when working in New Zealand.

See the information sheet ACC593 Getting help with an injury if you've been travelling overseas. You can order this online or by phoning the Stationery Order Line on **0800 802 444**, option 0, and quoting the ACC number in the title (e.g. ACC593).



Cover for visitors to New Zealand

Visitors to New Zealand are covered for personal injuries and ACC can help pay for treatment while they're in New Zealand once the claim's accepted. We're not able to reimburse visitors for rehabilitation or treatment costs in their home countries, or for loss of income.

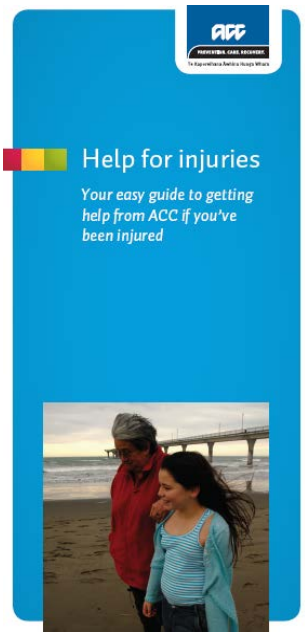
The information sheet ACC592 'Getting help if you're injured visiting our country' can be ordered online or by phoning the Stationery Order Line on 0800 802 444, option 0, and quoting the ACC number in the title.

The brochure is also available in Māori, Samoan, Tongan, Cook Island Māori, Chinese, Hindi and Korean. You can select the brochure in the language you want at the ACC website under For Providers > Publications > In your language.

Cover for Kiwis in New Zealand

The information sheet ACC583 Help for injuries explains for clients how the claims process works in New Zealand.

You can order this online or by phoning the Stationery Order Line on **0800 802 444**, option 0, and quoting the ACC number in title.



Terminology: clients and patients

ACC uses the word 'clients' to describe patients whose claims have been accepted for cover and have therefore become ACC clients. The term is used throughout this Handbook to reinforce the importance of lodging claims in order to access entitlements for people. We recognise, however, that you may prefer to use alternative terms.

Cultural services

The Cultural Services team

ACC's Cultural Services team is a group of cultural case advisors including Pae Ārahi (Māori cultural case advisors), Pacific cultural case advisors and Asian cultural case advisors. You can contact these advisors through case managers and other frontline staff in ACC.

Code of Claimants' Rights: respect, culture and values

All ACC claims are managed under the Code of ACC Claimants' Rights.

The pamphlet explains what clients can do if they are unhappy with the service they receive and outlines what they can expect from ACC in their dealings with us.

You can order this online or by phoning the Stationery Order Line on **0800 802 444**, option 0, and quoting the ACC number in title.

It's available in eight languages and each language has a different ACC number at the beginning of the title:

ACC2393 (English), ACC5320 (Cook Islands Māori), ACC5321 (Samoan), ACC5322 (Tongan), ACC5323 (Māori), ACC5324 (Hindi), ACC5325 (Chinese), ACC5326 (Korean).

For more information, see the legislation covering ACC claimants' rights.

Māori cultural guidelines

The ACC booklet ACC1625 Guidelines on Maori Cultural Competencies for Providers can be viewed online. It was created to help you give appropriate advice, care and treatment to Māori clients.

You can order this online or by phoning the Stationery Order Line on **0800 802 444**, option 0, and quoting the ACC number in title.

The booklet comes with a DVD and is available as:

- an A4-size document with the code number ACC1625, or
- a shorter version with the code number ACC1626.

Please quote the ACC number and your provider number when ordering.

Treaty of Waitangi

In line with our Treaty of Waitangi obligations for Māori and also our obligations to the people of the Pacific Islands and Asia, ACC obtains input from Cultural Services for appropriate service delivery and to ensure these clients have positive experiences of our service.

Services to Māori

ACC is committed to ensuring that appropriate services are delivered to all who meet our entitlement criteria. However, we know that Māori make significantly fewer claims than New Zealand Europeans.

You can play a key role in helping to address disparities by, for example, ensuring that your services are more engaging to Māori

If you're a new provider you can indicate your ethnicity or language capability on the ACC24 application form. This can enable us to offer your treatment services to clients seeking services from culturally experienced providers.

Alternatively you can contact the ACC Provider Registration team by phoning 04 560 5211, emailing Registrations@acc.co.nz or writing to ACC Provider Registration, PO Box 30 823, Lower Hutt 5040.

All our service contracts have a 'Hauora Māori – Cultural Competency' clause. The clause outlines the criteria with which providers must comply with during tendering and evaluation processes and while delivering services to Māori. It aims to ensure that services are delivered to Māori clients in ways that recognise and respect Māori cultural values and beliefs.

Services for Asian and Pacific peoples

In the past few years ACC has also concentrated on increasing access for Asian and Pacific peoples through respective access strategies and community outreach. With recent evidence that shows improved access by Asian and Pacific peoples, ACC is now concentrating on achieving best rehabilitation outcomes for Asian and Pacific clients.

Rehabilitation and treatment entitlements - overview

Managing rehabilitation

Rehabilitation is important in returning injured people to work and independence. To enable rehabilitation ACC engages with providers to deliver necessary services. If a client's injury is significant, it's managed in a branch by a case manager who has access to a panel of experts, typically a medical advisor, a branch psychologist, a technical advisor and a team manager with a rehabilitation focus. These experts will help the case manager by giving direction for rehabilitation.

The aim of rehabilitation is to help restore a client's pre-injury health, independence and participation in society as much as possible.

For more information on rehabilitation please see Section 7 - Rehabilitation.

Managing treatment

Treatment includes:

- physical rehabilitation
- cognitive rehabilitation
- examinations or assessments for the purpose of providing a certificate to ACC (such as a medical certificate for time off work, or assessments to help determine treatment plans).

ACC supports clients' treatment by contributing to:

- client consultations and procedures delivered by treatment providers, according to the Injury Prevention, Rehabilitation, and Compensation [IPRC] (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003. See also, How ACC Pays.
- treatment services such as elective surgery and hand therapy, usually under contract
- pharmaceuticals prescribed for ACC-covered injuries (see also Pharmaceuticals)
- bulk funding to the Crown for emergency department, acute inpatient and follow-up medical outpatient services, and some associated ancillary services.

Increasingly, multiple interventions are used alongside treatment, including 'non-clinical' tools such as exercise programmes and education for clients.

We encourage you to participate in early planning and discussions with clients, and may also pay for you to attend case conferences where multiple parties, including families and employers, can be represented.

What help clients can receive

ACC clients can receive a range of treatment and rehabilitation services and may also be eligible for compensation. The AC Act 2001, which forms the legislative base for most of ACC's activities, outlines what clients with approved cover may be entitled to receive.

This includes:

- weekly compensation while a client is unable to work
- lump sum compensation for permanent impairment
- rehabilitation, which covers:
  - treatment
  - social rehabilitation (support in everyday living activities)
  - vocational rehabilitation (support to maintain or obtain employment)
  - associated ancillary services.
- accidental death – help for survivors.

Details on these entitlements are listed in the sections below.

Weekly compensation

Clients may be eligible for compensation for lost earnings if they need to take time off work because of their injuries.

Only medical practitioners and nurse practitioners can certify time off work for ACC clients. The exception is for the first week off work after a work-related personal injury, when the client's employer can nominate and pay a registered health professional, e.g. a nurse, occupational therapist, physiotherapist, to complete the certificate.

For more information see Medical Certificates, ACC18.

Lump sum compensation

Lump sum compensation is generally available for clients whose injuries lead to permanent impairment. The type of compensation available is based on claim type.

You can get more information through the Provider Helpline on **0800 222 070** or by emailing providerhelp@acc.co.nz. Your patient can get more information by calling the Client/Patient Helpline on **0800 101 996**.

The information sheet LSIAIS01 All About Lump Sum Payments & Independence Allowances also gives details on lump sum compensation calculation procedures.

Social rehabilitation

Social rehabilitation is available to support clients whose injuries have a moderate or significant impact on their lives. It supports the client's rehabilitation through services such as:

- home and community support services, e.g. home help, child care, attendant care
- equipment that is based on the client's assessed needs, e.g. wheelchairs, shower stools and walking frames
- modifications to the home or vehicle
- needs assessment services
- post-acute rehabilitation delivered by DHBs and some Trust Hospitals.

The aim of social rehabilitation is to help clients achieve as much independence as possible. For details on the assessment criteria for social rehabilitation, see Social rehabilitation assessment

Specialised rehabilitation

Specialised rehabilitation is available to support clients whose injuries have a significant long-term (or life-long) impact on their lives. It supports the client's rehabilitation through services such as:

- residential rehabilitation services
- transition services
- 'Training for Independence' programmes
- community based services
- disability support services
- education support.

The aim of specialised rehabilitation is to help clients achieve the best possible outcomes by providing early intensive rehabilitation and community support

For details on specialised rehabilitation, see ACC Contracts

Vocational rehabilitation

Vocational rehabilitation is available to help clients recovering from significant injuries to maintain or obtain work, or to regain vocational independence. Where possible, it's best for clients to stay in their pre-injury jobs. Together with suppliers and providers, we can help them to do this by:

- reviewing their working environment and discussing ways to help them do all or some of their work tasks as their rehabilitation progresses
- providing equipment to help them at work
- helping with pain management.

In some cases clients start in stay at work programmes before they return to work and while they are rehabilitating. Employers are asked to take all practical steps to help injured employees rehabilitate, regardless of whether their injuries are work related.

We have a range of tools to help clients who are unable to return to their pre-injury jobs. These include:

- initial occupational assessments which identify the types of work that may be suitable for them
- initial medical assessments which identify whether those types of work are medically sustainable and if any further rehabilitation is required
- work readiness programmes which include pre-employment preparation and/or strengthening programmes and can include work trials.

Following rehabilitation, we may ask a client to have their vocational independence assessed by an occupational assessor and a medical assessor. This is to ensure that the full extent of rehabilitation has been provided and we have addressed any injury-related barriers to employment or vocational independence. The assessments will help determine whether the client can return to work full time or whether further alternative rehabilitation is necessary.

For details on vocational rehabilitation see Work and rehabilitation.

Pain management services

Pain Management services aim to reduce a client's pain through exercise activities and education. Early screening can determine if a client will need further assessments to establish if they have an increased risk of disability.

A pain management programme works best for the client when there's a clear connection between the programme and getting the client back to independence. This is achieved when:

- the programme sets client-specific goals to restore independence for pre-injury activities, e.g. vacuuming, or getting in and out of a truck
- the client can continue the programme once the formal supervision has finished, if they choose to do so.
- the client is comfortable that there isn't any other reason(s) for their pain, i.e. red flags have been dismissed.

ACC has a range of tools to help clients identify, manage and recover from pain. These include:

- a functional reactivation programme
- a progressive goal attainment programme
- pain management psychological services
- a pain disability prevention programme
- comprehensive pain assessment
- an activity focus programme
- a multidisciplinary pain programme
- interventional pain management

For details on vocational rehabilitation see Pain Management Services.

Accidental death – help for families

When we accept a claim for entitlements arising from fatal injuries, we can help with:

- a funeral grant (to the maximum amount set by regulations)
- a grant (for the spouse, children and other dependants)
- weekly compensation for the dependants if the deceased person was in employment at the time they died (the spouse can apply to convert this into a lump sum)
- payments to cover childcare for the deceased's children.

Ancillary services

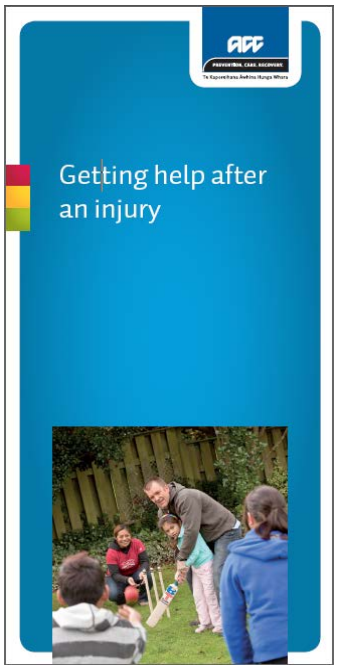
Ancillary services help clients to access treatment and rehabilitation. They include:

- pharmaceuticals and laboratory services
- emergency transport by ambulance, and transport to treatment
- transport to and from certain types of vocational and social rehabilitation
- travel for support people in specific situations
- help with accommodation for clients and/or their support people.

When a client's care is being funded under the Public Heath Acute Services (PHAS) agreement, the DHB provides their ancillary services.

Helping clients to understand what help they can receive

Our clients often ask their treatment providers about what help they can get from ACC and how ACC works. While we don't expect treatment providers to understand all of the ins and outs of the scheme the brochure ACC2399 Getting help after an injury covers the basics of how we can help.



You can order free copies by phoning the Stationery Order Line on **0800 802 444**, option 0, and quoting the ACC number in the title.

For detailed information you can direct clients to www.acc.co.nz. Under 'Making a claim' where they can click on What support can I get? They can also call the client/patient helpline on **0800 101 996**.

If you have any questions about entitlements, please contact the Provider Helpline either by phone on **0800 222 070** or by email at providerhelp@acc.co.nz.

How ACC pays

Criteria for covering costs

ACC pays for, or contributes to, the costs of treating a covered personal injury. See also Invoicing and payments and Electronic invoicing: eSchedules.

ACC makes decisions according to the AC Act 2001 and regulations, which states that treatment must:

- be necessary and appropriate
- meet the quality required
- be given the appropriate number of times, and 'in person'
- be given at the appropriate time and place
- be reasonably required to facilitate treatment (for ancillary services)
- normally be provided by your type of treatment provider, and you must be qualified to provide that treatment
- have prior approval (if required).

In deciding whether these points apply to a client's treatment, the AC Act 2001 says that ACC must take into account the:

- nature and severity of the injury
- generally accepted treatment for the injury in New Zealand
- other treatment options available in New Zealand for such an injury
- cost in New Zealand of both the generally accepted treatment and the other options, compared with the benefit to the client of the treatment.

Requirements for providers seeking payment

Providers seeking payment from ACC for services or treatment must ensure that:

- the service provided and invoiced for includes clinical records that meet ACC's recommendations and their profession's standard
- clinical records demonstrate that the treatment provided meets the legislative requirements (listed above)
- the treatment provided and the clinical records can withstand scrutiny through peer review, an audit (medical or financial) or a medico-legal challenge
- the date of an appointment is the same on the invoices as recorded in any clinical notes.

Our policy on treating yourself or your family

ACC agrees with the statement of the Medical Council of New Zealand that "other than in exceptional circumstances you should not provide medical care to yourself or anyone with whom you have a close personal relationship". ACC considers this to be relevant to all types of treatment providers and includes treatment of work colleagues.

We generally consider it unacceptable and unethical for providers to claim payment from ACC for treating those that are close to them. We will only consider paying for treatment in exceptional circumstances.

Exceptional circumstances include:

- acute treatment provided in an emergency situation where, in your reasonable judgement, the need for treatment is urgent given the likely clinical effect on the person of any delay in treatment
- situations in rural areas where there is no other appropriately qualified treatment provider available to give the required treatment.

We're unable to fund:

- treatment provided in a non-emergency situation.
- emergency treatment that would ordinarily be provided by a family member who is not a provider

The provider claim lodgement framework

To enable us to verify claims lodged on behalf of patients, we have worked with professional bodies to incorporate 'scopes of practice' into our frameworks.

The 'provider claim lodgement framework' covers various injury types. It refers to common Read Codes to show which injuries a provider can complete an ACC45 Injury Claim form and provide initial treatment for. If the injury is within the provider's scope of practice we can make a cover decision.

If the injury is not within a provider's scope of practice (as defined in the provider claim lodgement framework) the provider can give initial treatment and initiate the process of completion of an ACC45 form. They must then refer the client to a medical practitioner for confirmation of diagnosis before we can determine cover.

This means the patient will see two providers before their claim is considered. ACC will pay for the initial treatment but won't be able to pay for any subsequent treatment until a suitably qualified practitioner has completed lodgement. The types of providers this rule applies to include acupuncturists, osteopaths and speech therapists.

For more information on lodging claims, see the online documents:

- Provider claim lodgement framework
- Lodge a claim electronically
- Lodging a claim with ACC or an Accredited Employer.

How ACC funds providers in training

ACC only pays for treatment given by qualified treatment providers who take full responsibility for their treatment.

If you're a provider in training (e.g. an intern, or a university or polytechnic student undertaking practical work for their study) we can provide funding if you're:

- already a qualified practitioner who is undertaking further study, or
- unqualified but have gained consent from the client, and are supervised by a qualified practitioner who is personally present throughout the treatment delivery and takes responsibility for assuring its standard.

Note: An important exception is that sexual abuse counselling must always be provided by a fully qualified counsellor.

Three ways to provide services to ACC

There are three different ways to provide services to ACC:

- Service Contracts

Every ACC contract for services includes details of the invoicing and payment arrangements that apply to those who sign it. Contract terms can differ from the Regulations, and when this happens the contracted terms take precedence over the Regulations.

- Payments under agreed costs

Agreements between ACC and the providers based on the treatment costs. If an ACC case manager requests services at an agreed cost, you'll need to request a seven digit purchase order number from ACC. This needs to be included on every invoice. For more information, phone the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

- regulations, e.g. the:
  - IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003
  - IPRC (Ancillary Services) Regulations 2002
  - PHAS (Public Health Acute Services) Regulations 2002
  - any later amendments ('the Regulations').

Payments under Regulations

The Regulations cover a large number of treatment providers, including:

- Acupuncturists
- Audiologists
- Chiropractors
- Counsellors
- Dentists
- Hyperbaric oxygen treatment providers
- Medical Practitioners
- Nurses or nurse practitioners
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Radiologists
- Registered specialists
- Speech therapists

ACC contributes to treatment costs at the rates/amounts specified in the Regulations. The Regulations cover basic treatment provider costs, while Schedules to the Regulations specify amounts for treatments/procedures types.

These include rates/amounts:

- per consultation/visit, as long as you examined, assessed and/or treated the client in person, for an injury or condition covered by ACC (for details see, Consultations/Visits).
- per treatment/procedure given to a client during a consultation/visit as long as the Schedule includes an amount for that treatment/procedure for your type of provider.

Providers' payment options

If you're a 'Specified Treatment Provider' (or 'Allied Provider') working under the Regulations you have the choice of being paid on a per-treatment basis or on an hourly-rate basis. These hourly rates are also specified in the Regulations. For details see, Specified treatment providers.

Treatment/Procedure guide for medical practitioners and nurses

For guidance on items in the Regulations for medical practitioners and nurses see Guide to invoicing for medical practitioners and nurses.

How to find Regulations online

Information sheets regarding the Cost of Treatment Regulations, which give information on the amounts you are able to claim from ACC, can be found online at New Zealand legislation.

Privacy

We take privacy seriously

ACC deals with personal and health information for a large number of people. Sometimes you'll need access to this information to carry out services for ACC.

It's important to us that we each do our part, and work together to protect this information. This includes doing everything we can to make sure it's not mishandled.

Not only does this help us meet the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994, but it also enables us to work with an enhanced level of transparency on breaches/near misses.

To achieve a high level of transparency we expect all providers to have effective preventative measures in place to avoid breaches and near misses.

What to expect

If you have access to personal or health information we would like you to:

- work with us in a transparent way
- notify us of potential risk
- notify us of a breach or near miss
- resolve issues as they arise
- maintain a privacy register that includes breaches, near misses and remedial action plans.

What do we mean by 'breach' and 'near miss'?

A *breach* is when personal information is disclosed to an external party when it should not have been, e.g. by error, mistake or without legal authority.

A *near miss* is when you can identify something you, or your staff, did that would have lead to a privacy breach but didn't because the information wasn't disclosed.

Obligations

Every business has obligations under the Privacy Act 1993. When dealing with personal information, you need to ensure you comply with the 12 Information Privacy Principles that cover the collection, handling and use of personal information, set out in the Act. The Act also requires every business to have a Privacy Officer to oversee their compliance with the Act and investigate any complaints when they arise.

A Privacy Pack has been developed to help you with managing the privacy of your client's person information. It is available from our website and was developed with information from the Office of the Privacy Commissioner.

Further information can be obtained by contacting the Office of the Privacy Commissioner either online at www.privacy.org.nz or by calling their helpline on 09 302 8655 (or 0800 803 909). You can also refer to ACC's Privacy Management section on our website

3. Supporting quality

Resources for providers and clients

Resources to help you

ACC produces a range of resources to inform, encourage and support the use of best clinical practice. They include:

Case studies

These are in-depth studies on the diagnosis and treatment practices used by providers for particular health issues. They allow you to compare you own practices on selected health issues with those of your peers, and with the views of expert commentators. Case studies are developed by surveying treatment providers on their diagnosis and management of a specific case, described in a vignette. The responses are then collated and published along with expert commentary

Feedback reports

ACC has created a suite of feedback reports as part of its work to support performance excellence. These are provided at both a provider and supplier level. The reports summarise treatments provided and in some cases compare them with peer or overall data. They aim to provide a valuable opportunity to help you self-evaluate and consider decision-making approaches.

ACC reviews

ACC reviews summarise the latest best practice on injury management and rehabilitation from a clinical perspective, drawing on recent available evidence and clinical guidelines. The reviews are developed by clinical subject matter experts in conjunction with ACC staff and relevant peer review groups.

Clinical practice guidelines

Clinical practice guidelines help providers and clients to make decisions about medical care in specific clinical circumstances using the best available evidence. Developing guidelines is a systematic process that involves reviewing evidence, consulting clinical experts and working with multidisciplinary advisory groups

Resources for clients

You can help your patients to understand their injuries by giving them information from the ‘caring for your…’ leaflet series. This series gives clients tips on how to look after their injuries.

These leaflets are available from our website to order through the Publications section.

Research

Research involvement

ACC invests in ongoing research as part of our commitment to ensuring the most appropriate rehabilitation and treatment for clients. This is often done in collaboration with partners in the broader clinical and health sectors.

Our Research team conducts in-house research, and manages research done by external agencies that is funded by ACC. We also partner in research, where initiatives can cover consensus guidelines, evidence-based health care, and innovations in rehabilitation and treatment.

