PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

ACC Treatment Provider Handbook 2011

This is a living document and will be updated as required

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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, please see the applicable legislation and regulations.

Section 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 make a swift 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 provider 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.

If you're not familiar with any of the terms used in the Handbook, please refer to the Glossary (p105).

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

Ralph Stewart
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

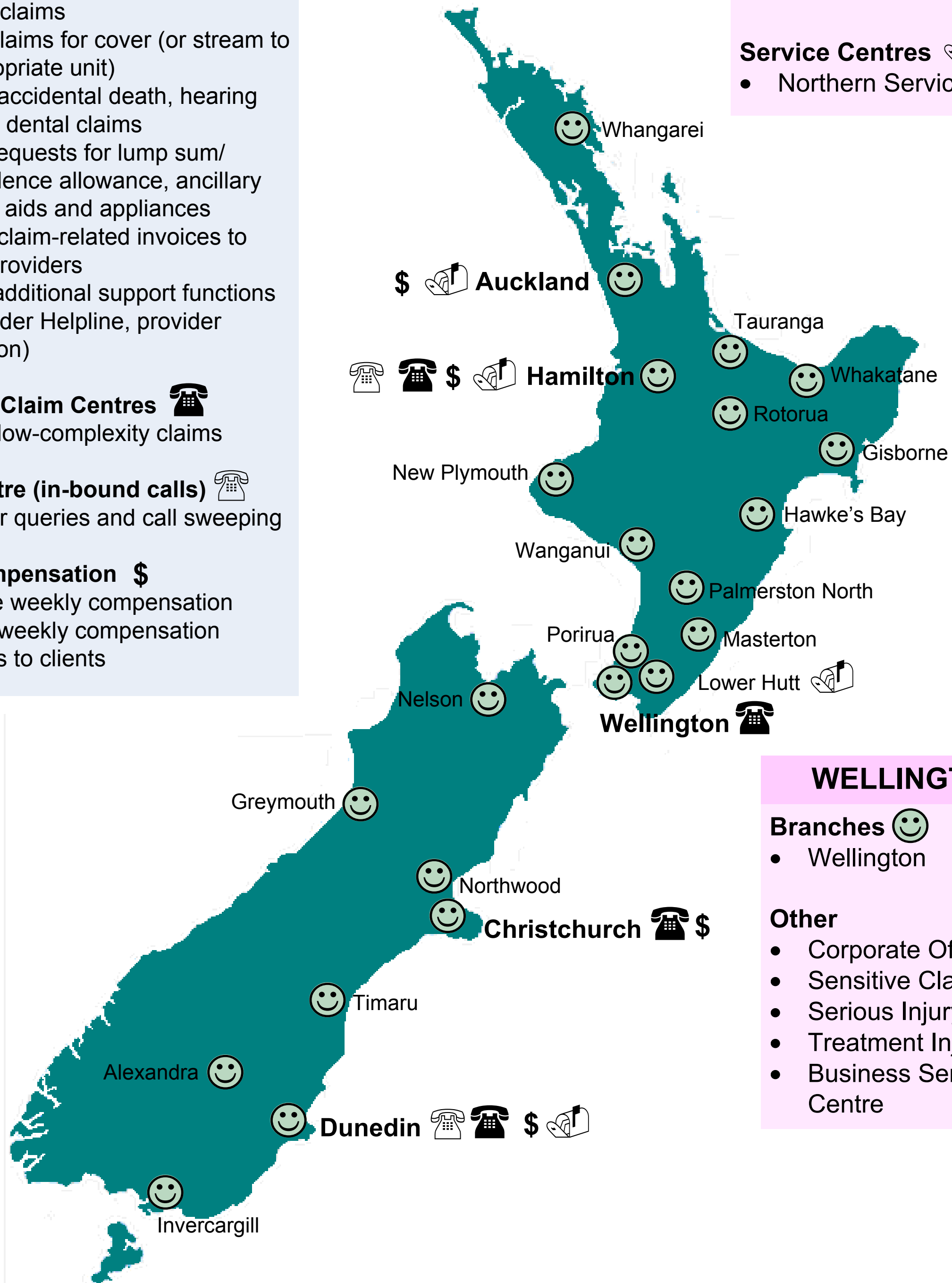
Inquiry Centre (in-bound calls)
- Customer queries and call sweeping