Research advice

The Research team is committed to the principles of evidence-based health care. It helps to inform our decision-making, guides our health purchasing and supports best practice among treatment providers. The team's objectives include:

- providing advice to ensure that ACC's purchasing decisions are based on good evidence
- promoting best practice in injury management and rehabilitation
- evaluating new ACC services and primary health care initiatives
- consulting and collaborating with health care providers
- seeking feedback from providers and other partners through surveys and market research
- identifying new and emerging issues that might affect ACC in the future.

Research partnerships

The team uses accepted methods to summarise and evaluate existing clinical research on effectiveness and safety. This is followed by a considered judgement process that involves consulting treatment providers and other experts to recommend effective practice.

In partnership with a purchasing advisory group that also includes providers and other experts', the team advises on which treatments, products and services ACC should purchase.

Visit our website www.acc.co.nz for recent evidence-based healthcare reports, Considered Judgement Forms (which support the purchasing advisory group discussions) and information about the Research team.

Clinical records

ACC's emphasis on clinical records

Your clinical records should show the history you obtained, the examination you undertook, how you formulated your diagnosis, and how you planned a client's treatment. Reviewing your records will help ACC and others to see how you reached your conclusions.

It can be easy to forget details of a client's presentation or what you said and did in the consultation/visit. Good clinical note-taking can help you to review your practice and avoid uncertainties.

In the unlikely event of a complaint or adverse event for a client, good records help to show your standard of care and document your decisions and advice. It is therefore vital that you keep full and accurate clinical records, for your own and the clients' protection and support.

All bodies endorse the responsibility of professionals to regard record-keeping as a key area of competence, and most have processes to support and encourage this. Each profession also has its own standards for record-keeping, so check what your professional body suggests.

All services that you provide and for which you invoice us must be supported by clinical records that meet your profession's standards and ACC's recommendations. See What we recommend for all clinical records

Requesting your clinical records

People wanting to lodge claims for injuries can have complex or confusing presentations. ACC has a legislated right to view your clinical records at any time. Your clinical records provide us with the necessary clinical evidence to determine whether your patients' injuries meet the legislative requirements for different types of cover and that your treatment was necessary and appropriate.

If a patient's injury is covered, they may be given treatment and other support as their 'entitlement'. Normally, primary care consultations/visits get automatic financial contributions under the Regulations, but for special services such as surgery, pain management, weekly compensation and home help, we're obliged to check that the requested support is directly related to the client's injury. Your records can be crucial in helping us to determine entitlements and overall rehabilitation plans.

We will require copies of relevant clinical records when you submit an ACC32 Request for Prior Approval of Treatment form.

Requesting your clinical records – *continued*

Your clinical records might also be requested:

- by other agencies for other reasons, such as an adverse patient outcome or patient complaint
- for certain invoiced services to ensure they are clinically justified
- by other treatment providers (you'll need patient consent for this)
- by your patients (you should be aware of the rules around such requests)
- if your practice undergoes one of our periodic audits.

What we recommend for all clinical records

Because they're so important, your clinical records for each patient need to:

- provide client identifiers such as their name, date of birth, and ethnicity
- provide your name, a legible signature (if on paper) and the date and time of each

consultation/visit
- be written at the time of the consultation/visit or shortly afterwards and have any later records dated and countersigned
- be written in English on a permanent electronic record or, if on paper, be legible and in pen, not pencil
- record any tests or communication that influenced your diagnosis or treatment
- record any prescribed medications the patient is taking
- provide clinical reasons to justify any consultation/visit or ongoing treatment
- provide a provisional diagnosis and supporting rationale if there is a differential diagnosis
- identify a treatment plan and rehabilitation expectations, as discussed with the patient
- record any referrals made
- show consistency between your appointment record and invoice dates
- be stored securely for a minimum of 10 years after the final consultation/visit
- be transported (physically or electronically) only when essential, taking all steps necessary to protect that information. See Privacy.
- withstand scrutiny on the treatment provided, in the event of peer review, audit (medical or financial) or a medico-legal challenge.

What to avoid in your clinical records

Make sure you do not:

- use ambiguous abbreviations
- use offensive or humorous comments
- alter notes or disguise additions.

Our recommendations for the initial consultation/visit

To help us make appropriate decisions, as swiftly as possible, we ask that in the initial consultation/visit you record details of the:

- accident, how it occurred, and any mechanisms of injury
- injury symptoms and clinical significance
- reason for the presentation, or the main reason if the consultation/visit involves more than one condition
- history and examination findings, including important negatives
- relevant past history including medications
- initial working diagnosis
- initial advice you've given the patient, e.g. about work fitness or injury-related restrictions.
- treatment undertaken and tests and investigations required
- management and follow up plan

Our recommendations for follow-up consultations/ visits

Your records for any follow-up consultations or visits should demonstrate that your treatment meets the legislative requirements of being necessary and appropriate. We ask that you detail:

- the patients' progress
- your evaluation of the effectiveness of previous treatment

- new aspects of history and examination, and the results of any new tests or investigations
- any restated or revised diagnosis
- any subsequent advice given to the patient
- any treatment provided
- the reason for any change to an earlier treatment plan
- any reports or communications relating to this injury.

Peer reviews

To ensure that we have the best possible information, we may sometimes approach peers in your clinical area for independent advice. These may be medical advisors employed by ACC or external advisors nominated by your professional body.

Provider monitoring, audit and fraud control

ACC's quality assurance practices

ACC requires assurance that suppliers/providers are providing services that match ACC's requirements, and that the invoices you submit are valid and correct.

The legal basis for any monitoring is set out in:

- Any service contracts agreed between providers and ACC, and/or
- IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003, which cover invoicing and payments under the AC Act 2001.

ACC guides providers towards best-practice behaviour and contract compliance to help improve client services and relationships.

The assistance we offer includes:

- working with providers in an educative and supportive way
- monitoring activity in accordance with ACC's performance and monitoring framework and tracking providers whose invoicing patterns cause concern
- helping to develop, negotiate and implement improvement plans for providers
- managing and resolving provider issues that impact on client outcomes.

The performance and monitoring framework outlines ACC's approach to monitoring provider performance and outcomes achieved through contracted and regulated services. See Performance Framework

How an audit works

An audit provides an independent and objective review of how suppliers /providers are delivering services and can include all aspects of provider practice.

Audit details

ACC carries out a wide range of quality assurance and provider support initiatives including random reviews of Supplier performance and practice. Audits are designed to examine the strength of your practice control environment by looking at the arrangements for purchasing, implementing and monitoring ACC-related work.

Supplier/provider audits formally examine how well you or your organisation:

- complies with a service contract
- can validate service provision
- have provided services that match fees or contributions invoiced for
- keep clinical notes
- have provided appropriate treatment.

An audit may also include an assessment of compliance with applicable laws, regulations, policies and clinical appropriateness. These audits are completed in compliance with audit standards and all relevant legislation including the Privacy Act.

How ACC investigates and controls fraud

ACC defines fraud as:

"Any person who commits an act or omission that is dishonest and without claim of right and for the purpose of obtaining a pecuniary advantage (money) or other valuable consideration (e.g. an entitlement) for oneself or any other person, commits fraud."

ACC has zero tolerance of fraud and the remedies that we consider when we detect fraud include:

- formal warnings
- recovering money unlawfully or inappropriately obtained
- billing restrictions
- complaints to professional bodies
- prosecution
- penalties under legislation
- civil court action.

Investigating fraud

ACC has an Investigation Unit that's responsible for implementing our counter-fraud strategy. Investigators and intelligence staff are based throughout New Zealand. The team uses a variety of detection and investigation methods, including reviews, surveys and interviews.

Examples of client fraud

- Working while receiving weekly compensation without advising ACC.
- Misrepresenting an accident and/or injury.
- Misrepresenting incapacity to gain entitlements.
- Making false declarations.
- Altering documents to gain entitlements.

Examples of provider fraud

- Claiming for treatments and services not provided.
- Claiming times in excess of the time spent with a client, i.e. hourly billing when should be direct billing.
- Over-servicing for financial gain.

- Forging billing schedules and documents.
- Making false statements.

Reporting fraud

If you think someone is being dishonest, please contact the Investigation Unit on **0508 222 37283** or by email at fraud@acc.co.nz or by following the 'Reporting Fraud' link at www.acc.co.nz.

You may provide information anonymously.

4. Provider registration

Registering to become an ACC provider

Why become a registered ACC provider

Registration with ACC enables you to:

- lodge claims for cover on your patients' behalf
- provide treatment for ACC clients within your scope of practice
- invoice us for the services you provide to our clients
- order stationery such as ACC claim forms
- receive important communications.

Who can register

Any treatment provider who wants to be paid for services given to ACC clients needs to register with ACC. Registration is open to all those identified under the AC Act 2001 as treatment providers. This table shows the vocations that qualify, noting the groups that are identified under the Act as 'Registered Health Professionals' and under the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 as 'Specified Treatment Providers'.

Vocational classification	Treatment Provider	Specified Treatment Provider	Registered Health Professional
Acupuncturist	✓	✓	
Audiologist	✓		
Chiropractor	✓	✓	✓
Clinical dental technician			✓
Counsellor	✓		
Dental technician			✓
Dentist	✓		✓
Medical laboratory technologist	✓		✓
Medical practitioner	✓		✓
Medical radiation technologist			✓
Midwife			✓
Nurse	✓		✓

Nurse practitioner	✓		✓
Occupational therapist	✓	✓	✓
Optometrist	✓		✓
Osteopath	✓	✓	
Pharmacist			✓
Physiotherapist	✓	✓	✓
Podiatrist	✓	✓	✓
Speech therapist	✓	✓	

Note: Acupuncturists must be members of either New Zealand Register of Acupuncturists or New Zealand Acupuncture Standards Authority at the time of delivering treatment.

ACC's registration requirements

The qualification, registration and certification requirements that treatment providers must meet, differ slightly between groups. For details for all the different invoicing arrangements see Invoicing and payments.

Registered health professionals

Providers categorised as 'registered health professionals' are asked to demonstrate qualifications in a way that directly reflects the registration and professional standards required of them (and their peers) by the HPCA Act 2003.

Registered health professionals can include those holding interim practising certificates but only when they are acting in accordance with any conditions of their certification, as stated in the HPCA Act.

Nurses and nurse practitioners

Under the AC Act 2001, nurses and nurse practitioners are those who are registered as such in terms of the HPCA Act and hold current annual practising certificates. These categories do **not** therefore include enrolled nurses or nurse assistants.

Specified Treatment Providers

'Specified Treatment Providers' are designated in the Cost of Treatment regulations. Their registration process is similar to that followed by registered health professionals.

Specified Treatment Providers have special arrangements for invoicing and payment that include the option of hourly rates or fixed rates per treatment. This reflects the way they provide treatment. For details see Invoicing and payment – Specified Treatment Providers.

Counsellors

Counsellors work with ACC in a slightly different way. Reflecting these differences, they have a separate registration process. See Counsellor registration.

Registering to provide contracted services

While some services can be provided under Regulations, others can only be provided under contract. If you're interested in registering as an ACC health provider, and want to take up a contract, your key initial contact will be the Health Procurement and Contracting team. This team negotiates and manages ACC contracting opportunities.

ACC's contracted services govern client assessment, planning and rehabilitation/treatment. We contract directly with rehabilitation and treatment providers to enable our clients to receive a wide range of services. That service range is summarised on our website under For Providers > Contracts and performance > All contracts.

For more information about applying for a contract you can:

- contact the Health Procurement and Contracting team on **0800 400 503** or by emailing health.procurement@acc.co.nz.
- visit our website at For Providers > Contracts and performance > How to apply for a contract with ACC.

Individual registration

How to register as an individual treatment provider

If the organisation (vendor) for which you work has a contract with ACC you may not be required to go through a registration process for yourself. For example, clinics or practices holding Accident and Medical contracts or Rural General Practice Services contracts register in a different way.

If you do need to register as an individual, you'll need to supply:

- a completed ACC024 Application for ACC Health Provider Registration form
- a copy of your current annual practising certificate
- your bank account details, either on a pre-printed bank deposit slip or via bank verification.

For more information and registration forms visit our website at For Providers > Set up and work with ACC > Register with ACC.

Alternatively, you can call the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz and we can fax, post or email the relevant application form to you.

Once you've completed the form and attached all additional information required, please send it to:

ACC Provider Registrations
PO Box 30823
Lower Hutt 5040

Alternatively, you can fax your form to 04 560 5213 or email scanned images of the signed form to registrations@acc.co.nz.

The Health Practitioner Index (HPI)

The HPI is a Ministry of Health initiative that ACC supports. The HPI is a new identification system that replaces the:

- ACC provider number with an HPI person number
- ACC vendor number with an HPI organisation number
- ACC facility number with an HPI facility number.

ACC will register you with your HPI – Common Person Number (HPI – CPN). If this is not possible, you will be allocated your own ACC provider number. We may contact you directly to change from an ACC number to an HPI number. Individual providers may already be using HPI – CPN, issued by their Registration Authorities.

Receiving your registration number

We'll let you know in writing that we've accepted your application for registration, and confirm your provider number within five working days of receiving it.

ACC uses provider numbers to identify who has provided treatment, track payments and monitor treatment provider performance. Your provider number is therefore specific to you and must not be shared with other health professionals. Please use it whenever you can in communications and transactions with us.

If you're employed at more than one practice, you may need a separate provider number for each practice. This is due to restrictions with the electronic schedule and the invoice payment systems used by some practices. Please contact the ACC Provider Registration team on **04 560 5211**, to find the best solution.

Keeping your details up-to-date

It's important we hold up-to-date contact details for you and ask that you contact us if you've changed your name, postal or email address, or phone or fax number. You can update your details with us by phoning the Provider Helpline on **0800 222 070** or emailing registrations@acc.co.nz (please make sure you include your provider number in the email).

We'll update your records, send you confirmation of the change, and give your new details directly to our printing and distribution partners, so they have the correct details in their databases when you order stationery.

All bank account changes require either a pre-printed bank deposit slip or bank verification. We can also accept faxed or emailed copies if they are received via a previously verified email address or fax number.

To check the details we currently have recorded for you, please get in touch with the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz

Counsellor registration

Who can be an ACC counsellor

ACC accepts applications from suitably qualified and experienced counsellors, including social workers, psychotherapists, psychologists and psychiatrists.

Benefits of being an ACC counsellor

Counsellors registered with ACC can lodge ACC45 Injury Claim forms on behalf of clients, which can make it faster and easier for clients to receive our services.

We'll pay for your counselling services at published rates in accordance with the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 or updates. The rates differ slightly according to whether treatment is given by a counsellor or a psychiatrist (a medical practitioner).

See also Payment for Counsellors.

Counselling services purchased by ACC

ACC purchases counselling services for clients with:

- sensitive claims
- mental injuries from physical injuries or a workplace event.

ACC also has a Sensitive Claims Unit that specialises in helping people to recover and rehabilitate from mental and physical trauma caused by criminal acts such as sexual violation, indecent assault and unlawful sexual connection. Counselling services are key to the recovery of these clients.

We also help people to recover from mental injury that is the direct result of a covered physical injury or traumatic work related event.

For more information, see Mental injuries, sensitive claims and counselling

If you have any questions about our counselling work, please contact the Provider Registration team on **04 560 5211** or email registrations@acc.co.nz.

Required qualifications, skills and experience

To be registered as an ACC-approved counsellor, psychologist, psychotherapist or psychiatrist, you need some specific qualifications, skills and experience.

The requirements include:

- membership of an appropriate professional body
- qualifications that reflect your nominated area of expertise
- previous and ongoing supervision arrangements
- cultural competency
- proof of relevant ongoing training or experience in sexual abuse or physical injury counselling.

You will need to include other supporting documents:

- A completed application form
- Two case studies
- Consent for a police check
- A copy of your current annual practising certificate

If you belong to another profession you'll need to provide additional items, including certified copies of your academic and qualifications. You'll also need to arrange for your supervisor to provide details about you, and about their own membership of an appropriate professional body.

You can get more information on the required qualifications by:

- phoning the ACC Provider Registrations team on **04 560 5211**
- emailing registrations@acc.co.nz
- reading the FSCR01 Counsellor Registration Information fact sheet.

Applying for registration

To find out about how to apply to become an ACC-approved counsellor, we recommend that you:

- visit our website at For Providers > Set up and work with ACC > Register with ACC
- read the information sheet FSCR01 Counsellor Registration Information, which explains the factors that may prevent your registration, such as a criminal record.

How we assess your application

All applications are reviewed by an external evaluation panel made up of nominated representatives from various New Zealand counselling bodies.

The panel will assess your qualifications and experience against the ACC criteria and make its recommendation to us, which will determine the final decision.

The application process includes a police check to find out if New Zealand Police holds any information about you. This includes details of criminal convictions, except those covered by section 7 of the Criminal Records (Clean Slate) Act 2004.

Letting you know

We aim to advise you of our decision within six weeks of receiving your completed application.

5. Lodging claims

Lodging a claim with ACC or an Accredited Employer

Forms used to lodge claims

There are five main forms used to lodge claims and most can be lodged electronically:

ACC45 Injury Claim form

The ACC45 injury claim form is the primary form used to lodge a claim for cover, and should be used wherever possible. This is because it has a unique number for security reasons, which we also use to monitor claims, and provides sufficient prompts within the form to ensure all of the necessary information is provided. See Completing the claim form, for more information. If your patient requires further time off work, you'll also need to complete an ACC18 Medical Certificate.

ACC2152 Treatment Injury Claim form

Use this form in addition to the ACC45 when lodging a treatment injury claim. For more information, see Treatment injury.

ACC18 Medical Certificate

Use the ACC18 Medical Certificate if you're a medical practitioner or a nurse practitioner and you need to describe a person's ability to work. This is the only certificate we accept for compensating clients for time off work. For more information see, Medical certificates (ACC18) An ACC18 can also be used to request ACC to change or add a new diagnosis to an already existing claim.

ACC42 Dental Injury Claim form

The ACC42 Dental Injury Claim form is a specialised form of the ACC45 Injury Claim form that dentists use to provide more specific details about clients' dental injuries.

ACC32 Request for Additional Treatment form

The ACC32 form can be used for several different purposes (refer to ACC32) – such as when your patient's injury is covered and you:

- anticipate that you'll need prior approval from ACC for additional treatment funding
- want to add or change a diagnosis. (See also What Information does ACC need?)
- want additional splinting costs.
- this form can also be used when the client requires initial time off work.

Ordering new forms

The easiest way to lodge a form is electronically, however, if you don't have access to a computer, printed forms can be requested.

To order new forms, reply-paid envelopes and other ACC supplies:

- phone the Stationery order Line on **0800 802 444**
- key in your ACC provider number, or press 0 to speak to an operator.

The claims lodgement process

When you lodge a claim using the Injury Claim forms you're asking us to cover a patient's personal injury.

Please complete the form with your patient and send it to ACC either as a paper form or electronically. For more information on electronic lodgement:

- visit our website at For Providers > Set up and work with ACC > Work online with ACC > eLodgement
- see Working electronically with ACC.

Each ACC45 Injury Claim form has a unique secure reference number that identifies the patient's claim once it's been lodged. The form is used for many kinds of injuries and conditions and enables you to provide important information that can help start the rehabilitation, treatment and/or entitlements process.

Notes:

Only treatment providers defined by legislation can lodge claims on behalf of patients. See Who can register for a list of accepted providers, and visit our website at For providers > Lodge and manage claims for more information.

Only medical practitioners and nurse practitioners can certify incapacity for work. For more information, see Medical certificates (ACC18).

Lodging a claim with an Accredited Employer (AE) is slightly different. For more information, see Lodging Accredited Employer claims.

The processes for lodging specific claims can differ. See the links under For providers > Lodge a claim > How do I lodge a claim with ACC? and Treatment cover for details. on how to lodge:

- claims for mental injury caused by sexual abuse
- claims for treatment injury
- claims for work-related gradual processes, disease or infections
- late lodgement claims.

If you're not sure about how to lodge a claim with ACC we encourage you to check out the information on our website, or give us a call. This will make sure everything goes smoothly for you and your patient. If you have a question about lodging a claim, or a claim already submitted, please get in touch with the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

Completing the claim form

There is information about how to complete, sign and lodge a claim on our website under For providers > Lodge a claim > How do I lodge a claim with ACC? See also Where to send the claim forms.

Things to note when completing the form and before you submit it:

If you want check whether a claim has already been submitted

If you need help in finding out about a claim already submitted, call the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz with the patient and injury details. You can also check on a claim's status through the eLodgement system.

If your patient has claimed for their injury before

Quote the ACC45 number for their original claim. The number will be on the referral form, or the first ACC45 Injury Claim form.

Check the client's personal details (Part A) and employer details (Part B) and, if necessary, update them.

Include previous surnames if they've changed within the previous few years.

If your patient is in paid employment

Employer's names and addresses must be included for all claims where your patient is in paid employment regardless of whether the injury is work related.

If you can't find a Read Code that matches your diagnosis

If you can't enter a Read Code on the ACC45 Injury Claim form because there is no code that matches your diagnosis, provide a written description. For more information, see Managing Read Codes

If you think your patient needs help beyond ACC's contribution to treatment costs

For example if you think your patient needs further treatment, personal support or weekly compensation there are several places on the ACC45 Injury Claim form where you can specify a patient's additional needs.

You can also give them your professional assessment of these needs and encourage them to contact the Client/Patient helpline on **0800 101 996** as soon as possible. In most cases they can apply for entitlements over the phone. However, entitlements aren't granted until cover is accepted, so it's still essential that you lodge the ACC45 Injury Claim forms promptly.

If your patient presents with a sexual abuse injury

- It's important you also ask them whether they want mail from ACC or providers to be sent to a different address from the one on your records.

Before submitting the form

- add NHI numbers if you know them
- be sure to go over the Patient Declaration and Consent section on the back of the ACC45 Injury Claim form with the patient, to ensure they understand what they are signing.

Using Read Codes

Read Codes are a hierarchical coding system for injury types with each level giving a more specific diagnosis. Each Read Code has five characters. If a Read Code only has 4 numbers it will end in a dot, which becomes its fifth character.

Primary care providers are required to record Read Codes for all diagnosed injuries for ACC claims. Hospitals or secondary care providers can use International Classification of Diseases: 10 (ICD-10) codes instead, although can and often do also provide Read Codes. Having the correct Read Code helps ensure we're covering the correct injury and providing the client with the most appropriate support, rehabilitation and treatment.

Recording a Read Code

When completing an ACC form, eg.ACC45 Injury Claim Form, ACC 18 Medical Certificate, and ACC32 Request Approval for further treatments please:

- record the Read Code that best corresponds to your diagnosis of your patient's injury
- record the lowest relevant level of Read Code
- use a separate Read Code for each injury for a client with multiple injuries in the order of severity/complexity.
- ensure that each Read Code includes the dot, if necessary for the most accurate injury diagnosis
- use Code Z (unspecified condition) if there's no Read Code to match your diagnosis and provide a detailed written diagnosis. An ACC staff member will complete the Read Code field and may contact you if they need to clarify anything.

If you do not have access to the full Read Code directory via Read Code software, ACC can provide a quick Read Code reference list sorted by type and location of injury. Use this link ACC6343 Read Code reference list to download the reference list. You can also follow these links for Read Codes commonly used in Physiotherapy, Osteopathy and Chiropractic

Where to send the claim forms

If you're sending claims using eLodgement, do so regularly during the day. Most claim forms can be sent electronically.

For more information visit our website at:

- For Providers > Lodge and manage claims > Lodge a claim electronically
- For Providers > Set up and work with ACC > Work online with ACC

If you're sending claims by post or fax, visit our website at Contact Us > How to contact ACC > Write to us and send it by post or fax for a list of offices that deal with specific or general claims.

Claim forms and documentation for AEs must be sent directly to employers.

What happens next

For details on how we process a lodged claim, visit our website at For Providers > Lodge and manage claims > Lodge a claim > What happens after you have lodged a claim?

When cover is accepted, we advise the client by letter. If you want to find out whether cover has been accepted, call the Provider Helpline on **0800 222 070** and quote the ACC45 claim number or email providerhelp@acc.co.nz. You can also check via the eLodgement system.

It's important we have all the information needed to make a decision. If we don't have enough information the claim can be put on hold, or worst case declined pending further information. We don't usually pay for claims with insufficient information to make a decision unless they are work-related gradual process claims, or sensitive claims.

Invoicing

For information on invoicing ACC and AEs:

see Invoicing ACC or AEs or visit our website at For Providers > Invoicing and payment

Lodging Accredited Employer claims

About Accredited Employers (AEs)

An AE is a business that has signed a 'Partnership Programme' contract with ACC. This allows it to deal directly with staff work place claims and health providers on behalf of ACC.

AEs pay lower ACC levies than other employers and are expected to provide the same cost contributions and quality of service as ACC. Some AEs also choose, at their discretion, to refund co-payments for their employees. They manage their own:

- workplace health and safety
- employee injuries, including rehabilitation
- employee workplace (but not non-workplace) injury claims.

Over a quarter of New Zealand's full-time employees work for AEs. If your patient isn't sure whether they work for an AE, you can use the Accredited Employers search tool (you'll need your ACC provider number) or phone the Provider Helpline on **0800 222 070**.

Third party administrators

An AE may, subject to ACC's approval, contract a 'third party administrator' (TPA) to deliver injury and claim management services to its injured employees. TPAs include Gallagher Bassett, WellNZ and WorkAon.

Note:

- TPAs can only act as payment agents and day-to-day points of contact.
- AEs remain responsible for managing their injured employees claims and injuries.

How to lodge an AE claim

Send all documentation for your AE patients (i.e. the initial ACC45 Injury Claim form, treatment and rehabilitation plans, and invoices) to the AE or their nominated TPA, rather than ACC.

For more information, see:

For Providers > Lodge and manage claims > Lodge a claim for employer of Accredited Employer

Accredited Employers and the ACC Partnership Programme: Treatment Providers' Most Frequently Asked Questions.

6. Treatment

Acute treatment

Definitions: acute treatment and acute admission

The AC Act 2001 describes **acute treatment** as:

- the first visit to a treatment provider to get treatment for an ACC-covered personal injury
- if, in the treatment provider's judgement, the need is urgent (given the likely clinical effect on the client of any delay in treatment):
  - any subsequent visit to that treatment provider for the covered injury
  - any referral by that treatment provider to any other treatment provider, for the covered injury.

The Act describes **acute admission** as an admission to a publicly funded or agreed facility within seven days of the decision being made to admit, unless otherwise specified in the Regulations. See 'Accident Services - A guide for DHB and ACC Staff' (see also Glossary).

Deciding if acute treatment/ admission is needed

You need to be appropriately qualified to decide whether an injury needs acute treatment. Otherwise you'll need to refer the client to a treatment provider who is qualified. The referred visit to another treatment provider is also regarded as acute treatment. The applicable qualification is described in the Claim lodgement framework.

If you determine that the client's injury is outside the scope of a primary care provider and acute specialist assessment/treatment, and/or acute hospital admission is required you must ensure the treatment is provided by:

- a publicly funded provider, or
- a provider that is not publicly funded, if:
  - ACC agrees beforehand (prior approval), or
  - for reasons of clinical safety, treatment by a publicly funded provider is no practicable.

Funding public health acute services (PHAS)

PHAS are funded by a bulk payment from ACC to the Crown. The Crown then funds the Ministry of Health to purchase these services from DHB's on behalf of ACC. You can find more details in the publication 'Accident Services - A guide for DHB and ACC Staff'.

Referring on for other acute services

Radiology

For X-ray referrals we recommend you complete your practice radiology referral form and remember to enclose a copy of it with the ACC45 Injury Claim form. If your patient is likely

to need acute treatment outside of the scope of a primary care provider in addition to radiology for their injury, refer them to the nearest public hospital.

High Tech Imaging (HTI)

Acute HTI such as MRIs and CT scans for ACC clients are provided as part of PHAS. If your patient needs HTI as part of their acute treatment, please refer them to the nearest DHB.

Non-acute MRIs are funded separately by ACC under contract. For more information on how to access this service, phone the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

Surgery and specialist treatment

Acute specialist and surgical treatment is provided under PHAS. If your patient needs these services, refer them to the nearest DHB.

Elective surgery and specialist treatment are paid for by ACC through both Regulations and contract. If you are considering elective surgery and/or specialist treatment, ACC case owners supported by medical advisors will be able to confirm cover and coordinate services for clients and providers.

Nursing Services

Nursing Services

Nursing services can be provided in two different ways to ACC patients who have a covered injury:

- under the Cost of Treatment Regulations (see How ACC pays)
- Contracted Nursing Services (community based service delivery within the client's home, a clinic or any other appropriate community location).

Contracted Nursing Services

These are services to patients whose nursing needs cannot be met by their Primary Care Team. This could be due to;

1) The patient has reduced mobility
2) The patient has little or no natural support making it unsafe or impractical for them to attend a medical centre
3) The injury related needs of ACC serious injury clients
4) The patient needs care outside of normal practice hours
5) Complex injuries – i.e.; ulcers, wounds with heavy exudate, large bacterial burden, pressure wounds, skin grafts etc.
6) Specialised treatment need – i.e.; stoma care, compression therapy, NPWT etc

7) Where the patient has a history of leg ulcers, slow healing wounds, immuno-compromised, heart disease, diabetes etc.

8) The patient is a student with a complex wound and cannot be managed by their primary health care team or school nurse. The supplier can provide services at the school, home or clinic

9) Where the patient has made a full or partial return to work and their individual rehabilitation plan states the treatment is to occur at the workplace. This requires prior approval from ACC.

Please note however, that eligibility for entry to this service is not influenced by patient preference or convenience.

Entry into this service is by referral only, including subsequent injuries. Referrals can be generated by:

- Primary Health Care Team (e.g. GP, Nurse Practitioner or Practice Nurse)
- Patient self referral (if the patient lives in a remote/rural area at least 50km or 30 minutes drive to the nearest medical centre which has a doctor in regular attendance).

Your referral should include sufficient information to satisfy the nursing supplier that there is a covered injury requiring nursing services input including:

- the patients personal details
- injury diagnosis
- treatments to date
- nursing needs
- rationale for requiring services outside of what can be provided by the Primary Health Care Team.

Requesting further treatment: Referring clients via the ACC32 Request for prior approval of treatment form

Using the ACC32

The ACC32 form can be used for several different purposes by Specified Treatment providers – such as when your patient's injury is covered and you:

- anticipate that you'll need ACC prior approval for additional treatment funding or are requesting additional splinting costs
- want to add a diagnosis to a covered injury. See also What Information does ACC need?
- want to change a diagnosis. See also What Information does ACC need?
- recommend another treatment provider in addition to completing another referral

Further treatment and costs

Prior approval for further treatment

Prior approval is required from ACC when either:

- it has been more than 12 months since the client last received treatment from a specified treatment provider, or
- a client first presents for management of an injury more than one year after the date of that injury, or
- the treatment trigger number for the covered injury has been (or is about to be) reached and your client requires more treatment.

Note: Each Read Code identifies the number of treatments (trigger numbers) you can provide, before you need ACC prior approval to fund further treatment. Please note that trigger points are a guide to expected recovery timeframes only and all decisions are based on individual clinical need.

ACC will consider each request on a case by case basis and will advise whether ongoing treatment has been approved or declined. It is important to include all available clinical information at the time of seeking prior approval. No payments will be made until prior approval is granted.

When completing an ACC32 request for prior approval of treatment it's important to specify the date of the injury(s), details of the covered injury(s) and the treatment given to date. If this information isn't available from the client, call the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

What treatment profile trigger applies if you are registered with ACC for more than one treatment modality

If you choose to move between different treatment modalities in the management of your client, the treatment profile trigger relating to the primary modality applies, regardless of the type or combination of modalities used.

Example: A provider is registered with ACC as a physiotherapist and also as an acupuncturist. The client's injury is primarily treated with physiotherapy but the provider also determines that acupuncture is required at the same presentation. Only the physiotherapy treatment profile trigger would apply.

A dual registered provider cannot refer to themselves for their second modality without first seeking prior approval by

- completing an ACC32 form
- supplying clinical records that demonstrate the need for the change in treatment modality.

The treatment profile trigger number for each modality cannot be added up or used one after the other for ongoing treatments. The services should be invoiced under the provider's primary vocational scope.

What to include in the ACC32

The information we need on the ACC32 will depend on what type of provider you are. As this is prior approved treatment it is important to send ACC your request well before your last treatment so that continuity of treatment can be assured. Please refer to your contract for details.

Physiotherapists:

If you're a physiotherapist or hand therapist you'll need to include both an 'outcome measure' report and the client's clinical notes with each ACC32 application.

Other Specified Treatment Provider groups:

Other Specified Treatment Providers only need to submit clinical records with ACC32 applications. The clinical records should be legible and in english, current records of treatment given to the dates of application (see What we recommend for all clinical records).

If the information you submit is incomplete, we'll return the form straight away and ask for the missing information.

If the treatment required is post-operative and within twelve months of the date of ACC-funded surgery, please note this on the ACC32 along with the date of surgery. Alternatively you can call the Provider Helpline on **0800 222 070** and obtain approval.

Outcome measures for physiotherapy

Outcome measures are a tool for measuring the effects of physiotherapy interventions over time. They give all parties a better understanding of the outcomes achieved from purchasing physiotherapy services for clients. They also enable physiotherapists to reflect on their clinical practice and quality of service.

Physiotherapists are required to use an evidence-based outcome measure. We recommend either:

- the Patient Specific Functional Scale (PSFS) outcome measure, or
- the Numeric Pain Rating Scale (NPRS).

However, an alternative standardised, evidence-based outcome measure can be used if it's more appropriate to a client's condition.

For guidance on using evidence-based outcome measures see the ACC Guide to Outcome Measure Reporting. This document focuses on the PSFS and NPRS because of their widespread acceptance among physiotherapists and other clinicians.

Please record a validated outcome measure for all ACC clients:

- at initial consultation/visit
- after six treatments
- on discharge.

When patients are referred by other types of provider

Approval for treatment is discipline specific and using the ACC32 to refer a client to a different provider type is not the same as using it to request ACC prior approval for further treatment.

If a provider of another discipline recommends referral to your discipline on an ACC32 that they have submitted to ACC, or uses an ACC32 to refer a client directly to you, you will still need to determine if your treatments require prior approval and submit an ACC32 yourself. Please attach the other provider's referral letter or ACC32 form when you submit your ACC32 request.

If a client has been referred to you by another provider of the same discipline as yourself, you'll need to confirm how many treatments the client has received, and complete another ACC32 if the treatment profile triggers have been reached.

Our decision process

Once you've completed the ACC32 form, and included all relevant information, please send it to your nearest Service Centre. We aim to either issue a decision or advise you of any delay within five working days of receiving the documents.

The requests are assessed by clinical advisors as necessary and we'll write to both you and the client with our decision. If we decline the request, we'll also try to contact the client to talk them through our decision.

What to do if you disagree with our decision

If we decline your request for funding additional treatment, you can seek clarification from an ACC clinical advisor. The client can also formally dispute the decision, as all decisions are issued with review rights, which means the client can have the decisions independently reviewed. A request for review needs to be submitted within three months of the date of our decision, although this can be extended if a situation beyond their control prevents the client from applying within that timeframe.

Criteria for approving requests

If we approve your request for treatment, we'll fund up to six treatments in addition to the treatment profile trigger as long as you invoice ACC in the order that the services are delivered.

If it's a request for a serious injury client we can approve more than six treatments if it's clinically justified. Please ensure that you include all supporting information.

Criteria for declining requests

We're unable to approve ACC32 treatment requests if:

- There's no causal link

There needs to be a clear link between the client's ongoing condition and the covered injury in order to receive funding. This link must be supported by medical evidence, as a condition may be similar to, but not caused by an injury.

- It's not injury related

If the request is for a condition not related to their injury then we're not able to cover it.

- It's not considered necessary or appropriate

If clinical records show there hasn't been any significant improvement as a result of treatment, further requests for treatment can't be justified.

- The injury site doesn't match the covered injury

We can only approve requests for covered injuries. If you're unsure about whether your patient's injury is covered please contact the Provider Helpline on **0800 222 070**.

- The surgery wasn't funded by ACC

If we haven't funded the surgery then we're unable to fund post-operative rehabilitation treatment.

- It's a gradual process injury

Unless it's a covered, work-related gradual process condition we're unable to fund treatment.

- It's for treatment plus cover, or cover only

Cover and entitlement are two different decisions. If you submit an ACC32 to add an injury, we need supporting clinical information. We may or may not approve cover while determining treatment. See Adding or changing a diagnosis and What Information does ACC need?

- It's a new claim

If as a result of a patient assessment you believe that their current condition doesn't relate to the initial accident, you should inform the patient and not submit an ACC32.

If during your assessment you find there has been a clear new event causing personal injury, your patient may want to submit a new ACC45 Injury Claim form.

Adding or changing a diagnosis

Adding a diagnosis to a covered injury

If, when you're treating your patient, you discover an additional injury(s) related to the injury we've covered you'll need to request an 'additional diagnosis' before we can provide assistance for that injury. Example: A client falls and sustains a shoulder injury. A claim has been lodged and accepted for the shoulder injury. However, you find out that they also sustained a knee injury in the fall, and you want to treat the knee injury under this claim.

Changing a diagnosis

We'll consider a request to change a diagnosis if there has been:

- an administrative error, eg a claim was lodged for the incorrect body site
- a change from an ICDICD-10 code to a Read Code
- initial diagnosis of the injury was incorrect

Example: A claim was lodged with the lumber sprain Read Code S572. However there is now a confirmed diagnosis that the client has a lumbar disc prolapse with the radiculopathy Read Code N12C2.

How to add or change a diagnosis

To request that ACC change a diagnosis or add an additional injury, please submit an ACC 18 Medical Certificate or ACC32 Request Approval for further treatments. When making your request, it is very important to provide sufficient information for a timely decision to be made. If we don't have enough information the claim will be put on hold, or worst case declined pending further information. We don't usually pay for claims with insufficient information to make a decision unless they are work-related gradual process claims, or sensitive claims.

What Information does ACC need?

When requesting to add or change a diagnosis, you will need to provide your clinical justification and provide any supporting documentation.

Where possible, please include the following information to support the additional injury or the change in diagnosis:

- the date of the original event
- the original injury diagnosis
- description of how the new or additional injury would have occurred
- the body site of the new injury
- Read Code for the new /additional diagnosis
- a description of the causal link from the original event and diagnosis/diagnoses and the new or additional diagnosis
- medical evidence; eg clinical notes, reports, correspondence, x-ray, MRI or other scan results

What happens next?

An ACC case owner will review the information you have provided and consider your request. They may also seek further internal clinical advice. For example from an ACC branch medical advisor (BMA).

If we need to clarify anything with you, an ACC case owner will get in touch with you prior to a decision being made. They will contact you and the client when a decision is made.

Work-related gradual process, disease or infection

Cover under legislation

ACC covers a range of gradually-arising processes, diseases or infections if:

- it involves a personal injury as defined in Section 26 of the AC Act 2001, and
- there is a causal link between the injury and the person's employment.

Eligibility criteria

To be eligible for this cover, clients must meet either of two criteria:

1. The client's work environment shows that:

- there is a particular property or characteristic in a work task or the work environment that can be identified as having caused the condition
- the property or characteristic is not materially present outside the person's work environment
- those performing the work task or employed in that work environment are at significantly greater risk of developing the condition.

The more common musculoskeletal injuries that can develop over an extended period of time through work are epicondylitis (lateral or medial), tenosynovitis (e.g. de Quervain's), prepatella bursitis and rotator cuff syndrome. Claims for these need to satisfy the three-part test above which reflects section 30 of the AC Act 2001.

If your patient has noise-induced hearing loss

Patients with noise-induced hearing loss may be covered if they have been exposed to hazardous noise levels while working in New Zealand and meet the above criteria. In addition, the amount of occupational noise-induced hearing loss (i.e. 'net of age' corrections and an allowance for other otological conditions) must be at least 6%.

2. The injury is on the list of occupational diseases and their causative agents described in Schedule 2 of the AC Act 2001. Common Schedule 2 diseases include occupational asthma, allergic contact dermatitis, mesothelioma, leptospirosis and lead poisoning. This list enables an injured person to be granted ACC cover more quickly and easily than the above criteria.

A person will be covered for a listed disease if evidence shows that they have the disease and were exposed to contributing factors while working in New Zealand. If it's unclear that the disease is linked to employment, ACC must establish that the Schedule 2 disease is not work-related.

Lodging a gradual process injury claim

Work-related gradual process injury claims can only be lodged by medical practitioners. Any other provider who believes a person has a gradual process disease or injury should refer them to a GP for an ACC45 Injury Claim form as quickly as possible. Any treatments given for the injury (e.g. by a physiotherapist) before the patient has seen a GP or medical specialist won't qualify for payment.

When we receive the ACC45 Injury Claim form we send three questionnaires to the patient. The patient must fill in their sections and ensure that their employer and GP fill in theirs. All the questionnaires must be returned to ACC so that a cover decisions can be made. As the patient will only be able to receive their entitlement (e.g. weekly compensation for incapacity) once we have accepted their claim it's important that you fill in your questionnaire promptly.

For more information on gradual process claims, see Work-related gradual process, disease or infection.

Notes:

We may ask for a copy of your clinical notes

As we require evidence of actual damage, including a specific diagnosis of the gradual process injury, disease or infection, we may ask for a copy of your clinical notes and require test results. Providing details of the patient's clinical history and your examination findings at the time you lodge the claim, will speed up the cover decision process for them.

If the cause is work task or place related

If you're documenting aspects of work task or place cause (to help establish plausible consequence, an absence of non-work factors, and epidemiological evidence), please give details of where the causative agent is present. This means accurately identifying the specific property or characteristic in the task or workplace that has caused, or contributed to, the person's condition. We may also request a worksite assessment to clarify these factors.

You might also need to get information on the person's non-work activities.

Treatment injury

How ACC defines treatment injury

Treatment injury is defined in the AC Act as:

'An injury caused as a result of seeking or receiving treatment from a registered health professional'.

Before July 2005, medical misadventure legislation covered these injuries. Claims lodged before this date continue to be managed under the previous legislation.

What treatment injury covers

If a patient is injured as a result of treatment, they may be able to make a claim and get help through ACC. However, we don't cover all treatment that doesn't turn out as expected, so we encourage you and your patient to contact us before lodging a claim to discuss whether a treatment injury has occurred.

Treatment needs to be provided by a covered registered professional

The covered registered health professionals are:

- chiropractor
- medical practitioner – doctor, surgeon, anaesthetist, etc.
- optometrist
- clinical dental technician
- medical radiation technologist
- pharmacist
- dental technician
- midwife
- physiotherapist
- dentist
- nurse
- nurse practitioner
- podiatrist
- medical laboratory technologist
- occupational therapist

Several other provider groups qualify as ACC treatment providers but their treatment cannot be the subject of a “treatment injury” claim.

However, patients who receive injuries from these treatment providers may still be covered under the wider ACC personal injury claim provisions. Such as treatment provided by an:

- acupuncturist
- counsellor
- speech therapist
  - audiologist
  - osteopath

Lodging a treatment injury claim

Treatment injury claims are lodged on the ACC45 Injury Claim form, or ACC42 Dental Injury Claim form along with an ACC2152 Treatment Injury Claim form.

The ACC2152 is available on the For Providers section of our website. Payment for the consultation when the ACC45/42 is submitted is made separately.

For more information on treatment injuries and how to lodge claims, visit our website at For providers > Lodge a claim > Lodge a claim for treatment injury, or phone the Treatment Injury Centre on **0800 735 566**.

Notes:

Who can complete the ACC45 and ACC2152 forms

The best person to complete the forms may be the registered health professional involved in the treatment that caused the injury.

The forms can also be completed if you’re a treatment provider who wasn’t involved in the treatment injury (e.g. if you’re helping a patient) so long as you have enough information.

If you don't have enough information you should only complete the ACC45 Injury Claim form and:

- tick the 'Treatment Injury Box'
- provide the place of treatment
- provide the name(s) of the person(s) involved in the treatment that caused injury
- provide any relevant clinical information

We'll contact the health professional who provided the treatment for more information.