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



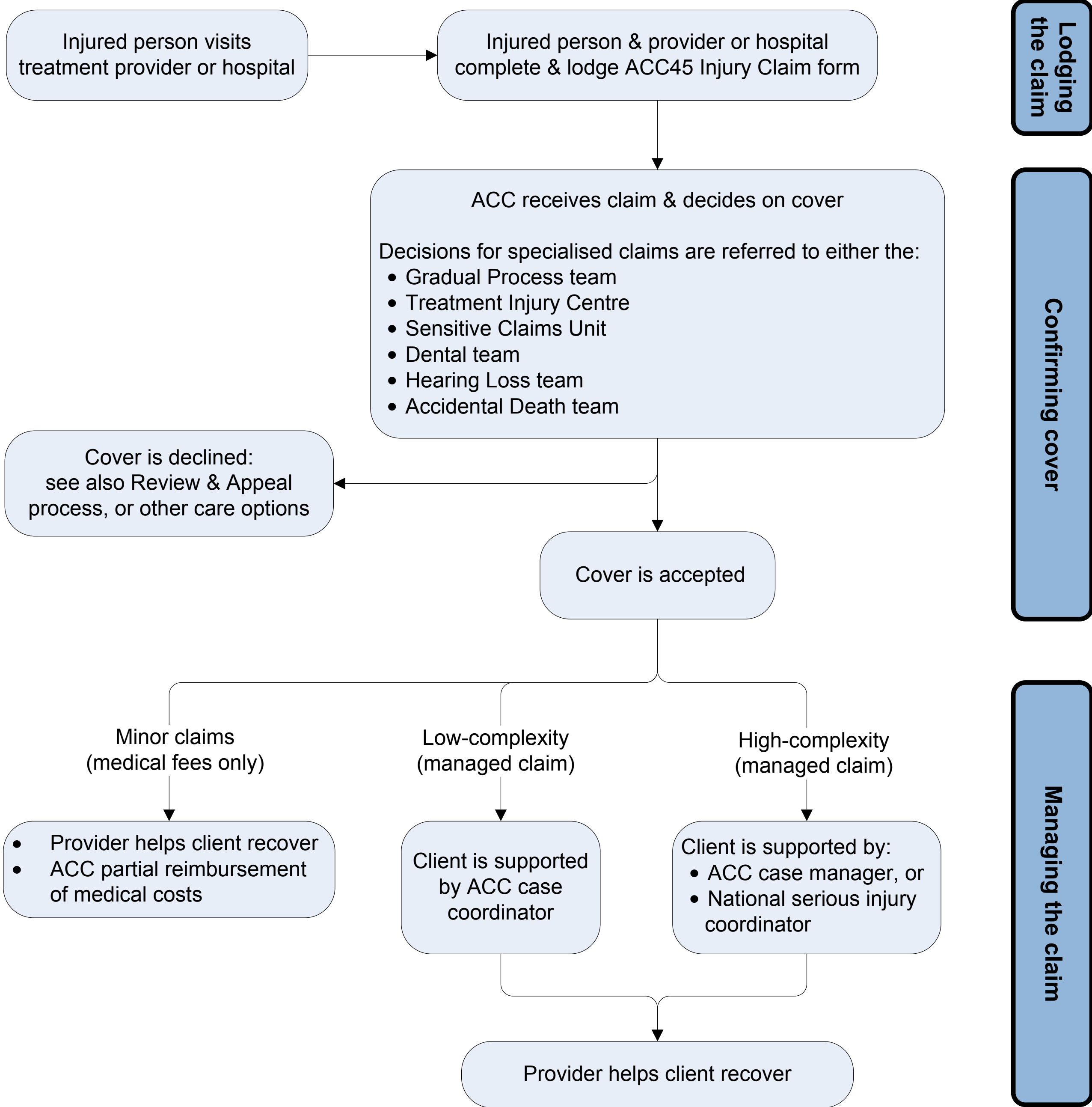
WELLINGTON

Branches
- Wellington

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

1

How ACC cover works at a glance



Scope of entitlements

Rehabilitation and/or treatment can include:

- acute treatment • Public Health Acute Services • elective surgery
- pharmaceuticals • imaging • transport • weekly compensation
- home-based rehabilitation • house or vehicle modifications
- rehabilitation programmes (eg Stay at Work, social rehabilitation)

ACC may review ongoing cover and/or entitlements at any time

1

Key ACC contacts for treatment providers

Provider Helpline	Ph: 0800 222 070	Email: xxxxxxxxxxxx@xxx.xx.xx
Client/Patient helpline	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: registxxxxxxx@xxx.xx.xx Post: ACC, PO Box 30 823 Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994 option 1	Email: xxxxxxxxxxxxx@xxx.xx.xx
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	Fax: 09 354 8301
	For New Plymouth, Gisborne and all areas south Post to: ACC Dunedin Service Centre, PO Box 408, Dunedin 9054	Fax: 0800 222 463
Stationery Order Line (forms and brochures)	Ph: 0800 802 444	
Dental Stationary	Ph: 0800 226 440	
Sensitive claims (sexual abuse) -------------------- **Treatment injury**	Ph: 0800 735 566	
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:

Section 2 – Partnership: ACC explained

2

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 accidents 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 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.

The Glossary (p105) outlines the terms we use in our policies and procedures for claims, providers and treatment.

Note: This Handbook is intended to assist you to operate within the scheme by summarising the effect of the key provisions of the legislation and regulations. As such the full provisions are not set out here. For all legal purposes the legislation and the regulations apply and you need to refer to them in the case of any doubt.

ACC's governing legislation

The AC Act 2001 is ACC's governing legislation. It requires us to be satisfied that all clients are eligible for treatment costs, and that treatment delivered is 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 provider 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

To maintain strong relationships, ACC ensures that wherever possible our requirements of providers (as stated in the law or regulations) are tightly linked to professional standards set by practitioner bodies. We also align with 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 people and their families in an extended partnership with treatment providers, other health sector professionals, employers and supporting groups.

Many providers have only occasional contact with patients who become ACC clients, but others may work with us almost daily. This Handbook explains your connections with ACC, particularly the formal arrangements such as policies, processes and tools.

As a health services provider seeking funding to treat clients with ACC covered injuries, you are responsible for:

- providing them with the best care
- thinking creatively about how they can best be helped to return to work or independence
- knowing about and following best practice, including treatment profiles
- complying with the AC Act 2001, our policies and procedures, and your professional standards when treating and making claims for ACC clients
- maintaining appropriate clinical records.

We encourage you to get to know us and to feel free to make personal contact with us locally, eg through your local Relationship & Performance Manager, or your local branch.

Relationship & Performance Managers – key contacts

Relationship & Performance Managers work in the community with contracted providers and treatment providers, including general practice staff and district health boards (DHBs). Their contact numbers for the location you work in are on the Relationship & Performance Managers map (p8).

We liaise with New Zealand’s professional associations and bodies, registration boards, and DHBs in many ways.

Relationship & Performance Managers on the map

For detailed Relationship & Performance Manager information see Relationship & Performance Managers Contact Details

What ACC covers

Treatment cover

ACC receives about 1.8 million claims a year for personal injuries and mental injuries. See also, Rehabilitation and treatment entitlements (p15) and the full Treatment cover section (p45).

The most common injuries that ACC covers 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
- pharmaceuticals.

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 contact us through the Client/Patient helpline on **0800 101 966** or by emailing xxxxxx@xxx.xx.xx

Personal injuries

Personal injuries encompass:

- 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, eg:
  - asbestosis
  - work-related hearing loss

- treatment injuries, ie physical injuries sustained unexpectedly while having 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's mental injury is accepted as resulting from their physical injury, it is not treated as a new claim but is added to the existing physical injury claim.

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 (p105).

Mental injury is a complex area of cover determination. Decisions are made in each case on the basis of diagnosis and evidence provided by a psychiatrist or psychologist. Their reports need to prove that the physical injury or 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 (p56).

What ACC doesn't cover

ACC does not cover:

- injuries to teeth arising from their natural use (eg 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
- hernias from coughing or sneezing.

Disentitlements

In some cases a person's injury will be covered, but we can't provide entitlements, eg in some instances of self harm (see the Glossary p105). If you have a claim of this nature, please contact the client/patient helpline as soon as possible by phone on **0800 101 996**.

Who ACC covers

Three categories of people covered

ACC covers:

- 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 Clients' Rights

All ACC claims are managed under the Code of ACC Clients' 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. The Code itself (p6) tells clients how ACC must treat them.