If you're helping a patient to compete a claim form, you don't need to ascertain the cause of the injury being treated. We understand you may not have access to this information (e.g. for older injuries, or when records are incomplete).

Who can't complete the form

Some health professionals can't lodge a treatment injury claim even if they were involved in the treatment that caused the injury. These include:

- clinical dental technicians
- dental technicians
- medical radiation therapists
- midwives
- pharmacists

What to say to your patients

If possible you should let your patient know that we'll assess the claim and may ask for more information about the injury and the events that led to it, including from other treatment providers involved. This means that it could take a few weeks or more to reach a decision on their claim.

Note: Legislation gives up to nine months to make a decision after a treatment injury claim has been lodged. However we aim to determine cover as quickly as possible.

Eligibility criteria for clients

A patient may qualify for cover if they are injured as a result of treatment by a registered health professional and the treatment, not the patient's health condition or some other factor, is the cause of the injury.

The treatment from which injuries may stem includes:

- the treatment itself, either given or directed by the health professional
- a lack of treatment that should have been provided.

Under special conditions, we'll consider a claim for someone who was part of an approved clinical trial, and they suffered complications. We're unable to accept claims that result from trials that are mainly for the benefit of the maker or distributor of the item being tested.

Assessing treatment injury claims

ACC's Treatment Injury Centre assesses all treatment injury claims. It also assesses claims for any potential risk of harm to the public.

The Centre starts the claim assessment process as soon as the ACC45 Injury Claim form, along with an ACC2152 Treatment Injury Claim form and/or supporting medical records are received. If only an ACC45 Injury Claim form is received, we'll need to obtain the ACC2152 and other records before processing the claim.

Each claim is allocated to one of the Centre's clinical advisors who have clinical experience in nursing, midwifery, pharmacy, physiotherapy and medicine. Their role is to make cover decisions on whether to accept claims by assessing the individual facts of the claim and applying the legislative criteria.

Once a cover decision is made, the Centre informs the client and advises them to let their health professional know about it (it doesn't contact the health professional directly). For an accepted claim, we either pay the relevant invoices (if no further help is needed) or transfer the claim to be managed by the client's local branch (if the client still needs help).

Assessing potential public harm

The Treatment Injury Centre analyses treatment injury data to assess the potential risk of harm to the public.

The results are shared through monthly treatment injury case studies in Well Said (our electronic provider newsletter), and at presentations to clinical meetings, conferences and seminars. Notifications are also made monthly to authorities such as the Director General of Health, Medsafe and, in some circumstances, registration councils or boards.

Mental injuries, sensitive claims and counselling

Definition of mental injury

A mental injury is defined as a 'clinically significant behavioural, cognitive, or psychological dysfunction". ACC covers the effects of the mental injury from the event, rather than the event itself.

Client eligibility

ACC funds counselling under regulations for:

- mental injuries arising from physical injuries or a work place event
- sensitive claims, i.e. mental injuries arising from certain criminal acts listed in Schedule 3 of the AC Act 2001.

When a person's mental injury has been caused by sexual abuse, they can lodge their claim through either a medical practitioner or an ACC-registered counsellor.

Mental injury caused by physical injury & work related mental injury

In making a cover decision for a person who has a mental injury caused by a physical injury or through a traumatic event at work, we need at least two medical reports:

- a report from the person's treating practitioner
- a comprehensive assessment by a registered psychiatrist or clinical psychologist, usually contracted to ACC.

After receiving the treating medical practitioner's report, we may make a referral to obtain an assessment from a psychiatrist or a clinical psychologist. The assessment is designed to help us understand more about the injury's clinical significance, and the casual link to the event. We may also seek appropriate treatment recommendations.

Exception

The only exception to this process is when a treating practitioner advises that there is no clinically significant mental condition.

In this case we may decline the claim without a psychiatric report as long as we have confirmation from an ACC medical advisor that it's appropriate to do so. The decision will depend on the facts of each situation. For example, when the advice is from a GP, a claim will likely only be declined if they have recent and regular contact with the client.

Treatment options

The recommended treatment options outlined in the psychiatric report can include referral to a counsellor, psychotherapist, psychiatrist or psychologist for treatment or counselling. We can contribute to the funding of treatment if the provider is registered with us to provide counselling services under Regulations or Contract. We're unable to fund services for non-registered providers.

For a full list of ACC-registered counsellors call the Provider Helpline on **0800 222 070**.

To find out more about registering as an ACC counsellor see, Counsellor registration, or contact the Provider Registrations team on **04 560 5211** or by emailing registrations@acc.co.nz.

Sensitive claims injuries

A sensitive claim is a mental and/or physical injury caused by a sexual abuse crime such as sexual violation, indecent assault and unlawful sexual connection.

Because these claims are confidential and personal in nature we have a special Sensitive Claims Unit to help people with these injuries. The claims can often be complicated, and ACC staff may need to gather more information than what's collected on an ACC45 Injury Claim form. As a result it can take longer to determine cover for these claims, the legislation makes allowances for this.

Sexual abuse crimes considered by ACC are listed in Schedule 3 of the AC Act 2001. ACC staff may refer to the 'event' as a 'Schedule 3 event'. You can find the Schedule 3 list on our website under For providers > Lodge a claim > Lodge a sensitive claim, and under the right hand page heading 'Related information' click on 'Sensitive claims'.

If you have any questions about a claim like this or wish to direct a patient to ACC for confidential advice, phone the Sensitive Claims Unit on **0800 735 566**.

Crisis care and early intervention

If your patient is distressed and there are serious concerns for their safety, contact the Crisis Assessment and Treatment Team (CATT) at your regional DHB. Each DHB has its own team, and details are available on all DHB websites.

The CATT teams provide 24-hour, seven-day assessment and short-term treatment services for people experiencing a serious mental health crises who have urgent safety issues.

ACC also funds early medical and forensic assessment and follow-up treatment through the Sexual Abuse Assessment and Treatment Service (SAATS). This service is delivered by DSAC (Doctors for Sexual Abuse Care) doctors and nurses under the local DHB. DSAC doctors and nurses are specifically trained in managing sexual assault cases. You can refer patients to the SAATS by contacting the local DHB or Police.

Lodging a sensitive claim

Only medical practitioners and ACC-approved counsellors can lodge sensitive claims.

GPs and counsellors can get help with lodging sensitive claims in two ACC guides:

ACC1149 GPs' Guide to Completing the ACC45 Injury Claims Form For a Sensitive Claim

ACC1363 Counsellors' Guide to Completing the ACC45 Injury Claims Form For a Sensitive Claim.

You'll find them on the 'Forms & Fact Sheets' side bar on our website at For Providers > Lodge a claim.

Counselling under Regulations

If your patient needs counselling support

If you are a counsellor and believe your patient needs counselling support please complete and send an ACC2922 Sensitive claims support sessions - Service Provider Notification along with the ACC45 Injury Claim form.

As soon as a claim is lodged a client is eligible to 16 hours of support sessions with a counsellor. For further information on support sessions and how these work visit our website at Support Session: Therapeutic Assessment and Recovery Support for Sensitive Claims. Once we receive more information the client can proceed to a cover assessment and be eligible for other entitlements.

For more information on sensitive claims processes visit our website at For Providers > Lodge and manage claims > Lodge a sensitive claim.

Please note there will be changes to the support sessions process at the end of November 2014. Refer to our website at Sensitive Claims Service Redesign to find out more or contact ACC's Specialised Treatment Category by emailing specialisedtreatment@acc.co.nz.

Lodging a sensitive claim – *continued*

Notes:

When describing a criminal act

Important: When lodging a sensitive claim, describe the criminal act and/or the relevant section listed in Schedule 3. The cover decision process is likely to be delayed if you use simplified wording such as 'sexual abuse', failure to describe the criminal act or give unclear details of a mental injury diagnosis.

When providing a preliminary mental injury diagnosis

- If you're unsure about identifying a preliminary mental injury diagnosis, or are not qualified to provide one, please use clinically relevant terms to the best of your ability.
- If in doubt, over-describe the symptoms, as this is likely to provide the most useful information to help us determine cover. Use a DSM-IV diagnosis, an ICD code, a Read Code or any other relevant diagnostic classification tool.
- At the various stages of seeing the patient, you should always check whether their contact details need updating.

Ensuring client safety and privacy

Given the nature of these claims, ask your patient for a safe address, which may be different than the one you have on record for them.

This is particularly important for clients aged between 13 and 16 we prefer a caregiver/guardian and/or family/whānau to be involved if possible.

Who can sign the ACC45 Injury Claim form

Only the patient or their legal representative can sign the ACC45 Injury Claim form.

If your patient is under 16, their parent or guardian must sign for them.

If any other person signs, or there's no signature we won't be able to register the claim and will return the form to you.

Before sending us the form

To avoid any delays it's really important to double-check that all mandatory sections have been completed (e.g. whether the patient is working).

Dealing with challenging behaviour

Dealing with an aggressive patient

Patient violence against providers is uncommon in New Zealand. However, some providers may find themselves on the receiving end of verbal abuse and on rare occasions physical assault. Dealing with an aggressive or violent patient can be a huge challenge for you and your practice colleagues.

In most cases patients are keen to get back to everyday life or work. Others, owing to injury or debilitation, take out their frustrations on treatment providers and may blame the broader accident compensation and rehabilitation system.

There may or may not be a direct connection between a patient's behaviour and their presenting condition. Abusive or threatening behaviour can also stem from compensation issues such as entitlement, eligibility for treatment or investigation, the legitimisation of a claim, and issues of cooperation in rehabilitation.

How we can help

It's important that you let us know about any violent and/or aggressive patients who are also our clients. We can help you to assess the situation and determine whether other known factors are contributing to the hostility.

If mental injury is a factor

If a patient has developed a mental illness post injury and this appears to contribute significantly to their aggression or violence, we can help by providing psychiatric evaluations and therapy or psychologist referrals. In these cases our staff can be crucial in working with you to rehabilitate the patient and help with your patient relationship.

If pain is a factor

If chronic pain resulting from an injury is central to a patient's frustration and escalating hostility, we can offer pain management options. This type of support could help you with returning your patient to everyday life and work. For more information, see Managing pain.

We also train our client service staff to deal with difficult or hostile clients, so they can support you in getting information from these patients. ACC staff usually hold interviews in rooms that offer some protection and security for participants.

Preventing or handling attacks

Sudden, violent attacks are rare; most incidents are preceded by mounting tension, frustration or escalating threats. To help you recognise the warning signs and take appropriate action practical guides are available through many professional bodies, including the New Zealand Medical Association and the Royal New Zealand College of General Practitioners. Working and communicating with a patient, their family/whānau, associated staff and other providers, can go a long way to reducing or eliminating a patient's hostility.

For example, there are steps that you can take before a patient arrives, when they make appointments, when they are on your premises, while the consultation/visit is underway, and if they become violent.

Here are some essential points to remember and develop in assessing the risks of and managing these situations:

Anticipate	Make sure you and your colleagues are always aware that you could encounter an aggressive or violent patient, and have mechanisms in place to deal with them.

Detect	Detecting high-risk patients early and implementing harm-reduction measures can stop threatening behaviour escalating into full-blown violence.
Analyse	Try to identify the factors that promote or encourage aggressive or violent tendencies in a patient. A careful analysis of patient, practice and provider features may identify the cause of the problem and enable management strategies that benefit you and your patients.
Team	Take a team approach to planning and managing aggressive or violent patients.
Support	Contact appropriate support if a patient becomes aggressive or threatens violence, eg the Police, ACC, the New Zealand Medical Association, the Medical Council of New Zealand, or other provider bodies.
Prevent and act	Effective prevention and appropriate action are crucial when dealing with violent and aggressive patients.
Practice and be prepared	Develop and practice strategies to make sure you and your staff know how to respond and keep yourselves safe.
Contact us	Call the Provider Helpline on 0800 222 070 as soon as possible to let us know what has happened. Make sure you speak directly to one of our staff.

Pharmaceuticals

ACC's definition

Pharmaceuticals are described in the Act as:

- prescription medicines, restricted medicines or pharmacy-only medicines, as listed in Parts 1, 2 and 3 of Schedule 1 of the Medicines Regulations 1984
- controlled drugs as defined in the Misuse of Drugs Act 1975.

Helping with costs

ACC may be able to contribute to prescription costs for clients who are prescribed medication to help them recover and rehabilitate after injury.

To be eligible for assistance clients will need to complete the ACC249 Request for Reimbursement of Pharmaceutical Costs.

It comes with an Information Sheet explaining what reimbursement we offer, and what we need to be able to reimburse costs, E.g. the types of receipts and invoices that will need to be sent with the form.

How we decide to reimburse

ACC will consider helping with the cost of pharmaceuticals if a claim has been accepted and the item prescribed:

- is reasonably required to help the client's treatment or rehabilitation based on their injury and clinical information
- is prescribed within the scope of practice of the prescribing provider
- is classified as a prescription medicine, restricted medicine, pharmacy-only medicine or controlled drug
- follows best practice prescribing protocols
- follows best practice rehabilitation pathways.

We'll also consider the availability of similar pharmaceuticals and generic alternatives listed in the Pharmaceutical Schedule (www.pharmac.govt.nz).

If there isn't enough information to support a reimbursement request, we may ask for more information.

What we're unable to reimburse

We are not able to reimburse any:

- administration charges added by the prescriber or dispensing pharmacy
- the cost of substances that are not considered pharmaceuticals such as herbal remedies and complementary medications.

How we contribute to costs

We pay for clients' pharmaceuticals in several ways.

By contract

If the contract includes providing pharmaceuticals, we will pay the contracted price. Clients should not be charged pharmaceutical costs if the contract price covers pharmaceuticals.

By reimbursement

We reimburse clients or pharmacies:

for co-payments on community pharmaceuticals

a contribution towards part-charges for partly subsidised community pharmaceuticals

a contribution towards pharmaceuticals that aren't on the Pharmaceutical Schedule or that don't meet its subsidy criteria, as long as we have pre-approved them.

Via Public Health Acute Services (PHAS)

The bulk amount that we pay to the Crown via the PHAS agreement covers pharmaceuticals that are:

- required by clients during acute hospital admissions or emergency department visits
- given as part of the treatment associated with a client's outpatient follow-ups for up to six weeks from discharge or treatment
- used during treatment given by medical practitioners less than seven days after referral by other medical practitioners
- listed on the Pharmaceutical Schedule, meet its subsidy criteria and are used in the community.

Pharmacies, clients and other providers do not need to invoice ACC for these pharmaceutical costs as they are already paid for under the PHAS agreement.

When you're prescribing medicines

When prescribing medicines please record:

- the ACC45 Injury Claim form number against each item
- a Ministry of Health identifier for all medical illness scripts to distinguish between accident and medical cases.

When to seek prior approval

Prior-approval is needed for all non-subsidised pharmaceuticals.

If a client needs non-subsidised pharmaceuticals, that are not already covered by the PHAS time period or under another ACC contract, we may be able to partially reimburse the costs.

You'll need to seek funding approval from us before prescribing the pharmaceuticals. If you prescribe them without our prior approval, we ask that you let the client know that we may not be able to contribute to the cost.

Requesting funding for non-subsidised pharmaceuticals

To apply for prior approval, complete the forms listed below with your patient.

We'll need to know how the non-subsidised medication will help treat the injury and why other subsidised medication is unsuitable. This type of approval is for a limited time only.

Initially you need to complete the ACC1171 Request for funding from ACC for non-subsidised pharmaceuticals. You can seek a further contribution to costs by completing the ACC1172 Evaluation of Pharmaceutical Use.

Things to note when prescribing

When prescribing, please ensure that you:

- prescribe subsidised pharmaceuticals that meet the Pharmaceutical Schedule criteria for community pharmaceutical use.
  Note: Non-subsidised pharmaceuticals should be rarely prescribed
- always apply for Pharmac special authority when this is available – our clients qualify for this
- code prescriptions as A4 – all our clients are eligible people in New Zealand, including non-residents whose injuries are covered by ACC.
  Note: You'll need to change the code on the script if it's computer generated and you've categorised the client as non-resident in your practice management system
- prescribe generic names rather than brand name, e.g. diclofenac tablets, not Voltaren tablets. If this means your client needs a new generic brand, you may need to support their changeover. Information sheets are available from Pharmac at http://www.pharmac.govt.nz/patients/AboutPHARMAC/infosheets
- support patient adherence –use the tool at http://guidance.nice.org.uk/CG76/QuickRefGuide/pdf/English.
- prescribe small quantities when trialling new medicines
- Report adverse reactions to the Centre for Adverse Reactions Monitoring, PO Box 913, Dunedin 9054.
- More information, updates forms and guidelines can be found on: ACC Website

Work and rehabilitation

ACC's definition of rehabilitation

Rehabilitation is the term we use to cover the overall process of helping clients return to work or, if they weren't working at the time of their injury, to independence in their daily lives as much as possible.

Rehabilitation can involve combinations of:

- treatment for the effects of an injury
- specialised inpatient rehabilitation
- support to maintain employment
- support to obtain employment
- education support
- support to regain independence
- support in everyday living activities.

It's a dynamic process in which we involve treatment providers and help make connections to other providers. It recognises that one clinician or organisation can seldom meet a client's total needs in isolation.

Our rehabilitation framework

Our clients' circumstances vary greatly according to injury, health, work and other factors. We have created a range of pathways to make it easier to tailor the best support for each person and help them achieve the results that will be the most benefit to them.

Together, the pathways fit into an overall rehabilitation framework. The table below summarises the core concepts as developed in conjunction with stakeholders and staff:

Intent	Rehabilitation framework principles
An inclusive relationship of support	Rehabilitation is based on listening to, and understanding, the person in the context of their personal circumstances and community.
A service approach based on client need	ACC works with the person and their family, employer and provider to plan and deliver the agreed rehabilitation tailored to the individual.
ACC acts as a partner and facilitates the expertise of others	We mobilise existing support and provide any additional support and services needed to help people return to productive lives.

Rehabilitation and you

Your involvement in helping our clients rehabilitate

As a treatment provider you may become involved with our clients at various stages of their rehabilitation.

You might initiate rehabilitation yourself by treating an injury, or make a referral to elective surgery or other specialists.

The client might also need social and vocational rehabilitation services. Through your understanding of their needs, you can help us to identify where support in their environment could help them.

Managing pain

At all stages of rehabilitation you should consider whether there are any pain-related disability factors that could inhibit the client's progress. We have a number of pain management services to which you can refer clients, or you can let us know your concerns so we can consider the best option.

For more information see:

For Providers > All contracts > Pain management services - a brief summary of each service

ACC4467 Pain management quick reference guide to our services.

Vocational rehabilitation

'Vocational rehabilitation' aims to help clients maintain or obtain employment, or regain or acquire vocational independence. The range of tools and programmes spans:

- helping clients to rehabilitate at work e.g. via the stay at work service
- helping clients to rehabilitate who have to consider different work
- retraining clients when necessary to help them to find different work

When clients have some capacity to work and are at low risk of re-injury, we can work with employers to arrange alternative work duties or hours.

Clients might need ongoing help to return to work, including return to work monitoring, an Employment Maintenance or graduated return to work programme, work trials, agreed recovery initiatives such as lifestyle changes, help with workplace access, or adaptation and other equipment to enable their independence.

ACC, or sometimes another contracted provider, may ask you to verify that a client is medically fit for vocational rehabilitation programmes.

If a client's return to work isn't progressing as expected, discuss it with us. There may be other options such as pain management services.

Assessing a client's work capacity – overview

As part of a client's rehabilitation, we'll ask an appropriately skilled treatment provider to assess their capacity to work. We might also ask them to assess any medical grounds on which we can compensate the client while they're unable to work.

Stay at Work (SAW) providers

The provider will seek to understand the constraints, demands and risks of the client's workplace and how those factors fit within their rehabilitation needs. If you're a Stay at

Work (SAW) service provider you'll be involved in outlining a plan for modifying the work tasks and gradually increasing the hours a client works as their recovery progresses.

Stay at Work (SAW) service

SAW service providers visit clients and employers at the workplace, review the work tasks and environment, and develop return-to-work plans.

A good early intervention is the SAW level 1 service, in which a SAW service provider helps clients and employers develop suitable return-to-work plans, including possible short-term modifications to the employee's work tasks.

The SAW level 2-4 services are longer term, cover more complex needs and require progress reports from providers. Levels 3 and 4 are multidisciplinary programmes that include both functional and vocational rehabilitation components and monitoring of the client's return to work.

SAW providers

SAW providers come from a range of backgrounds. They are registered or certified members of their chosen fields, have ergonomic and health and safety expertise and are skilled in working with injured people in the workplace.

Assessing a client's disability duration – resources

Tools to help you assess the duration of incapacity include:

- Treatment profiles for some primary care professions
- the ACC14191 Return to Work Guide first published in May 2006.

These help to summarise current best practice for common injuries and provide a starting point for how to manage a client's rehabilitation at work or their return to work with 'time off work' certification.

They should be used when possible. If you'd like paper copies, please phone the Stationery Order Line on **0800 802 444**, option 0.

Factors that influence disability duration

The duration of a disability can be affected by factors such as dominant versus non-dominant arm, work requirements (use of wrist, forearm), conservative versus surgical treatment, and compliance with the rehabilitation programme.

There is a minimum recovery time that most people will need to return to work at the same performance level as before the injuries. Clients may be fit to return to work in a shorter timeframe, particularly if there are suitable selected or modified duties, or other support.

Likewise there is the time identified when most people are likely to be able to return to work, subject to good health care and no significant complications and/or co-morbid medical conditions.

There is a time at which additional review and evaluation should occur to determine when (and if) a person may be able to return to work and whether there are specific factors, including psychosocial, that need to be addressed.

Definitions for degree of work

For details on work types see For Providers > Work Type Details Sheets. The work types are listed at the bottom of that page.

Work type	Definition
Sedentary	Exerting up to 4.5 kilograms (kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull or otherwise move objects, including the human body. Involves sitting most of the time, but may involve walking or standing for brief periods.
Light	Exerting up to 9kg of force occasionally and/or up to 4.5kg of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements exceed those for sedentary work. Usually requires walking or standing to a significant degree. However, if the use of any arm and/or leg controls requires exertion of forces greater than those for sedentary work, and the worker sits most of the time, the job is rated light work.
Medium	Exerting up to 22.5kg of force occasionally and/or up to 9kg of force frequently and/or up to 4.5kg of force constantly to move objects.
Heavy	Exerting up to 45kg of force occasionally and/or up to 22.5kg of force frequently and/or up to 9kg of force constantly to move objects.
Very heavy	Exerting over 45kg of force occasionally and/or over 22.5kg of force frequently and/or over 9kg of force constantly to move objects.