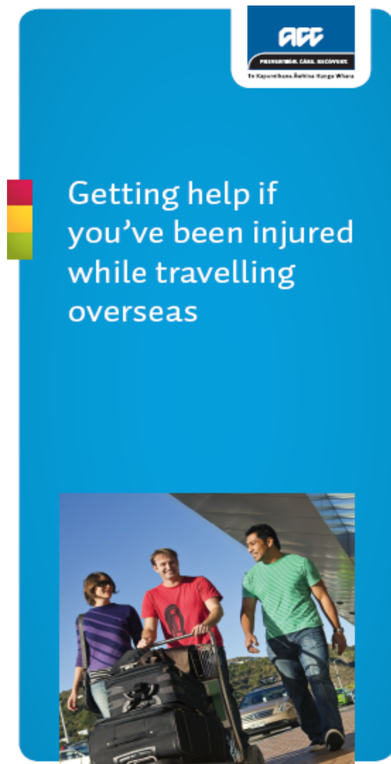
For more information see Code of Clients' Rights: respect, culture, and values (p13).

Cover for Kiwis injured overseas

New Zealanders may also be covered for some types of rehabilitation and entitlement in New Zealand if they have been injured overseas, as long as they meet ACC's 'ordinarily resident' criteria (see the Glossary p105).

Only New Zealanders suffering work-related personal injuries overseas can receive payment for overseas treatment. Also, ACC does not reimburse New Zealand providers for treatment given overseas (eg when accompanying sports tours) as if they are operating under the ACC scheme 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 Stationary Order Line on **0800 802 444**, option 0, and quoting the ACC number in the title (eg ACC593).



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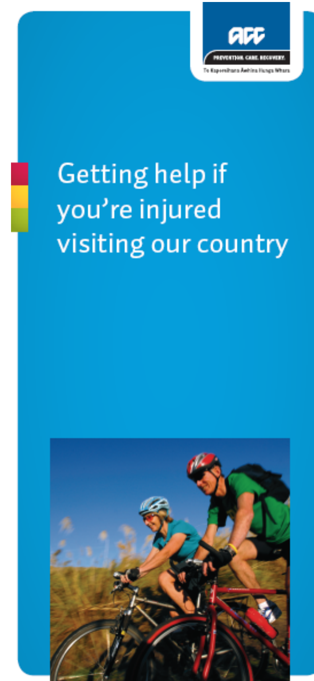
Cover for visitors to New Zealand

Visitors to New Zealand are covered for personal injuries and ACC can help pay for treatment in this country if the claims are accepted. However, we can't 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 Stationary Order Line on **0800 802 444**, option 0, and quoting the ACC number in the title.

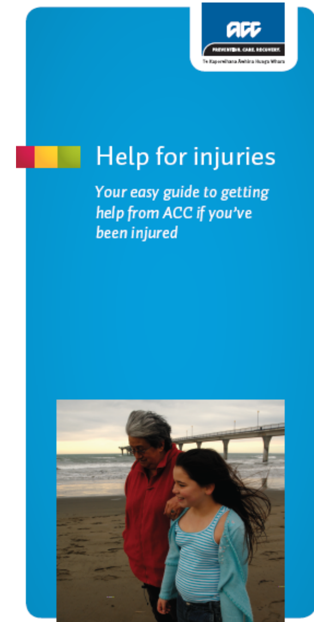
The brochure is also available in Māori, Samoan, Tongan, Cook Island Māori, Chinese, Hindi and Korean. You can select the brochure in the language you want at the ACC website under For Providers > Publications > In your language.



Cover for Kiwis in New Zealand

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

You can order this online or by phoning the Stationary 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 emphasis

The Cultural Services team

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

Code of Clients' Rights: respect, culture and values

All ACC claims are managed under the Code of ACC Clients' Rights. These 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. The Code itself (p6) tells clients how ACC must treat them.

You can order free copies online or by calling the Stationary Order Line on **0800 802 444**, option 0, and quoting the ACC number in the 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 clients' rights.

Māori cultural guidelines

The ACC booklet ACC1625 Guidelines on Māori 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 also order free copies online or via the Provider Helpline on **0800 222 070**, or by phoning the Stationary Order Line on **0800 802 444**, option 0, and quoting the ACC number in the 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.

2

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. For example, in the year ended 30 June 2009 the number of new claims registered for Māori males per month per 1,000 population was 25.5 compared with an average for all New Zealanders of 33.1. Similarly, the number of Māori female new claims registered per month per 1,000 population was 16.7 compared with an average for all New Zealanders of 28.0.