Frequency scale for degree of work example

This table gives an example of how often the degree of work can apply to a client when their work type work capacity and disability duration are being assessed.

Frequency	% of an 8-hour day	Example
Occasional	0-33	One lift every 30 minutes
Frequent	34-66	One lift every two minutes
Constant	67-100	One lift every 15 seconds

Medical certificates (ACC18)

Why medical certificates are important

Medical certificates (ACC18s) must be firmly grounded in your clinical assessment as they verify that clients are entitled to ongoing ACC weekly compensation while they're off work recovering.

You can also use an ACC18 to:

- alert us early that a client might need extra rehabilitation support so we can look at the options
- recommend home help, personal care, a second opinion or an assessment for the client.
- change a diagnosis or add an additional diagnosis to a covered injury

We encourage you to use the spaces provided on the form, as well as other communication methods, to give us your views on a client's needs. If you're unsure about specifics, please still pass on any general concerns to our case managers.

Discussing confidentialities

If you'd like to talk to us about matters that you're not comfortable writing onto a client's ACC18, please tick the option 'I would like to discuss this with the client's case manager'.

In complex cases it can be in the client's interest for you to meet our staff, rehabilitation experts, the client, their family and others in a case conference facilitated by ACC.

How medical certificates work

When clients need time off work to recover from their injuries, the medical certificates validate this and specify specific tasks, or exposures, they should avoid while recovering. They also allow us to provide workers with compensation for lost income while they're off work. Please emphasise to clients that the sooner they send us their ACC18s, the sooner we can process their applications for compensation.

Only a medical practitioner (e.g. GP, Specialist or Emergency Department Doctor) or Nurse Practitioner can complete an ACC18 Medical Certificate.

The practitioner records the client's incapacity details on either the:

- ACC45 Injury Claim form if this is the client's first visit. This can be used to certify incapacity for up to 14 days.
- ACC18 Medical Certificate if an ACC45 has already been lodged. The ACC18 provides a detailed description of how the client's injury affects their capacity for work and their prospects for rehabilitation.

The certificate must show:

- that the client's examination was done in person, not by phone or based on third party reports
- your clinical assessment following the examination – this should be in line with the relevant treatment profile
- your diagnosis, comments and recommendations to meet the overarching needs of care. The care must be necessary, appropriate and of the required quality.

How to fill in an ACC18 Medical Certificate

Give a confirmed diagnosis

After you've examined the client, enter a Read Code and/or a diagnosis (preferably both) on the form. You can also use the ACC18 to add or change a diagnosis. If you do, you'll need to record a new Read Code along with the supporting clinical evidence..

Get work information

Find out:

- the type of work the client does and the tasks involved
- key facts about their work history (tasks, skills)
- what their work environment is like
- any problems or injuries they had before the accident
- any concerns or fears they have about returning to work
- what tasks they can still do

An ACC18 can help you to gather this information. It provides you with an early opportunity to advise us about possible risk factors in the client's work that could affect their rehabilitation.

Indicate a client's capacity for work

If the client can't do the job they had before their accident, they may still have other work options, so it's important to indicate whether they have a capacity for work.

Marking that they have some capacity (i.e. are fit for selected part-time or alternative work) enables us to negotiate with all parties for the client to return to other available duties within the medical limitations imposed by the injury. This doesn't mean that we'll stop their weekly compensation payments. When negotiating a partial return to work we'll need to ensure that payment levels are appropriate and in line with the client's entitlement.

If the client doesn't think there are light duties available, contact us so that we can discuss this with their employer and look at alternatives.

Determining fitness for work

To be fully unfit for work the client must be unable to:

- travel to and from work, and
- be at the workplace, and
- do specified tasks at the workplace.

If you identify only one or two of these points we can look at ways to help the client to overcome their barriers. It's important that we know their functional limitations, eg if they can't lift more than10kg, lift above shoulder height or stretch etc.

Important: The client must sign the ACC18 to say that it accurately reflects their activity restrictions.

Specify the time off work

Time off work is usually certified from when the client first presents with an injury until the next scheduled consultation/visit, usually two weeks or less.

If they have a severe or chronic condition, you may need to certify for a longer period, usually a maximum of 13 weeks. However, in some cases, such as if the client has a serious injury; they may need medical certificates at intervals of more than 13 weeks, e.g. six- or 12-monthly intervals. The case manager will let you know if the client meets the criteria.

A client can have a medical certificate for more than 13 weeks (up to a maximum of 12 months) if:

- their functional restrictions have stabilised and are likely to remain unchanged, and
- these restrictions mean they can't perform any work, and
- their eligibility for long-term entitlements is not in doubt.

Highlight next steps towards a return to work

Estimate when you expect the client to be fit for normal work. This helps us to negotiate with their employer and develop appropriate rehabilitation and return-to-work programmes.

The client's return to work should always focus first on their pre-injury employment role, tasks and hours. If the client can't do their usual tasks or hours, options include part-time work, vocational rehabilitation services, and temporary alternative duties.

Send in the ACC18 form

Electronically by eACC18: You can send us the form by post or electronically (eACC18) through BPAC (the Best Practice Advocacy Centre) which is accessed through a BPAC module in your PMS.

See the certification page on our external website for more information.

If you're using the eACC18, the form is sent to us as soon as you press the 'Submit' button.

Before you submit it, print a copy for the client to give to their employer.

You can also give them a copy to keep. The client must also sign the consent section, declaring that the information they have given is true and correct, and authorising us to collect all relevant information. We recommend that for audit purposes, you keep a signed copy of the eACC18 in paper or image form.

Manually by post: Give the paper form to the client to post to us. Emphasise to them that the sooner they send us the form, the sooner we can process the application and begin compensation payments.

Sustained return to work

Helping your patients return to work

The benefits of early return to work are recognised by health professionals and employers. Modern practice supports safe and sustainable work that quickly integrates people back into their workplace and their normal lives.

Informed work fitness certification is vital to opening the doors to the range of vocational rehabilitation assistance ACC can deliver to your patients.

Returning to work after an injury has to be sustainable if it's to be successful. To establish your patient's work capacity there's a few things you can do:

1. Get in touch with their employer to:

   - understand the specific demands of the job
   - identify any barriers to returning to work
   - troubleshooting the barriers.

2. Let us know if barriers are indentified.

3. Call the case owner looking after your patient if you're unable to make contact with the employer.

There's a lot of good information on supporting and coordinating an effective return to work in the ACC2360 Return to Work Guide, which was developed by both ACC and treatment providers. It includes best practice information and practical help for managing rehabilitation and supporting your decisions.

Understanding the demands of your patient's job

The first step in helping you assess your patient's ability to return to work involves identifying your patient's work tasks. These might include things like sitting, standing, climbing a ladder, lifting heavy loads, or working on a keyboard most of the day.

'Work type detail sheets' are available to help you. They specify tasks for various work categories and can be found on our website by scrolling to the bottom this page: For Providers > Work type detail sheets.

Check if the client can complete any of the employer's minimum requirements. Observing directly is the most accurate way to do this.

How to identify return-to-work barriers

A number of barriers can affect your patient's fitness to return to full, partial or graduated work activities. A vocational/occupational provider may need to be involved. They'll consult with you and any rehabilitation providers involved in your patient's care on the following:

Disability and physical impairment

Residual impairments can stop a client returning to work fully. It's important to diagnose these and seek the help of providers with appropriate expertise to manage the rehabilitation.

Injury factors

Injury factors include safety, biomechanical, cognitive, perceptual and functional limitations. Pain itself is not a contraindication to activity and work. If you identify specific safety concerns they may apply to only part of the job. Identifying the part(s) of the job the client can still do is an important starting point for returning them to work part time, or using a graduated approach.

Individual factors

Individual factors include the client's beliefs about their injury and symptoms, e.g. their fear of pain from movement. A client may believe that pain intensity signals significant damage to the body and that all activity and work must be avoided until the problem is completely fixed. This means they often respond to the anticipation of pain, which engenders a 'fear-and-avoidance cycle'.

In these cases you should consider prescribing appropriate pharmaceuticals as part of your response, and to ensure they're being used correctly.

Workplace factors

Workplace factors include job satisfaction, work organisation issues, and relationships with managers and co-workers. An employer's willingness and/or ability to offer temporary modifications to work tasks are critical.

To see an example of how to complete a return-to-work plan with your patient, see Appendix 3 of the ACC2360 Return to Work Guide.

Advising us of barriers preventing return to work

When your patient has ongoing restrictions or specific limitations, please let us know so we can get in touch with their employer to arrange duties and a phased return to work as appropriate.

A phased programme may involve:

- selected or alternative duties, so that the tasks they can still do become the temporary focus of their work
- a graduated return to work, where they undertake full or selected duties for part of the day and steadily increases them over a few weeks. With this option it's important to

keep to the usual work starting time.
- an employment maintenance programme, which provides an individual return-to-work plan containing physical and vocational rehabilitation targets
- part time work, which is considered a temporary last resort and only used in exceptional circumstances, e.g. significant fatigue or serious medication side-effects. See Lifestyle substitution.

Our main focus is to return your patient to a full day of selected duties and activity rather than a limited day of full duties.

Dealing with return-to-work barriers

Fear of pain from movement

If there are no specific safety concerns, your patient's activity levels should be based on time rather than pain. They should be given clear guidelines on steadily increasing their activity level to avoid the risk of 'disuse or inactivity syndrome' developing from a long-term withdrawal from activity. Reassurance, motivation and encouragement can often help to counter this problem.

Lifestyle substitution

A graduated return to work may not advance beyond, for example a four-hour day, but it enables your patient to experience the benefits of work while avoiding the lifestyle pressures associated with working longer hours.

To change this pattern, ask them to work a full day followed by a short day, then steadily move towards every day being a full day.

Workplace barriers

An ergonomic review of the workplace, organisation and processes might be needed. These might not have caused the injury but could be barriers to a full and sustainable return to work. Health professionals who specialise in the work environment will usually conduct these reviews.

Please watch carefully for other return-to-work barriers. Anecdotal evidence indicates that highly motivated people (such as the self-employed) return to work more quickly than other groups of workers. However, a few may need close monitoring to ensure they temporarily modify their workloads and do not end up prolonging their recovery.

Support is important within the first few days, as this is when most return-to-work problems occur. Many concerns can be resolved by contacting your patient's ACC case manager and/or their employer (manager or supervisor). If this fails, you might consider a referral to a health professional specialising in the work environment.

Referral and rehabilitation services

Other health professionals involved

A number of health professionals specialise in the work environment including:

- occupational health nurses

- occupational physicians
- occupational physiotherapists
- occupational therapists
- vocational rehabilitation providers.

Your patient's problems will indicate which provider is the most appropriate. Please contact their case manager to discuss any referral, as you might need prior ACC approval.

Vocational rehabilitation services

Some of our most common assessment, service and/or rehabilitation programmes available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table gives an indication of the contract type.

Service	Purpose	Provider criteria
Initial Occupational Assessment	Assesses a client's education, training and work experience and identifies suitable work types.	Occupational assessor
Initial Medical Assessment	Assesses a client's medical and injury-related conditions, and any non-injury-related barriers to ensure they can medically sustain rehabilitation with safety.	Medical assessor
Stay at Work 1 and Stay at Work 2	Evaluates and reviews a worksite, then implements a supervised increase of hours with the client via a documented plan, including troubleshooting.	Rehabilitation professional
Stay at Work 3 and Stay at Work 4	Evaluates a client's worksite and involves the key work contact to identify changes needed to make the environment safe or for the client to return to work. It is a multidisciplinary service where functional rehabilitation is provided alongside monitoring of the client's return to work.	Rehabilitation professional
Clinical Review of Fitness for Work	Allows certifying practitioners and claims managers to request an expert medical view of a client's fitness for work. The service helps clients return to work quickly and safely following injury. The CRFW provider consults with all parties to ensure agreement on fitness for work.	Medical Practitioner with Vocational training
Work Readiness	Helps clients to become work ready when, even after all practicable	Vocational practitioner

Programme	rehabilitation has been completed, they aren't expected to return to their pre-injury job or can't maintain their current job due to injury-related factors.	

Social Rehabilitation Services

Some of our most common assessment, service and/or social rehabilitation programmes available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table gives an indication of the contract type.

Service	Purpose	Provider criteria
Equipment	Provides equipment, aids and appliance based on the client's assessed needs to support their rehabilitation.	Contracted providers
Home and Community Support Services	Provides high quality, flexible support service in the client's home and community to support rehabilitation and help them return to an 'everyday life'. Some services include home help, attendant care and/or childcare.	Contracted providers or personal carer
Housing modifications	Provides project management and advice for housing modifications approved by ACC, such as the removal of structural barriers or addition of fixed features that are based on the client's assessed injury related needs.	Contracted consultants
Inpatient non-acute rehabilitation	This contract is for clients who, as a result of personal injury, require fast-stream inpatient rehabilitation in a rehabilitation unit.	DHBs and some Trust Hospitals
Social Rehabilitation Assessments	To recommend to ACC the most appropriate and cost-effective combination of social rehabilitation services to enable the claimant to achieve the expected outcome in the most rapid and durable manner.	Contracted providers

Specialised Rehabilitation Services

Some of our most common assessment, service and/or specialised rehabilitation programmes available to ACC clients are described in the table below. In almost all cases

these are provided by contracted providers. The provider criteria in the table gives an indication of the contract type.

Service	Purpose	Provider criteria
Concussion services	An interdisciplinary traumatic brain injury (TBI) service. The service aims to prevent long-term consequences, such as post-concussion syndrome (PCS), by identifying clients at risk of PCS and giving them effective interventions and education.	Multidisciplinary providers
Spinal cord active rehabilitation and/or reassessment	Non acute impatient rehabilitation services for clients who have sustained a Spinal Cord Injury (SCI) to assist them to return to acute participation in their home, work, leisure and community in a planned and timely manner. Reassessments support clients to maintain their health and wellbeing and prevent secondary complications through regular and routine reassessment.	Multidisciplinary providers
Visual impairment services	Provides clients who are visually impaired as a result of their injury the support they need to regain the skills they need in everyday life.	Multidisciplinary providers
Education support	Aims to meet the short and long term injury-related learning support needs of children and young people attending early childhood education centres, primary and secondary institutions and the long-term injury-related learning support needs of students in tertiary education.	Education support workers
Traumatic Brain Injury Residential Rehabilitation (TBI RR) Services	Supports clients who have sustained a moderate-severe TBI to return to active and meaningful participation in their community. If appropriate supports clients return to work in a planned, timely, supported and sustainable manner.	Multidisciplinary providers
Child and adolescent rehabilitation services (CARS)	Specialist inpatient, community rehabilitation and follow-up services for children and young people aged 0-16. It aims to enable these children to achieve and maintain their optimal	Multidisciplinary providers

	level of functioning, participate in developmentally appropriate activities, prevent further injury and provide advice on appropriate rehabilitation planning.	
Training for Independence	Trains and coaches a client as they adapt to the impact of their injury and helps maximise their participation in home and community activities.	Multidisciplinary providers
Residential Support Services	Provides slow stream rehabilitation or a 'home for life' environment for clients who have suffered a serious injury.	Contracted or designated provider

Pain Management Services

Some of our most common pain management services available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table gives an indication of the contract type.

Service	Purpose	Provider criteria
Pain Management Psychological Service	Uses psychological assessments and interventions to help clients cope and adapt to their injuries.	Clinical Psychologist/psychiatrist
Pain Disability Prevention (PDP) Programme	Targets psychosocial risk factors for pain and disability for clients who have additional mental health-related issues, such as depression.	Medical Practitioner, Clinical Psychologist or Health Psychologist
Progressive Goal Attainment Programme (PGAP)	Activity mobilisation programme which is tailored to meet the rehabilitation needs of clients who are struggling with the challenges of a wide range of persistent pain conditions.	Physiotherapist, Occupational Therapist, Registered Nurse, Osteopath, or Chiropractor
Functional Reactivation Programme (FRP)	Provides and individualised exercise programme that incorporates education in pain management and the practical applications of self-management principles.	Registered Physiotherapists and/or Occupational Therapist
Comprehensive Pain Assessment (CPA)	A comprehensive, fully integrated, and independent clinical assessment. The	Multidisciplinary providers

	emphasis is on determining functional goals for the client's rehabilitation. The CPA consists of three separate clinical assessments (medical, functional and psychological) followed by a team discussion. The team produces a combined 'formulation' with recommendations.	
Activity Focus Programme (AFP)	For clients who have a persistent pain-related disability with significant functional problems which are due to an injury. The purpose of this programme is to help clients adopt a self-management approach to independent functioning both at work and home, despite pain.	Multidisciplinary providers
Multi-disciplinary Persistent Pain (MDPP) Programme	A three-week residential programme that primarily focuses on helping modify the client's response to pain, rather than removing the pain stimulus.	Multidisciplinary providers
Interventional Pain Management	Provides specialised assessments and treatment for clients who have an accepted claim for cover for a personal injury. Pain is a complex phenomenon and best treated using an integrated approach. IPM procedures should be undertaken within the wider context of the client's rehabilitation (i.e. it is not appropriate for a client to be receiving IPM procedures in isolation, with no concurrent rehabilitation).	Contracted specialised medical practitioners

7. Invoicing and payments

Our legislation and policies

Payment criteria

ACC pays providers for the costs of treating clients' personal injuries that are covered by the scheme.

It is important to note that legislation and policies specify that the treatment provided must be for the purpose of restoring the client's health to the maximum extent practicable. That means it needs to be:

- necessary and appropriate
- of the quality required
- given at the appropriate time and place, with only the necessary number of treatments
- given prior approval, if required
- provided by an appropriately qualified treatment provider holding a current annual practising certificate
- clearly documented.

In deciding whether the points above apply to a client's treatment, the legislation also says ACC must take into account the:

- nature and severity of the injury
- generally accepted treatment for the injury in New Zealand
- other treatment options available in New Zealand for such an injury
- New Zealand cost of both the generally accepted treatment and the other options, compared with the likely benefit to the client of the treatment.

Your provider responsibilities are significant. In the course of making payments to you, we may at times need to query and verify aspects of your treatment or approach. This is to ensure that treatment meets the criteria including 'necessary', 'appropriate' and 'of the quality required', and that all providers are supporting the treatment given with auditable clinical records. For more information on monitoring, see Audits, fraud control and monitoring.

Invoicing

You can invoice ACC:

- under the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003, and amendments (Regulations)
- through a contract arrangement (see your particular contract for details of the invoicing process)
- by agreement with ACC against a purchase order

Note: If you're providing services under an ACC contract, you need to follow the invoicing or payment arrangements in the contract, as these will supersede the Regulations.

For more information, visit our website at For providers > How to invoice ACC, or phone the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

See also, Electronic invoicing: eSchedules.

Invoicing under Regulations –key points

The Regulations referred to are the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

ACC and Accredited Employers (AEs) pay, or contribute to, costs at the rates and/or amounts specified in these Regulations or later amendments. These contributions are towards basic consultation costs and additional costs for specific treatment and procedure types. For details of the contributions please see the Schedule

The Regulations allow invoicing for:

- a consultation/visit relating to an injury or condition covered by ACC. The price for the consultation includes any procedures not specified in the Regulations.
- a treatment or procedure carried out during the consultation/visit if an amount for it is specified in the Schedule. The amount we pay includes the cost of the most effective treatment materials for the client's injury. Procedures that don't have a specified price in the schedule are included in the price for the consultation and can't be invoiced separately.

You can only invoice us for payments if your client is eligible for the service you provide. Our policy is to recover any money paid through incorrect invoicing.

For more details about inclusions and exclusions for invoicing treatments and procedures see, Consultation/Visit and procedures costs and codes.

Invoicing ACC and AEs

ACC

We pay you once we have accepted a claim and received your invoice for services, usually on an ACC40 schedule (for medical practitioners) or ACC47 schedule (for other treatment providers), or electronically through your Practice Management System (PMS).

Accredited Employers

If your patient works for an Accredited Employer you'll need to send your invoices directly to the AE. If you have any queries about invoice payments, prior approval or injury management when treating an employee of an AE, please discuss these with the employer's contact person or their nominated Third Party Administrator. For more information see Lodging Accredited Employer claims.

Consultations/Visits

Definition of a consultation/ visit

For ACC to pay for a consultation/visit, it must be a necessary and appropriate face-to-face assessment, treatment or service relating to a covered injury.

This includes providing injury-related advice, completing prescriptions, making referrals, issuing any certificate to ACC and all relevant documentation that may result from the consultation/visit. It does not include insubstantial medical services for which clients wouldn't normally pay, e.g. phone consultations or informal encounters.

For billing purposes, a consultation/ visit also includes:

- removing sutures
- removing a non-embedded foreign body from an eye, mouth, auditory canal or other site (excluding rectum or vagina) without incision
- dressing minor single burns or abrasions
- re-dressing wounds that don't need significant dressings
- checking a plaster cast
- removing casts or splinting
- removing packing of the nose, an abscess or haematoma
- cleaning of and minor dressings for (e.g. small gauze or non-stick dressings) small burns or abrasions
- cleaning of and minor dressings for (e.g. plaster strips) small, open wounds
- managing minor sprains that don't need significant splinting.

For more details about inclusions and exclusions for invoicing consultations/visits, see Consultation/Visit and procedures costs and codes.

When appointments are missed

You can invoice us for missed appointments or cancellations only if:

- we made the appointment and agreed to pay a non-attendance fee as part of arranging it
- your contract with us covers payments for non-attendance by clients.

Paying for more than one consultation/ visit per day

Generally, we only pay for one consultation/visit per day per client, for all provider types. However, we consider each case individually and if clinically justified we may pay for a second consultation/visit.

Criteria for more than one payment

Paying for two consultations/visits in one day may be clinically justified if:

- you need to reassess the client for a second time later in the day, e.g. if you need to change a dressing or check a client whose condition may deteriorate or be likely to deteriorate
- the client initiates the second consultation/visit because of concerns about their condition
- the client is treated for one injury then leaves the consultation/visit and has a second, separate accident that day.

We're unable to pay for more than one consultation/visit in a day when:

- a client is referred for X-ray and returns for a consultation/visit afterwards to discuss the outcome
- more than one covered injury is managed at the same presentation.

If you have any queries, please call the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

Make sure you let us know why a second consultation/visit was necessary

To help us make quick decisions on invoices for additional same-day consultations/visits, please explain why they were necessary. If you use manual invoices or a bulk billing schedule, note your reasons on the invoice. If you invoice electronically, phone the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz.

Medical practitioners' treatment costs

Medical practitioners' costs that we cover

We pay for two aspects of a medical practitioner's treatment costs:

- A consultation/visit fee for a covered injury or condition.
  Note: The rate we pay depends on the client's age and is specified in the Regulations. We pay a higher rate for clients under 13 years old than we do for all other clients.
- Specific treatment or procedures a client receives during a consultation/visit.
  Note: The treatment or procedure must be listed under the heading 'Medical Practitioners' and Nurses' costs'. We pay the amount stated in the Schedule to the Regulations.

How to invoice when different injuries need different treatments

If a client has more than one injury and needs procedures for more than one injury at the same consultation/visit, the fees we pay are scaled.

We pay:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

Example 1: An adult client needs three treatments or procedures for more than one injury.

Example 1	Regulated amount $	Invoice shows $
Treatment/Procedure A	$34.83	@ 50% = $17.52
Treatment/Procedure B	$75.44 (highest-cost procedure overall)	@ 100% = $75.44
Treatment/Procedure C	$40.35	@ 50% = $20.18
Consultation/Visit	$35.48	$35.48
Invoice Total		$148.62

Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.

How to invoice when the same injury needs different treatments

If a client receives a basic treatment or procedure that is then expanded on during the same consultation/visit, we pay only the most expensive procedure.

If you need help clarifying whether the rules for dual treatments apply, contact the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz. We also recommend using the list of treatments and procedures from the Schedule in the Regulations to find the most appropriate category.

Nurses' treatment costs

'Nurse' defined for invoicing

For ACC purposes a 'nurse' means a registered nurse, including a nurse practitioner, but not an enrolled nurse or nurse assistant.

Nurses' costs that we cover

We pay for two aspects of a nurse's treatment costs:

- a consultation/visit fee for a covered injury or condition
  Note: The rate we pay depends on whether you are a Registered Nurse or a Nurse Practitioner. We pay a higher rate for clients under 13 years old than we do for all other clients.
- specific treatment or procedure a client receives during a consultation/visit.
  Note: The treatment or procedure must be listed under the heading 'Medical Practitioners' and Nurses' costs'. We pay the amount stated in the Schedule to the Regulations.

These payments apply to nurses, or providers of nursing services, who don't have contracts with ACC. Nurses and Nurse Practitioners wanting to claim under the Regulations need to be registered with us as individual treatment providers.

How to invoice when different injuries need different treatments

If a client has more than one injury and needs two or more treatments or procedures at the same consultation/visit, the fees we pay are scaled. See Example 1 in the table above. We pay:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

How to invoice when the same injury needs different treatments

If a client receives a basic treatment or procedure that is then expanded on during the same consultation/visit, we'll pay only the most expensive procedure.

If you need help clarifying whether the rules for dual treatments apply, contact the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz. We also recommend using the list of treatments and procedures from the Schedule in the Regulations to find the most appropriate category.

Joint medical practitioner and nurse treatment costs

Joint treatment costs that we cover

If both a nurse and a medical practitioner treat a client during the same consultation/visit and each one makes relevant clinical notes, we pay for both aspects of the treatment costs:

- a joint consultation/visit fee for a covered injury or condition
  Note: The rate we pay depends on the client's age and is specified in the Regulations. We pay a higher rate for clients under 13 years old than we do for all other clients.
- a specific treatment or procedure a client receives during a consultation/visit.
  Note: The treatment or procedure must be listed under the heading 'Medical Practitioners' and Nurses' costs'. We pay the amount stated in the Schedule to the Regulations.

When you invoice for a joint consultation/visit use only the medical practitioner's provider number.

Note that when we pay for a joint consultation/visit we don't pay:

- more than once for the same treatment
- the individual consultation costs specified for a registered nurse, nurse practitioner or a medical practitioner.

Invoicing for joint work on multiple treatments and procedures

If a client has more than one injury and needs two or more treatments or procedures from a nurse and a medical practitioner working together at the same consultation/visit, we pay for:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

Example 2: An adult client needs three treatments or procedures for more than one injury. At a joint consultation/visit a nurse and medical practitioner work together on each treatment or procedure.

Example 2	Regulated amount $	Invoice shows $	Provider Type
Treatment/Procedure A	$34.83	@ 50% = $17.42	Nurse

Treatment/Procedure B	$75.44 (highest-cost procedure)	@ 100% = $75.44	Medical practitioner
Treatment/Procedure C	40.35	@ 50% = $20.18	Nurse
Joint Consultation/Visit	$38.79	$38.79	Medical Practitioner
Invoice Total		$151.83	

Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.

Invoicing for joint work when the same injury needs different treatments

If at a joint consultation/visit a client receives a basic treatment or procedure that is then expanded on during the same consultation/visit, we pay only the higher amount for the more comprehensive service.

If you need help clarifying whether the criteria for dual treatments apply, contact the Provider Helpline on **0800 222 070** or email providerhelp@acc.co.nz. We also recommend using the list of treatments and procedures from the Schedule in the Regulations to find the most appropriate category.

Working separately on multiple treatments or procedures

When a nurse and a medical practitioner work separately to provide more than one treatment or procedure for a client for more than one injury during a joint consultation/visit, we pay:

The nurse	The medical practitioner
The full amount specified in the Schedule for the most expensive treatment/procedure the client is given by the nurse. 50% of the amount stated in the Schedule for each other treatment/procedure given by the nurse.	The full amount stated in the Schedule for the most expensive treatment/procedure the client is given by the practitioner. 50% of the amount stated in the Schedule for each other treatment/procedure given by the practitioner.

Example 3: An adult client needs several treatments or procedures for more than one injury. At a joint consultation/visit a nurse and medical practitioner work separately on each treatment or procedure. We pay:

Example 3	Regulated amount $	Invoice shows $	Provider number
Treatment/Procedure by nurse A	$34.83	@ 100% = $34.83	Nurse

Treatment/Procedure by nurse A	$32.16	@ 50% = $16.08	Nurse
Treatment/Procedure by medical practitioner B	$113.09	@ 100% = $113.09	Medical practitioner
Treatment/Procedure by medical practitioner B	$68.59	@ 50% = $34.30	Medical practitioner
Joint Consultation/Visit	$38.79	$38.79	Medical practitioner
Invoice Total		$237.09	

Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.

Specified treatment providers

Defining specified treatment providers

Specified treatment providers are acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists and speech therapists, as listed in Regulation 3 of the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Rule for invoicing

Specified treatment providers can provide services to our clients either under contract or under the Regulations.

Invoicing under contract

Providers invoicing for services given under contract should follow the invoicing requirements specified in the contract.

The following applies to invoicing and payment under the Regulations.

Invoicing under the Regulations

All specified treatment providers invoicing under the Regulations must choose whether they want to be paid **per hour or per treatment**.

When you start invoicing under one approach we take that as your chosen option. To change your invoicing option, please write with your reasons to ACC Provider Registrations, PO Box 30823, Lower Hutt, 5040 or email registrations@acc.co.nz.

Our policy is to allow one option change without the need for internal ACC approval. Any further changes are referred by Provider Registrations to ACC's Health Procurement and Contracting Unit for approval.

When you request a change to your invoicing option you won't be eligible to receive any back payments for services. Your new invoicing option will be effective from the date of receipt of the change request.

The Regulations specify the rates for invoices per hour or per consultation. For more information visit our website at For Providers > Invoicing and payment or contact the Provider Helpline by phoning **0800 222 070** or email providerhelp@acc.co.nz.

Invoicing per hour

If you provide 'direct treatment' for less than one hour, we calculate the payment in increments of five minutes, e.g. if your treatment takes 44 minutes, we pay for 45 minutes of the hourly rate (i.e. ¾ of the hourly rate).

Direct treatment

You provide 'direct treatment' when you directly apply your expertise to a client's treatment. Direct treatment includes:

- assessing and/or reviewing a client's injuries
- developing a treatment plan with the client (including taking patient history and writing clinical notes during consultation)
- physically applying treatment(s)
- observing the client while treatments are in place

If you are only seeing one client at a time you can invoice ACC for the time you are not providing direct treatment, as long as you are immediately available for the client should they require assistance

When attending to multiple clients you cannot invoice concurrently. Instead, calculate the total time spent in direct treatment with each. You cannot invoice for more than one hour's treatment in any hour.

If you treat a client for less than 60 minutes or multiple clients within 60 minutes the below rates in the part-hour payments table below apply.

It is important to note that the below rules for invoicing for multiple clients per hour apply and you cannot invoice ACC for more than 60 minutes in any given hour.

Part-hour payments		
Minutes	Hourly Rate $(GST excl)	Hourly Rate $(GST incl)
5	4.73	5.44
10	9.46	10.88
15	14.19	16.32
20	18.92	21.76
25	23.65	27.20

Part-hour payments		
30	28.38	32.64
35	33.11	38.07
40	37.84	43.51
45	42.57	48.95
50	47.30	54.39
55	52.03	59.83
60	56.76	65.27

Please note: these prices are as per Regulations effective 01/04/2014 and may have been updated since. For current prices see ACC1523 on our homepage.

In all cases your clinical records must support and document your direct treatment. If it's clinically justified, you can claim for a block of direct treatments of more than an hour's duration, as long as you document it in your clinical records.

Please note that we'll follow up any invoicing patterns outside of expected norms for that discipline. For more information on provider monitoring and other quality assurance functions, see Audits, fraud control and monitoring.

Invoicing on the hourly rate for more than one client

If you treat more than one client in an hour, we pay only up to 60 minutes in total.

Example: You treat six clients in a group for an hour.

- You can invoice us for six individual clients for 10 minutes each (i.e. invoice us for a total of one hour of your time).
- You can't invoice us for an hour for each client (i.e. invoice us for a total of six hours for one hour of your time).

Please note: Your records still need to demonstrate that your clinical input is necessary and appropriate. See Supporting quality.

You can invoice us in five minute increments for accuracy – that is for 5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55 or 60 minutes of treatment.

Example: You treat a client from 10:00am to 10:30am (30 minutes), and another from 10:15am to 11:00am (45 minutes).

- We'll pay for the hour between 10:00am and 11:00am, but not for 75 minutes of treatment time.

However, if your second client's 45-minute slot begins at 10:20am (so finishes at 11:05am) we'll pay for one hour and five minutes.

You can't invoice us for the overlap of the clients' treatment during the hour, but you can invoice us for the five minutes beyond the hour.

Limitations to invoicing per treatment

If treatment profiles and their trigger numbers apply to your treatment, you can't combine the number of treatments for different injuries (i.e. the sum of different Read Codes) to give an aggregated number of treatments. You can only provide treatments up to the highest individual trigger number before you need to provide an ACC32 Request for prior approval of treatments.

Example 4: A client has a mountain bike accident and sustains multiple injuries:

Example 4	Injury	Trigger number of treatment profiles
S50	Sprain shoulder	12
SE31.	Contusion elbow	12
S5400	Sprain knee joint	14

The injury with the most treatments before you need to get ACC approval for additional treatment is the S5400 sprain knee joint. You can invoice us for up to 14 treatments in this example, but not the sum of the treatment trigger numbers for all the injuries, which would be 38 treatments.

Similarly, if you are dual registered (i.e. as a chiropractor and acupuncturist) you can't combine the number of treatments under both provider types to give an aggregated number of treatments. You can only provide treatments up to the highest individual trigger number before you need to provide an ACC32 Request for prior approval of treatments.

Examples: A chiropractor can provide up to a trigger of 18 treatments, whereas an acupuncturist can provide up to 16 treatments before prior approval is required. You can invoice us for up to 18 treatments in this example, but not the sum of the treatment trigger numbers for all the injuries, which would be 34 treatments.

If none of the injuries have a treatment profile with a treatment trigger, then you can provide 6 treatments before requesting approval for additional treatments.

If you anticipate that the trigger number is likely to be exceeded, complete an ACC32 Request for Prior Approval of Treatment. For more information, see Further treatment: Referring clients via the ACC32 form.

Payment for counsellors

How to invoice

The Regulations specify counsellors' invoicing and payment arrangements. They require you to provide treatment face to face.

Exception

There is one exception. You can provide and invoice for one session of counselling provided in another way (eg by phone) if the client urgently needs it for mental injury

caused by certain criminal acts outlined in section 21 of the AC Act 2001. See also, Mental injuries, sensitive claims and counselling.

ACC will pay either the:

- hourly rate fixed in the Regulations for treatment provided by a counsellor who's a medical practitioner, or
- hourly rate fixed in the Regulations for treatment provided by a counsellor.

Actual rates may be adjusted from time to time. You can get the latest rates from us by phoning the Provider Helpline on **0800 222 070** or emailing providerhelp@acc.co.nz.

Different invoicing and payment arrangements may apply to counsellors who deliver treatment or services under contracts with ACC.

Invoicing for services given under contract or Regulations

If you're providing services under an ACC contract, you need to follow the invoicing or payment arrangements in the contract; these will supersede the Regulations.

Services and reports

Invoicing for imaging services

You'll find a list of imaging services and fixed rates for treatments and procedures in the Schedule to the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003. The Schedule covers a wide range of radiological procedures used in everyday practice, including mammography, ultrasound and special procedures such as myelogram and arthrogram.

High-tech imaging

The Schedule doesn't cover more high-technology items such as MRI scans. You can only access them – and have us pay for them if you're working under contract for these services. See also: Further treatment: Referring clients via the ACC32 form , Types of acute referrals.

Invoicing for supplying reports and records

If we ask you to provide a report, you can invoice us for a report fee at the rate quoted in our request letter. You need to cite the purchase order number and the appropriate report code, e.g. STPR for specified treatment providers and MEDR for medical practitioners.

The standards we expect in your reports are the same as those of your professional organisation, i.e. they must be honest, impartial, unbiased, clear and relevant. They will serve your patients' interests best if they focus on verifiable clinical evidence wherever possible.

We sometimes ask for copies of existing clinical notes and typically pay the expenses for providing this information at identified rates. You can get the latest rates from your local Supplier Manager or by phoning the Provider Helpline on **0800 222 070** or emailing providerhelp@acc.co.nz

Important: Under section 309(4) of the AC Act 2001 you're required to provide us with any information we ask for if the client has authorised us to make the request and you have notice of that authorisation. Clients give us this authority when they sign their ACC45 Injury Claim forms.

It is an offence not to supply the information without a reasonable excuse, as we use it to make decisions about entitlements and to detect fraud.

If a patient asks for their own medical records, you must supply them free of charge – unless the patient has requested the same information within the past 12 months, or the information includes video recordings, X-rays and CAT scans.

Invoicing correctly

Procedures for invoicing ACC

How you invoice ACC will depend on the conditions of your contract, purchase order or the Regulations. If you are:

- contracted to ACC, follow the invoicing process in the contract
- seeking payment for services that we've asked you to provide, make sure you have a seven-digit purchase order number from us and include it on your invoice to the requesting unit. It will be processed by our Accounts Payable team.
- invoicing under the Regulations, see For providers > Invoicing and payment > How to invoice ACC.

A claim needs to be lodged prior to an invoice being submitted. When invoicing, please be aware of the following:

- only one consultation per day/per client can be invoiced to ACC
- where there are exceptional circumstances and a client returns for a second consultation on the same day, full details of this (including the relevant clinical records) should be provided to ACC for consideration
- where multiple injuries are being managed at the same consultation, you can only invoice ACC for the most significant injury
- where you choose to utilise elements of more than one treatment modality eg chiropractic and acupuncture, at the same consultation (or on the same day), you can only invoice ACC once under one provider ID
- all invoices need to be complete and accurate
- at times ACC will request copies of clinical records. Failure to provide these could result in non-payment.

Ensure the following information is correct for every line:

- ACC Claim number or ACC45 number or both
- READ code
- Full client name (no abbreviations or incorrect spelling)
- Date of injury
- Date of service
- Date of birth

Completing and sending a bulk-billing schedule

ACC prefers that all providers invoice electronically, but still enables the manual process. (see Electronic invoicing: eSchedules)

The 'bulk-billing' process applies to all invoices from treatment providers. It enables you to send several invoices at once on either an ACC40 schedule (for medical practitioners) or an ACC47 schedule (for other treatment providers).

Every schedule must show your GST number.

Directions for bulk-billing are on our website at For providers > Invoicing and payment > How to invoice ACC > Manual bulk-billing.

Where to send your schedule

Please send your schedule to the Medical Fees unit for your area, see Key ACC contacts for treatment providers.

If you have any queries about the process, or about a specific payment, phone the Provider Helpline on **0800 22 070** or email providerhelp@acc.co.nz.

8. Working electronically with ACC

Digital certificates

How to get a digital certificate

The forms you need to use to apply for eLodgement, eSchedules, eLookup and digital certificates are listed in step 6 of What you need to use eLodgement.

For more information:

- see Apply for a digital certificate on our website
- visit HealthLink's website www.healthlink.net, HealthLink creates, distributes and supports digital certificates.

Receiving and connecting your digital certificate

Digital certificates are approved and administered by the Zealand Health and Disability Sector Registration Authority (NZHSRA).

Before issuing your digital certificate the NZHSRA will send you a test email (if you have an email address). Once you've replied to this email your digital certificate will be couriered to you from HealthLink on a CD-ROM.

Call HealthLink on **0800 288 887** to get the installation password which you need to install your digital certificate. HealthLink can also talk you through the installation if you need help.

The ACC eBusiness team will contact you to schedule a phone training session, which will take approximately 30 minutes. They'll also monitor your progress to ensure everything is running smoothly.

Electronic claims lodgement: eLodgement

About eLodgement

Any provider who submits ACC45 Injury Claim forms can use eLodgement.

You can learn about the benefits of using eLodgement at For providers > Set up and work with ACC > Work online with ACC > eLodgement.

What you need to use eLodgement

To start using eLodgement you need:

1. A personal computer (PC or Mac). We recommend:

- a 200MHz processor in a Pentium or similar PC
- 32Mb RAM
- a 500Mb hard disk
- a 32-bit operating system, i.e. Windows 98, Mac OSX or later versions.

2. A digital certificate - a software application that creates your unique digital signature. Issued on CD-ROM and stored on your computer, your digital certificate authenticates the origin of data and secures data as it travels between you and ACC. Your digital certificate is free, renewed annually and issued by ACC. For more information see Digital certificates.

3. A compatible Practice Management System (PMS). Your PMS will generate ACC45s complete with data you normally use and prompt you for any additional data needed. To find out about PMSs:

   - see our online list of PMS systems that support eLodgement
   - phone our eBusiness team on **0800 222 994**, option 1
   - email ebusinessinfo@acc.co.nz.

   If you don't have a PMS you can still take advantage of the system by using our eLodgement website.

4. A compatible communications link, eg an internet broadband or dial-up connection, or HealthLink Online.

5. A compatible web browser (eg Internet Explorer 6.0+, Mozilla Firefox 1.0+, Apple Safari 1.0+). The browser should support 128-bit SSL, 1024-bit digital certificates. This specification is the minimum recommended for adequate performance, and it will depend on your system's power.

6. To register by completing three forms:

   - HealthSecure Organisation Registration
   - HealthSecure User Registration
   - ACC1534 Change of vendor details

   The forms include addresses to send them to.

You might also like to read our Security Policy for Electronic Business document.

Electronic invoicing: eSchedules

Who can use eSchedules

You can use eSchedules if you submit invoices to us for payment under business rules specified in a contract, purchase order or the Regulations.

You can use the service to send us your ACC40 or ACC47 schedules (invoices) electronically, either from your PMS or through our eForm web page.

The benefits of eSchedule

eScheduling offers you the benefits of:

- faster payments, normally within seven working days, as electronic invoices have priority
- easy online tracking to check the progress of your schedules and payments and the registration of an ACC45 Injury Claim form, 24 hours a day
- online remittance advices
- time and paper savings through streamlined processes
- quality information between systems
- easy checking of whether a claim is for an Accredited Employer(AE) and, if so, quick access to the AE's name and address
- schedule payments being processed within five days, if the information is complete and accurate
- partial payments for incomplete schedules, rather than having them held for payment in their entirety
- the ability to diagnose any invoicing and payment problems quickly and easily
- not having to submit printed schedules or copies of referral forms and approval letters.

Note: Make sure you keep copies of referrals and approval letters as we may need to see them to validate your invoices.

What you need to use eSchedules

Setting up eSchedule is the same as setting up eLodgement – although you'll also need to complete an ACC23 Application for Electronic Medical Fees Schedules for each provider in your practice.

If any providers aren't registered with us, they'll need to complete the ACC24 Application for ACC Health Provider Registration form which includes a section on electronic claiming. The team will advise you in writing when your request has been approved, usually within a week of your application being submitted.

How to send eSchedules

To send an eSchedule:

1. Check that your billing schedule is correct:

   - send separate schedules for nurses and medical practitioner, unless your practice holds an Accident and Medical contract, or a Rural General Practice Services contract
   - ensure you use the correct service codes to avoid payment delays
   - check that your claim numbers are correct and in the required format. Use ACC45 numbers where possible, but be careful not to use zero in place of the letter 'O' or vice versa. Enter alpha and numeric data only (i.e. not symbols such as / or –)
   - if you're providing services on an hourly rate, list the service duration(s).

2. Before you send your first eSchedule, check that your ACC provider number is loaded correctly in your system. There should be no gaps between the alpha character and numerals.

3. Check with your software vendor that system flags are correctly set for you to send live claims (otherwise your electronic claims will go into an ACC test system that can't make payments).

4. Send real schedules only.

5. The day after you send your first batch of schedules, phone the Provider Helpline on **0800 222 070** to check that they have arrived. Your PMS should receive acknowledgement, but acknowledged schedules can still be rejected for various reasons. The eBusiness team will let you know if you need to fix your system or resubmit the schedules.

   Note: If at any other time you want to check your payment schedules you can use eLookup, our eForm web page, or phone the Provider Helpline quoting your ACC provider number and each schedule number you're querying.

6. ACC pays the amount owing into the bank account you provided and sends you a payment advice letter confirming the amount.

Late invoicing

If you send us an invoice 12 months or more after providing the service, you'll need to give us extra information to show that we're still liable to pay for the service.

Querying payment delays

Where we have enough information we usually decide on cover for a claim within 24 hours. However, some claims (e.g. sensitive claims) can take a little longer because we need to get additional information. In these cases delays in payment are unfortunately inevitable. Payments can also be delayed if we've asked a client to visit another treatment provider for a second opinion.

The bulk billing payment advice and the Schedule Payment Status Query on our eForm web page will show you which payments have been withheld and why. You can also phone the Provider Helpline on **0800 222 070** to discuss late payments or email providerhelp@acc.co.nz, or if you think a claim has been accepted for payment but you haven't been paid.

Electronic claims queries: eLookup

Who can use eLookup

Currently radiologists, DHBs and any organisation using ACC's eSchedule service can have access to eLookup.

The benefits of eLookup

With eLookup you can query:

the status of an ACC45 claim number to check if the claim:

- has been accepted or declined by ACC
- has come from an AE. If it has you'll receive the name and address of the AE concerned.

the current payment status of any schedule you've sent us, including:

- whether a schedule has been paid
- how much was paid
- the reason for a payment being put on hold or declined.

What you need to use eLookup

All you need to access eLookup is a PC with an internet connection and a Health Secure digital certificate.

If you're already using a digital certificate for other health sector transactions such as eLodgement, it's likely to be a Health Secure digital certificate which you can use for eLookup.

To check if you have the right digital certificate phone our eBusiness Team on **0800 222 994** option 1, or email ebusinessinfo@acc.co.nz.

If you need to apply for a Health Secure digital certificate complete the forms:

HealthSecure Organisation Registration

HealthSecure User Registration.

The forms include addresses to send them to.

Frequently asked questions on working electronically

Q: Why are claim numbers important?

A: The ACC system checks that claims belong to the people who are being claimed for.

If the ACC database and your database have different details for a client (name and date of birth), the discrepancy will be flagged so all involved can make sure they're sharing the correct details.

Q: If we eLodge, do we still need to send printed copies to ACC?

A: No, we only need the electronic copy. However, you must keep a signed copy in paper or image form that shows your patient has authorised you to lodge the claim on their behalf.

Q: Does the treatment provider who generates an ACC45 during a consultation or visit have to send it to ACC straight away?

A: No. If you have a network of practice computers, a practice administrator can pick up the ACC45 on their computer, check that the information is complete and submit it to ACC. This should be done once a day. However, all ACC45 claim forms should be lodged on the day of the consultation/visit.

Q: Do all treatment providers need a computer?

A: No, you can complete ACC45s by hand and give them to your administrative staff for input that day to minimise the time required on a computer.

Q: We already send invoices to ACC electronically – how will lodging the ACC45 claim form electronically affect our billing?

A: The eLodgement system allows you to lodge your ACC45s electronically without affecting your electronic invoicing. The process of invoicing ACC won't change.

However, you'll find that you can invoice us a lot faster when eLodging your ACC45s as we'll have details of your patients' claims in our system at the time you submit your invoices.

Q: Will the information I send electronically be secure?

A: Yes. The digital certificate protects the information you transmit by letting ACC know that it was you or your organisation that sent the data. Your computer system also encrypts (or 'scrambles') the data with your digital certificate to protect it as it travels from you to ACC.

Q: Does every treatment provider need a digital certificate?

A: No. You only need a digital certificate on the computer(s) that sends the data online to ACC. If you're using the ACC eLodgement website to capture and submit your data, you'll need a digital certificate to do this too.

9. Glossary

Introduction

Glossary covers definitions relating to the Regulations

This glossary covers terms used by treatment providers working under ACC's legislation.

Accordingly, most of the terms relate to the AC Act 2001 and associated ACC-specific Regulations, such as the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Definitions specific to contracts are not covered

Providers working under ACC contracts will find some of the definitions do not apply to, or are modified by the terms of, specific ACC service contracts.

If definitions in this Glossary differ from terms and definitions in service specifications (, eg consultation/visit for providers working under the ACC Rural General Practice Services contract), then the contract version applies.

Other definitions

You might also find the general Glossary of ACC terms helpful.

Definitions

Term	Meaning
ACC18 Medical Certificate	This certificate is completed by a medical practitioner or nurse practitioner to describe how an injury has affected a patient's capacity for work when they can't continue in their normal employment for a time because of their injury; or to confirm that they are now able to return to their normal work. We publish guidelines on how to complete the form and resources that help medical and nurse practitioners to determine their recommendations for time off work. This certificate can also be used to add or change a diagnosis. It is ACC's preference that Medical certificates are submitted electronically.

Term	Meaning
ACC32 Request for Prior Approval of Treatment form	This form is completed by a Specified Treatment Provider: • to add or change a diagnosis • when they believe a client needs additional treatment beyond the treatment profile trigger numbers • when a client needs to resume treatment after more than 12 months have passed. • When the client presents for treatment for the first time for an injury that is more than 12 months old
ACC45 Injury Claim form	This form is used to lodge a new injury and to determine ACC cover on a person's claim. It is completed by both the client, who provides a signed 'patient authority and consent', and the initial treatment provider.
ACC705 Referral for Support Services on Discharge	This form is used by a hospital to provide ACC with information about a clients' needs when the hospital's clinical team has identified that the client will need home support services on discharge. An ACC staff member acknowledges receipt by faxing back the form with details of action taken.
ACC706 Early Notification of Complex Case	This form is used by a hospital to refer to ACC when the clinical team has identified that a patient has complex needs post discharge and will require a range of support services. The form is faxed to ACC as soon as possible so that ACC's client service staff can liaise with DHB staff to arrange for the required supports before the client is discharged. ACC staff fax back the form to acknowledge receipt.
ACC1171 Request for Funding from ACC for Non-Subsidised Pharmaceuticals	This form is used to request pharmaceutical funding approval and should be completed by a provider and submitted to ACC before they prescribe a non-subsidised pharmaceutical for a client. ACC may contribute towards the cost of partly and non-subsidised pharmaceuticals. Approvals are for a limited time. Other related forms and checklists are detailed on.
ACC2152 Treatment Injury Claim form	This form is used by a treatment provider (always together with a new ACC45 form) when lodging a claim for injuries caused by treatment from a registered health professional.
Accident Compensation Act 2001 (the AC Act 2001)	The AC Act 2001 (and subsequent amendments) prescribes the ways in which ACC provides and pays for, or contributes to, the costs of comprehensive, no-fault cover and entitlements for all New Zealand citizens, residents and temporary visitors who sustain personal injuries in New Zealand.

Term	Meaning
Accredited Employer (AE)	This is an employer who has signed a contract with ACC taking responsibility for the management and costs of their employees' work-related injuries and illnesses and gradual process diseases for a specific period of time in exchange for a levy reduction.
Acute admission	This is an admission to a publicly funded hospital within seven days of a medical practitioner's decision to admit the person to hospital, unless otherwise specified in the Regulations. An acute admission may be from an emergency department, outpatient department or a GP/private specialist.
Acute treatment	Acute treatment, in relation to a client, means: (a) the first visit to a treatment provider for treatment for a personal injury for which the client has cover, and (b) if, in the treatment provider's reasonable clinical judgement, the need for the treatment is urgent (given the likely clinical effect on the client of any delay in treatment): (i) any subsequent visit to that treatment provider for the injury referred to in (a), and (ii) any referral by that treatment provider to any other appropriate treatment provider for the injury referred to in (a). *AC Act 2001, Part 1, Section 7*
Advocacy service	This service provides independent advocacy that is free to patients and funded by the Health and Disability Commissioner. It can help and support people to know their rights and the actions they can take if they have concerns about any health or disability service, including ACC.
Ancillary services	These are services that are 'ancillary' to a client's rehabilitation (i.e. the client needs them to be able to access or receive their rehabilitation). They include emergency transport, non-emergency transport to and from treatment, accommodation in relation to treatment, and payment to enable a client to be escorted to and from treatment (,e.g. if the client is a child). The AC Act 2001 also classifies pharmaceuticals and laboratory tests as ancillary services. Some ancillary services are funded through an agreement with the Ministry of Health (,e.g. community-pharmaceutical, and laboratory tests). The eligibility for many ancillary services is determined by ACC's client service staff, taking into consideration the context of the request and the claim.

Term	Meaning
Annual practicing certificate	This is a certificate issued annually to a medical practitioner and other health practitioners under the HPCA Act 2003 which allows them to practise their professions in New Zealand. The certificate is intended to ensure that health practitioners are competent and fit to practise.
Capacity for work	This describes a person's ability to perform work duties, based on their education, experience or training (or any combination of these) in relation to the consequences of their personal injury.
Client	An ACC client is a person who has sustained a personal injury and has had their claim for ACC cover approved under the AC Act 2001 or an earlier Act.
Client consent	A person's consent is required when an ACC claim is lodged on their behalf. This authorises the treatment provider to lodge the claim and ACC to collect and disclose certain information.
Clinical advisor	ACC clinical advisors are qualified health professionals. They range from medical practitioners to specialist practitioners, nurses, pharmacists, physiotherapists and other allied health professionals. Their role is to provide advice on claim cover and entitlement and in respect to treatment injury claims, the clinical advisor determines cover.
Code of Rights	All people who use a health or disability service have the protection of the 'Code of Health and Disability Services Consumers' Rights'. An independent Commissioner promotes and protects these rights under legislation. More details can be found at www.hdc.org.nz.

Term	Meaning
Consultation/Visit	A consultation/visit, as defined by the Regulations, means an assessment in person (face to face), and a necessary and appropriate service performed, or treatment provided, by a provider for an injury or condition covered by ACC. It includes providing claim-related advice, completing a prescription or referral, and issuing any certificate to ACC as a result of the consultation/visit. A consultation/visit does not include: • medical services where no substantial service is given by the provider and for which the patient would not reasonably be expected to pay • any telephone consultation • any informal encounter. A number of minor treatments/procedures are also included in a consultation/visit for billing purposes under the Regulations. For examples of these, see: Section 10 – Consultation/Visit and procedure costs and codes: Guide to invoicing for medical practitioners and nurses. Providers using hourly rates or variable fees should invoice ACC in a way that shows the proportion of time spent directly treating the client's ACC-covered injury or condition. (See also 'Direct treatment').
Co-payment	This is a fee that a treatment provider can charge a client over and above ACC's contribution to the treatment, unless the provider has signed a contract with ACC that doesn't permit them to charge co-payments.
Criminal disentitlement	ACC is unable to provide entitlements other than treatment for a client who is injured in the course of committing an offence for which they are subsequently charged, and then imprisoned or sentenced to home detention for the offence.
Direct treatment	This means the amount of time a treatment provider directly applies their expertise to a client's treatment. It includes assessing and/or reviewing their injury, developing a treatment plan with them and/or applying direct hands-on treatment.
Discharge summary	This is a report prepared by a health care facility or service responsible for a person's care when it discharges them from inpatient, custodial or residential care. It includes a statement on their health status immediately before discharge, their prognosis, the nature, duration and objective of any continuing treatment, care or support needed, and the ACC claim number (the ACC45 number).

Term	Meaning
Doctors for Sexual Abuse Care (DSAC)	DSAC is a professional organisation of doctors from many disciplines. Their prime focus is to educate and help medical practitioners maintain international best practice medical and forensic standards when managing victims of sexual assault. For more information, see www.dsac.org.nz.
Emergency transport	Emergency transport is transport needed to get urgent treatment for a client who has a personal injury. It must be dispatched by an Emergency Ambulance Communications Centre from a contracted provider within 24 hours of the client sustaining the personal injury, or being found after sustaining the injury (whichever is the later). Being 'found' relates to situations such as an injured person being located by search and rescue. ACC pays for emergency transport once cover for the claim has been approved.
Entitlement	A fundamental requirement of the ACC statutes is that people who become clients with cover for personal injury can apply for entitlements. The entitlements provided under the AC Act 2001 include: (a) rehabilitation, comprising treatment, social rehabilitation and vocational rehabilitation (b) first week compensation (c) weekly compensation (d) lump sum compensation for permanent impairment or independence allowance (e) funeral grants, survivors' grants, weekly compensation for the spouse (or partner), children and other dependants of a deceased client, and child care payments. If a client meets all the relevant statutory criteria, ACC has a legal obligation to pay or contribute to the cost of entitlements. These are often delivered by providers working under the Regulations or ACC contracts.
Hāuora Māori – Cultural Competency	All contracts between ACC and providers include an organisational quality standard, a Hāuora Māori clause, which takes into account the practical application of the articles of the Treaty of Waitangi when providing services, and commits providers to complying with ACC's Guidelines on Māori Cultural Competencies for Providers.

Term	Meaning
Health Practitioners Competence Assurance Act 2003 (HPCA Act)	The HPCA Act supports the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession. This legislative framework allows for consistent procedures and terminology across the many professions regulated by the Act. The HPCA Act includes mechanisms to ensure that practitioners are competent and fit to practise their professions through their working lives.
Home and Community Support Services (HCSS)	This service provides high quality, flexible home and community support services (personal care, child care, home support) for Clients in their own homes and community. The service facilitates the achievement of clients' goals and is flexible to fit with the clients normal daily routine as far as practicable, and will be appropriately matched to the client's needs. There are three service types: 1. **Initial Support Package: (ISP):** Allows DHBs to refer Clients with low complexity and/or short term home support needs directly to the Supplier. Service includes service set-up and up to a maximum of 10 hours of support over a 2 week period 2. **Return To Independence (RTI):** 'For Clients with a time limited need for support whilst they recover from their injury. The Service will assist Clients to achieve their pre-injury level of independence within their everyday lives. 3. **Maximise Independence Service (MI):** For Clients who have a long term need for support to live their everyday lives.
Impairment	This is a general term for any loss, or abnormality, of the following bodily structures or functions: Psychological (relating to the mental state) Physiological (relating to body function) Anatomical (relating to body structure).
Incapacity	This describes an injured person's inability to work owing to personal injury, or an injured person's absence from work for necessary treatment owing to personal injury. See ACC Act 2001.

Term	Meaning
Independence allowance	This is an entitlement for a client who, as a result of an ACC-covered injury, has a permanent loss of bodily (physical and/or mental) functions. The independence allowance compensates for significant long-term impairment and is paid in addition to any other entitlements. ACC requires a medical certificate from a medical practitioner indicating that it is likely there is impairment, and that the condition is stable, before any assessment for this entitlement can be carried out.
Individual rehabilitation plan (IRP)	An IRP is the plan that ACC develops in consultation with a client and their family, employer and treatment provider. It outlines the rehabilitation support needed to meet the timeframes and rehabilitation goals.
Injury Prevention, Rehabilitation, and Compensation (IPRC)	IPRC was the previous name of the AC Act 2001 before the passing of the Accident Compensation Amendment Act 2010. Many of the regulations that pertain to the AC Act 2001 are still referred to as the IPRC Regulations.
Medical advisor	ACC medical advisors are medical doctors, often with specialist qualifications. They are part of ACC's clinical advisor group and their role is to provide medical advice and guidance to case managers and other ACC staff managing injury claims.
Medical Fees Processing (MFP)	MFP is ACC's computer software system for provider contracting, payments and service management. The software • is used to process health providers invoices using bulk billing and electronic schedules • can allow automatic approval and payment for goods or services that ACC purchases in relation to client rehabilitation or treatment • handles some areas of contract management.
Mental injury	ACC covers the treatment of mental injury that is shown to be 'a clinically significant behavioural, cognitive, or psychological dysfunction' and is the result of a covered personal injury (refer to definition of personal injury) A mental injury must be substantial enough to be observed, be diagnosable with a specific diagnosis and require treatment.
Missed appointments	You can't invoice ACC for missed appointments or cancellations unless we made the appointment for the client and agreed to pay a non-attendance fee as part of arranging it.

Term	Meaning
National Serious Injury Service: Client Support/Service Plan	This is a detailed support and rehabilitation plan developed with a client who has long-term or lifelong support needs due to a serious injury (i.e. spinal cord injury, moderate-severe traumatic brain injury, multiple amputations or severe burns). Each plan focuses on the client's goals and identifies the supports they need to achieve an 'everyday life'. The outcomes aim to maximise the client's independence and community participation and, if possible, sustainable employment.
Natural use of teeth	This term means the normal use of teeth for eating, such as chewing and biting, or using teeth to prise or tear food. Any injuries caused by the natural use of teeth are excluded from cover under the AC Act 2001. We will consider covering a claim for tooth damage that hasn't been caused by the natural use of teeth – such as a tooth damaged when a person bites a foreign object while eating (, eg a piece of glass in a bread roll).
Ordinarily resident	In general to be 'ordinarily resident' a client must: • hold the required citizenship, permit, or visa of a New Zealand resident or • be the spouse or dependant of an ordinarily resident person and generally accompany them, and have a permanent place of residence in New Zealand and • if overseas, have intended to return to New Zealand within six months of leaving. Other detailed conditions may apply.
Pain Management Services	Pain management services are designed to support a client's broader rehabilitation goals and act as an enabler to allow a client to access further rehabilitation services that they can't currently because of ongoing or chronic pain conditions.

Term	Meaning
Personal injury	Personal injury means a: • physical injury • mental injury resulting from a physical injury • mental injury resulting from sexual assault or abuse • mental injury caused by a traumatic work related event • person's death. Personal injury includes damage to: • dentures (other than wear and tear) • prostheses that replace a part of the human body (except for hearing aids, spectacles and contact lenses). Personal injury does not include hurt to emotions, stress or loss of enjoyment.
Pharmaceuticals	Pharmaceuticals are classified by the AC Act 2001 as prescription medicines, restricted medicines, pharmacy-only medicines and controlled drugs specified in legislation controlling such substances. ACC will only consider contributing to costs for pharmaceuticals within this definition.
Physical injury	The category of 'physical injury' requires an actual diagnosis of the injury and evidence that shows damage to the body. A diagnosis of pain is insufficient for establishing a physical injury.
Provider claim lodgement framework	The ACC provider claim lodgement framework lists injuries by description and Read Code and specifies the provider groups that are able to lodge ACC45 Injury Claim forms for cover on each one. The framework is designed to support claim lodgement by providers who are appropriate for specific types of injury.

Term	Meaning
Public Health Acute Services (PHAS)	Services from DHBs needed by ACC clients are funded under PHAS. ACC pays for these services through a bulk payment which is given, via the Treasury, to the Ministry of Health. The IPRC (PHAS) Regulations 2002 relate to services provided by a publicly funded provider (such as a DHB) to treat a client for a covered personal injury, including services provided: • as part of an acute admission • as part of an initial emergency department presentation, and any subsequent services given by the emergency department within seven days of that presentation • for an outpatient by a medical practitioner within six weeks of acute discharge or emergency department attendance • by a medical practitioner within seven days of the date on which the client is referred for those services by another medical practitioner • that are ancillary to any of the above services, such as travel and accommodation for the client, and an escort or support person, but excluding emergency transport • to aid treatment as above, such as consumables, diagnostic imaging and equipment. It also covers the costs of pharmaceuticals which are prescribed as per the listings in all parts of The Pharmaceutical Schedule and for community laboratory/diagnostic tests
Registered health professional	A registered health professional is defined in the AC Act 2001 as: (a) a chiropractor, clinical dental technician, dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, nurse practitioner, occupational therapist, optometrist, pharmacist, physiotherapist, or podiatrist, and (b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when they are acting in accordance with any conditions of such interim certificate, and (c) includes a member of any occupational group included in the definition of 'registered health professional' by Regulations made under section 322 of the Act.
Rehabilitation	Rehabilitation is a process of active change and support to help a person regain their health and independence, and therefore their ability to participate in their usual activities as far as possible. It comprises social rehabilitation, specialised rehabilitation, pain management, vocational rehabilitation and treatment.
Rehabilitation outcomes	These are rehabilitation goals, objectives or results that may stem from the rehabilitation intervention and are agreed by the client with ACC through an individual rehabilitation plan (IRP).

Term	Meaning
Review rights	A client has the right to have a decision made by ACC about their claim independently reviewed within a specified timeframe. ACC is required by its legislation to tell clients that they have the right to a review and what the review timeframe is. Clients must be told early enough to allow them the maximum amount of time to exercise the right.
Scope of practice	This means a health service that is part of a health profession. Scopes of practice for health professions covered by the HPCA Act 2003 are decided and published by the relevant registration authority (e.g. Medical Council of New Zealand). A practitioner must practise within any conditions imposed by their registering authority.
Self-harm	ACC has to decide if a self-inflicted injury or suicide was the result of wilful act, or from a covered or coverable mental injury. If not, we may withhold entitlements other than treatment.
Sensitive claims	For clients who have been injured by specific sexual crimes, ACC covers mental injuries as well as any physical injuries. These are called 'sensitive claims' owing to the sensitive and confidential nature of the injuries. ACC's national Sensitive Claims Unit specialises in managing these claims.
Short-term Claim Centre	ACC has four Short-term Claim Centres in Christchurch, Dunedin, Hamilton, and Wellington. They typically manage claims involving mild injuries, or injuries from which clients would usually make a complete recovery within several months.
Significant dressings	Significant dressings are specialised dressings, usually moderate to high cost per application, or multi-layered dressings. This term does not cover the application of simple gauze and tape, plaster strips or strips of adhesive tape, and the use of non-stick dressings.
Social rehabilitation	Social rehabilitation helps clients to regain their independence in daily living activities, as much as possible. It includes home and community services, equipment and for independence, training for independence, modification of vehicles or home, and education support. Provision of these services is based on the clients injury related needs which are identified through an appropriate assessment completed by a health professional.

Term	Meaning
Specialised rehabilitation	Specialised rehabilitation helps clients achieve the best possible rehabilitation and community participation outcomes for clients who have long-term or lifelong support needs owing to a significant injury, e.g. spinal cord injury or traumatic brain injury. Services include residential rehabilitation for clients who have sustained a spinal cord injury, TBI residential rehabilitation, child and adolescent rehabilitation, transition services, training for independence, community based rehabilitation, education support and services for the blind.
Specified Treatment Providers (STPs)	STPs (also known as allied providers) are specified in the Regulations as: acupuncturist, chiropractor, occupational therapist, osteopath, physiotherapist, podiatrist, and speech therapist.
Supervision for counselling	Clinical supervision plays a fundamental role in the successful progress of counselling. ACC Regulations require a counsellor, as a member of a professional body, to have effective, regular and ongoing supervision that involves ACC, and can make available its detailed written expectations.
Telephone counselling	ACC pays for counselling only when it's provided on a face to face basis. However, in a single exception under the Regulations, we can pay for one telephone counselling session for a client who has an accepted sensitive claim, if they need it urgently.
Treatment	Treatment includes physical rehabilitation, cognitive rehabilitation, and an examination to provide an ACC medical certificate and the provision of it.
Treatment injury	This is a personal injury that has occurred as a result of treatment provided by, or at the direction of, one or more registered health professionals. The injury must be directly caused by the treatment, and cannot be a necessary part or ordinary consequence of the required treatment.
Treatment profile	Treatment profiles are a collection of injury profiles developed by a group of independent practitioners that give providers standardised expectations about treatment and incapacity. They are published by ACC and distributed free of charge. The information on each injury includes: • appropriate treatment • the probable duration of the incapacity • the probable duration of the treatment • the possible complications • an illustration of the relevant injury site (for fractures).

Term	Meaning
Treatment profile number	This is the number of treatments for a specific diagnosis without complications, which has been referred for treatment at an appropriate stage in the healing process. These numbers provide a consensus on acceptable treatment ranges.
Treatment profile trigger number	Trigger numbers indicate the number of treatments after which ACC would seek a review of the services that have been provided.
Treatment provider	The following are treatment providers under the AC Act 2001 and can lodge claims within their own scopes of practice. • Acupuncturists • Audiologists • Chiropractors • Counsellors • Dentists • Medical laboratory technologists • Nurses and nurse practitioners • Occupational therapists • Optometrists • Osteopaths • Physiotherapists • Podiatrists • Medical practitioners (only medical practitioners can give clients a medical certificate for time off work) • Speech therapists. See also, For Providers > Lodge and manage claims > Provider claim lodgement framework.
Visitors	Overseas visitors injured in New Zealand are covered by ACC, so we can help pay for suitable treatment here if we accept their claim. However, we can't reimburse visitors for loss of income or for treatment costs in their home country.
Vocational independence	This means a client's capacity, as determined by the AC Act 2001, to engage in work for which they are suited by reason of their experience, education or training, or any combination of those things, and to do so for 30 hours or more a week.
Vocational rehabilitation	Vocational rehabilitation helps a client to maintain or obtain employment, or regain or acquire vocational independence. When helping to guide a client, the employment in question must be suitable for them in terms of their capacity to function, and appropriate for their levels of training and experience. Assessors are also encouraged to take the client's previous earning level into account.

Term	Meaning
Weekly compensation	This entitlement compensates a client for loss of earnings, or loss of potential earning capacity. A spouse, partner or dependant of a deceased client may also be entitled to weekly compensation.
work-related gradual process, disease or infection	There are three key criteria for establishing cover for a personal injury caused by work-related gradual process, disease or infection. 1. The person's employment tasks or employment environment must have a particular property or characteristic that caused or contributed to the cause of the personal injury. 2. The person's non-work activities or environment must not hold that same property or characteristic to any material extent. 3. There must be a greater risk of sustaining this type of personal injury for people who do this particular employment task or work in that environment, than for people who do not. Any condition must meet all the criteria of the AC Act 2001, although some occupational diseases are listed in Schedule 2 of the Act and have a simplified cover process.

10. Consultation/Visit and procedure costs and codes

Guide to invoicing for medical practitioners and nurses

Scope of this guide

This is a guide to invoicing under the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

The guide should be read in conjunction with the ACC1520 Medical Practitioners' and nurses' costs 2014.

Section 8 of this Handbook also has detailed information about invoicing under the Regulations.

What a consultation/ visit covers

You can invoice ACC for a consultation/visit, which is defined as including:

- a face to face examination and/or assessment
- a necessary and appropriate service or treatment, performed by a provider, for an injury or condition covered by ACC
- any claim-related advice, prescription or referral, and the issue of certificates as appropriate following the consultation/visit
- managing conditions, including providing a small range of minor treatments/procedures, such as:
  1. removing sutures
  2. removing a non-embedded foreign body from eye, mouth, auditory canal or other site (excluding rectum or vagina) without incision
  3. re-dressing wounds that don't require significant dressings
  4. performing a plaster check
  5. removing casts/splinting
  6. removing packing of nose, or packed abscesses or haematomas
  7. cleaning and minor dressings (eg small gauze or non-stick dressings) to small burns or abrasions
  8. cleaning and minor dressings (eg plaster strips) to small, open wounds
  9. managing minor sprains that don' involve significant splinting
  10. completing clinical records.

What a consultation/ visit does not include

A consultation/visit does not include:

- telephone consultations (except for a one-off phone counselling session if required)
- medical services where no substantial service is given by the provider and for which the patient would not reasonably be expected to pay.

All invoices for procedures, regardless of the number claimed, must be clinically justifiable.

Understanding procedure codes

The procedure codes start with two letters:

- the first letter is M which stands for ‘Management of’
- the second letter is phonetic and covers the procedure code topic (e.g. B for burns and D for dislocations).

The two letters are followed by a number that defines a sub-category within the code.

Summary of procedure codes

This table summarises the procedure codes, the injuries to which they refer and the recommended maximum treatments per injury.

Procedure code	Injury type	Recommended maximum treatments claimed per injury	Page reference
MB#	Burns and abrasions	4	121-122
MD#	Dislocations	1	123-124
MF#	Fractures	1 (except MF7, MF9 – MF12 = 3)	125-130
MM#	Miscellaneous	1	131-133
MW#	Open Wounds	1	134-135
MT#	Soft tissue injuries	1 (except MT3 = 2, and MT5 = 3)	136-138

Burns and abrasions

General invoicing criteria

Practitioners can invoice for treating burns and abrasions under the following eligibility criteria.

Eligible – all MB codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- treating significant skin damage
- cleaning and debriding wound(s)
- managing significant wound dressings
- providing a significant amount of practitioner time
- providing post-injury advice and patient education.

Not eligible – all MB codes

Services that are not eligible for invoicing include:

- treating trivial and superficial burns or abrasions, at a first or subsequent consultation/visit, and applying only a simple gauze or similar dressing. This is covered as part of a consultation/visit
- follow-up consultations/visits involving dressing removal, or re-dressing where significant dressings are not used, wound inspection, and recommendations about infection control. These are covered as part of a consultation/visit.

Invoicing criteria for each MB code

MB1 - Treatment of burns less than 4cm^2 (, eg 2cm x 2cm)	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB2 - Treatment of burns greater than 4cm^2 at a single site	
Included	See Eligible – all MB codes. Note: Claims in this category are usually few.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB3 - Treatment of significant abrasions less than 4cm2 at a single site	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB4 - Treatment of significant abrasions greater than 4cm^2 at a single site	

Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB5 - Significant burns or abrasions (not including fractures) at multiple sites (greater than 4cm^2), necessary wound cleaning, preparation, and dressing	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes. Note: If there are multiple wounds, but only one needs significant time or dressing, only one claim would be made for the significant wound under MB2 or MB4.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
This section should be read in conjunction with the ACC2136 MB and MW Codes. **Note:** To access the ACC2136 you can click on the link above or go to the ACC website and select For Providers > Publications, and click on either 'General practitioner resources' or 'Burns and scar management'.	

Dislocations

General invoicing criteria

Practitioners can invoice for treating confirmed dislocations on any of the five listed joints, under the following eligibility criteria.

Note: There must be evidence of significant joint dysfunction (major effusion or haemarthrosis and/or ligament laxity).

Eligible – all MD codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- referral for, review of and action on, an X-ray (if necessary)
- use of appropriate anaesthetic technique (including local, intravenous, or regional anaesthesia, or mild central sedation)
- treating significant subluxation
- providing post-injury advice and patient education
- management using best-practice splinting techniques, which may include providing a plaster cast. See also ACC579 Treatment profiles 2001 and ACC2373 Practical Techniques in Injury Management. The ACC2373 isn't available online but can be obtained through your local Supplier Manager.

Not eligible – all MD codes

Services that are not eligible for invoicing include:

- minor joint trauma, including minor sprains not involving confirmed dislocations or significant subluxation, and where there is no evidence of serious subsequent joint dysfunction. These are covered as part of a consultation/visit or by a soft tissue injury procedure, whichever fits best
- possible dislocations to joints not covered under the following five codes (MD1–5). In that case a 'nearest equivalent' treatment or procedure will be considered. However, a soft tissue injury procedure may be appropriate
- treatment, including temporary splinting, before referral to a specialist centre. This is covered under a soft tissue injury procedure
- follow-up assessments, including removal of splinting. These are covered as part of a consultation/visit
- treatment of injury that does not require the use of best-practice splinting with significant dressing cost. This is covered as part of a consultation/visit.

Invoicing criteria for each MD code

MD1 - Dislocation of finger or toe, with splint or strapping	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.

Procedures per injury	Recommend: one procedure claim per injury.
MD2 - Dislocation of thumb, closed reduction and immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD3 - Dislocation of elbow with radiological confirmation, closed reduction and immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD4 - Dislocation of shoulder, closed reduction and collar and cuff immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD5 - Dislocation of patella, closed reduction and cast immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.

Fractures

General invoicing criteria

Practitioners can invoice for treating diagnosed fractures under the following eligibility criteria. If there is no diagnosis of a fracture, a soft tissue injury code (MT) may be appropriate.

Note: Each service code includes tasks that can and can't be invoiced for, on top of the general invoicing eligibility criteria below that cover all codes.

Eligible – all MF codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- X-ray confirmation (or clinical certainty) of a fracture
- applying best-practice soft tissue splinting, or plaster cast immobilisation, for more than three weeks
- providing post-injury advice and patient education
- management that may include (where clinically appropriate):
    - the use of appropriate anaesthesia
    - fracture reduction.

Not eligible – all MF codes

Services that are not eligible for invoicing include:

- undisplaced simple fractures that do not need plaster cast immobilisation. These are covered as part of a simple soft tissue injury procedure
- plaster checks and removal. These are covered as part of a consultation/visit
- treatment, including providing temporary splinting before referral to a specialist centre. This is covered as part of a soft tissue injury procedure.

For fractures that aren't covered under these specific procedure codes, and where best practice would suggest a plaster cast, a 'nearest equivalent' procedure will be considered. In other cases, a soft tissue injury procedure may be appropriate. See also ACC579 Treatment profiles 2001 and ACC2373 Practical Techniques in Injury Management (available through your local Supplier Manager).

Invoicing criteria for each MF code

MF1 - Fractured finger or toe (proximal, middle or distal phalanx), closed reduction and immobilisation	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of a consultation/visit as they do not require the same degree of assessment or significant new splinting.

	See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF2 - Fractured finger or toe (proximal, middle or distal phalanx), requiring digital anaesthetic	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of a consultation/visit as they do not require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF3 - Fractured metatarsal: closed reduction (not requiring cast), closed reduction, immobilisation by strapping	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of a consultation/visit as they do not require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF4 - Fractured metacarpal(s) hand: with or without local anaesthetic, immobilisation by strapping	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of a consultation/visit as they do not require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF5 - Fractured carpal bone, including scaphoid: treatment by cast immobilisation, not requiring reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also

	eligible under this code.
Excluded	If a new plaster cast is not required, invoice for a soft tissue injury procedure if it involves significant best-practice soft tissue strapping or splinting. If it does not, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF6 - Fractured tarsal or metatarsal bones (excluding calcaneum or talus): treatment by cast immobilisation	
Included	See Eligible – all MF codes.
Excluded	If injury needs significant best-practice soft tissue splinting (rather than a plaster cast), invoice for a soft tissue injury procedure. If it does not, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF7 - Fractured calcaneum or talus: treatment by cast immobilisation	
Included	See Eligible – all MF codes.
Excluded	If injury needs significant best-practice soft tissue splinting (rather than a plaster cast), invoice for a soft tissue injury procedure. If it does not, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF8 - Fractured clavicle	
Included	See Eligible – all MF codes.
Excluded	These follow-up treatments are usually covered as part of a consultation/visit as they do not need the same degree of assessment, or any new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF9 - Fractured distal radius and ulna: cast immobilisation not requiring reduction	

Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF10 - Fractured distal radius and ulna requiring closed reduction, involving regional or other form of anaesthesia	
Included	See Eligible – all MF codes. Must involve use of appropriate anaesthetic (intra-fracture, arm block, and/or intravenous sedation)
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. Follow-up visits involving reapplying a plaster cast. These are invoiced under MF9. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF11 - Fractured shaft radius and ulna: treatment by cast immobilisation	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF12 - Fractured distal humerus (supracondylar or condylar): by cast immobilisation	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also

	eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. See also, Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF13 - Fractured proximal or shaft humerus: immobilisation by collar and cuff or U-slab	
Included	See Eligible – all MF codes. Involves immobilisation by collar and cuff, or U-slab.
Excluded	Follow-up visits involving fracture checks or removal of splinting. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF14 - Fractured shaft tibia and/or fibula: treatment by cast immobilisation with reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF15 - Fractured distal tibia and/or fibula: treatment by cast immobilisation with reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.

Procedures per injury	Recommend: three procedure claims per injury.
MF16 - Fractured fibula (without tibial fracture): immobilisation with soft tissue splinting, strapping, or cast	
Included	See Eligible – all MF codes. Covers either best-practice soft tissue splinting or strapping, or plaster cast, if appropriate. Follow-up treatments that involve reapplying appropriate splinting, strapping or plaster cast are also eligible under this code.
Excluded	Follow-up visits involving fracture checks or removal of splinting. These are covered as part of a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.

Miscellaneous

Invoicing criteria for each MM code

MM1 - Abscess or haematoma: drainage with incision (with or without local anaesthetic agent)	
Included	Incision and drainage of abscess or haematoma must involve a significant opening of lesion, drainage, and packing of cavity.
Excluded	Simple needle aspiration without packing wound. This is covered as part of a consultation/visit. Wound check. Re-packing cavity. Removal of dressings.
Procedures per injury	Recommend: one procedure claim per injury.
MM2 - Insertion of IV line to administer medications, electrolytes, or transfusions	
Included	Insertion of an IV cannula and administration of IV fluids or antibiotic infusion. This includes repeat infusions over a 24-hour period. Note: This must be provided under a local or national guideline approved by ACC.
Excluded	Administration of medication into an existing IV cannula. These are covered as part of a consultation/visit.
Procedures per injury	Recommend: one procedure claim per 24 hours. Normally no more than three IV insertions would be required.
MM3 – Nail: simple removal of	
Included	Removal of an adherent nail and significant dressing of the wound.
Excluded	Removal of non-adherent nail with wounds not requiring significant dressing.
Procedures per injury	Recommend: one procedure claim per injury.
MM4 – Nail: removal of or wedge resection, requiring the use of digital anaesthesia	
Included	Use of a digital anaesthesia, excision of wedge or whole nail, cauterisation of wound (if necessary) and the dressing of a nail bed with significant dressings.

Excluded	Simple nail removal. Wound checks. These are covered as part of a consultation/visit.
Procedures per injury	Recommend: one procedure claim per injury.
MM5 - Removal of embedded or impacted foreign body from cornea or conjunctiva (with use of topical anaesthetic), or from auditory canal or nasal passages, or from skin or subcutaneous tissue with incision, or from rectum or vagina	
Included	Foreign body that is impacted or embedded and requires active removal.
Excluded	Simple flushing or syringing, or removal using forceps or similar instrument without use of anaesthetic or incision. These are covered as part of a consultation/visit. Fluoroscein check of cornea/conjunctiva without removing embedded foreign body. These are covered as part of a consultation/visit.
Procedures per injury	Recommend: one procedure claim per injury.
MM6 - Pinch skin graft	
Included	Application of skin removed from separate site to cover open wound. Involves the dressing of donor and graft sites.
Excluded	Follow-up checks, and re-dressing. These are covered as part of a consultation/visit, unless the injury requires significant dressing, in which case it can be invoiced for.
Procedures per injury	Recommend: one procedure claim per injury.
MM7 - Dental anaesthetic	
Included	Insertion of dental local anaesthetic using best-practice dental treatments and procedures.
Excluded	Application of topical, oral or IV anaesthetic.
Procedures per injury	Recommend: one procedure claim per injury.
MM8 - Epistaxis: arrest during episode by nasal cavity packing with or without cautery	
Included	Application of first-aid measures, packing of nasal cavity using ribbon gauze and best-practice ear nose and throat treatments and procedures, and advice given to the client after treatment or

	procedure.
Excluded	Simple first-aid epistaxis measures or simple cautery of nostril. This is covered as part of a consultation/visit. Removing the packing.
Procedures per injury	Recommend: one procedure claim per injury.

Open wounds

General invoicing criteria

Eligible – all MW codes

You can invoice for treating open wounds under the following eligibility criteria, if the wound has significant full-thickness skin damage.

Note: Each service code includes tasks that can and can't be invoiced for, on top of the general invoicing eligibility criteria below that cover all codes.

Services that are eligible for invoicing include:

- assessment
- providing initial care, advice, and patient/caregiver education
- cleaning and debriding wound(s)
- closing wounds by active apposition of wound edges using appropriate wound closure materials, including wound closure strips, surgical glue or equivalent adhesive and suture materials
- management by appropriate wound dressings
- providing post-injury advice and patient education.

Not eligible – all MW codes

Services that are not eligible for invoicing include:

- treatment of trivial and superficial open wounds, at a first or subsequent consultation/visit, that need no more than a minor clean, and no more than a simple gauze, plaster strip or similar dressing. This is covered as part of a consultation/visit
- follow-up consultations/visits involving wound inspection, recommendations about infection control, dressing removal, or where re-dressings are not significant. These are covered as part of a consultation/visit.

Invoicing criteria for each MW code

The general invoicing criteria cover all MW codes, but each code may have additional inclusions and exclusions. The details below show what can and can't be invoiced for under each code. MW codes are for procedures that occur within 7 days of the initial injury.

MW1 - Closure of open wounds less than 2cm	
Included	Any necessary care and treatment, including cleaning, and debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.
Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW2 - Closure of open wound(s) of skin and subcutaneous tissue or mucous membrane 2cm to 7cm long	
Included	Any necessary care and treatment including cleaning, and debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.
Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW3 - Closure of open wound(s) of skin and subcutaneous tissue or mucous membrane greater than 7cm long	
Included	Any necessary care and treatment including cleaning, and debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.
Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW4 - Amputation of digit: including use of anaesthetic, debridement of bone and soft tissue, closure of wound	
Included	Removal of the whole or part of a digit, requiring use of a local anaesthetic, active excision and debridement of wound, attempted stump closure using flap or equivalent technique, and appropriate dressing of wound. See also Eligible – all MW codes.
Excluded	Follow-up wound checks. Removal of dressings. See also Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.

This section should be read in conjunction with the ACC2136 MB and MW Codes.

Soft tissue injuries

General invoicing criteria

You can invoice for sprains or soft tissue injuries that need compression or other best-practice splinting.

Note: Each service code includes tasks that can and can't be invoiced for, on top of the general invoicing eligibility criteria below that cover all codes.

Eligible – all MT codes

Services that are eligible for invoicing include:

- assessment
- providing initial care, advice, and patient education
- referral for and review of x-ray (if necessary)
- management by best-practice splinting (this may include providing a plaster cast)
- providing post-injury advice and patient education.

Not eligible – all MT codes

Services that are not eligible for invoicing include:

- minor soft tissue trauma, involving use of initial care and advice (such as rest, ice, compression and elevation (RICE), and not requiring application of simple wound compression which is covered as part of a consultation/visit.

Invoicing criteria for each MT code

The general invoicing criteria cover all MT codes, but each code may have additional inclusions and exclusions. The details below show what can and can't be invoiced for under each code

MT1 - Significant soft tissue injuries: managing simple sprain of wrist/ankle/knee/elbow/or other soft tissue injury requiring crepe bandage or similar immobilisation not requiring formal strapping	
Included	Splinting or compression dressings. Management of dislocations, subluxations and minor fractures that do not need plaster cast immobilisation. See also Eligible – all MT codes.
Excluded	See Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT2 - Soft tissue injury (other than splinting of dislocated or fractured digit), unless specified elsewhere	

Included	Limited best-practice application of plaster cast, padded splint or specific strapping to significant soft tissue injury (such as strained or ruptured Achilles tendon or serious ankle sprain) which needs more than three weeks immobilisation. See also Eligible – all MT codes.
Excluded	Soft tissue injuries requiring less than three weeks splinting or compression. These are invoiced under MT1. See also Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT3 - Aspiration of inflamed joint, tendon, bursa, or other subcutaneous tissue or space (with or without injection)	
Included	Significant soft tissue inflammation requiring either aspiration or injection of steroid, or both. See also Eligible – all MT codes.
Excluded	See Not eligible – all MT codes.
Procedures per injury	Recommend: two procedure claims per injury.
MT4 - Extensor tendon, primary repair	
Included	Primary repair of significantly damaged extensor tendon, requiring use of local anaesthetic and surgical repair using best-practice techniques. Dressing of wound, splinting of limb or digit, and providing post-operative advice. See also Eligible – all MT codes.
Excluded	Follow-up checks, including removal of dressings. These are covered as part of a consultation/visit. See also Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT5 - Ruptured tendon Achilles: management by plaster immobilisation	
Included	Rupture of Achilles tendon requiring plaster cast immobilisation for more than three weeks. Repeat applications of plaster cast. See also Eligible – all MT codes.
Excluded	Soft tissue splinting of strained or ruptured Achilles tendon for more than three weeks. These are invoiced under MT2. Soft tissue splinting or other care to strained Achilles tendon. These are invoiced under MT1.

	Follow-up checks, removal of plaster cast without re-applying the cast. See also Not eligible – all MT codes.
Procedures per injury	Recommend: three procedure claims per injury.