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

We're particularly interested in working with providers (Māori or otherwise) who are well attuned to working with Māori and can demonstrate this. Please let us know if you identify yourself as a Māori provider, whether as an individual or as an organisation.

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 Registrations 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

2

Managing rehabilitation

Rehabilitation is a crucial way that ACC helps people to return to everyday life. This can be by getting back to work or regaining their independence in daily activities.

Our staff involve appropriate treatment providers and access other providers as necessary. 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 health, independence and participation in society as much as possible.

For more information on rehabilitation please see Section7 - 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:

- treatment providers for consultations with and procedures for clients, 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 (p19).
- treatment services such as elective surgery and hand therapy, under contract
- pharmaceuticals prescribed for ACC-covered injuries (see also Pharmaceuticals p62)
- 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 treatment providers 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 clients are entitled to

ACC clients can receive a range of entitlements for rehabilitation and compensation. The entitlements are specified in the AC Act 2001, which forms the legislative base for most of our activities.

They include:

- 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 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 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 (eg a nurse, occupational therapist, physiotherapist) to complete the certificate.

For more information see Medical Certificates, ACC18 (p72).

Lump sum compensation

Lump sum compensation is generally available for clients who have permanent impairments from their injuries.

Several types of claim have specific rules for compensation. 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.

2

Social rehabilitation

Social rehabilitation aims to restore clients' functional independence when injuries have had significant impacts on their lives. It's provided through entitlements such as:

- aids and appliances, eg wheelchairs and walking frames
- home help, child care, education support and attendant care
- modifications to the home or vehicle
- 'Training for Independence' programmes
- community nursing.

For details on social rehabilitation, see Social rehabilitation assessment

Vocational rehabilitation

Vocational rehabilitation aims to help clients recovering from significant injuries to maintain or obtain work, or regain or acquire vocational independence. Where possible, it's best for clients to stay in their pre-injury jobs. Together with 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 (p67).

In some cases clients take part in employment maintenance 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.

ACC has 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.

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 their rehabilitation has 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 rehabilitation is necessary.

For details on vocational rehabilitation see Work and rehabilitation (p66).

Accidental death – help for survivors

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

- a funeral grant (to the maximum amount set by regulations)
- survivors' grant (for the surviving spouse, children and other dependants)
- weekly compensation for the dependants of the deceased person if the client was an earner (the surviving spouse can apply to convert this into a lump sum)
- child care payments 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 (p45), the DHB provides their ancillary services.

Helping clients to understand their entitlements

Our clients often expect their treatment providers to know about entitlements and to be able to explain how ACC works. The brochure ACC2399 Getting help after an injury lists entitlements in its 'How we can help' section. You can order free copies by phoning the Stationary 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' they can click to 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 xxxxxxxxxxxx@xxx.xx.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 (p81) and Electronic invoicing: eSchedules (p100).

According to the AC Act 2001, 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

As a provider seeking payment from ACC for services or treatment, your major responsibilities are to ensure that:

- the service you provide and invoice us for includes clinical records that meet our recommendations and your profession's standard
- your clinical records demonstrate that your treatment meets the legislative requirements (listed above)
- the treatment provided and your clinical records can withstand scrutiny through peer review, an audit (medical or financial) or a medico-legal challenge
- your appointment book or appointment record is consistent with the invoice dates and the dates shown on your clinical notes.

'Generally' no payment for providers who treat themselves or their family members

The view of ACC, the New Zealand Medical Association (NZMA) and the Medical Council of New Zealand is that it is not good clinical practice for their members to treat themselves or their close family members. This applies to all types of treatment provider.

We generally consider it unacceptable and unethical for providers to claim payment from external funders for treating close family. We will only consider paying for treatment provided to family members or yourself 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 will not fund:

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

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 and refers to common Read Codes to show injuries for which:

- a provider can give initial treatment and complete an ACC45 Injury Claim form, which we can use to make a cover decision
- a provider can give initial treatment and complete an ACC45 form, but must then refer the client to a medical practitioner before we'll determine cover. This means the patient will see two providers before their claim is considered.

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 (p40).

2

ACC's rules for funding providers in training

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

We will only fund treatment given by a provider in training (eg an intern, or a university or polytechnic student undertaking practical work for their study) if they are:

- 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 pay providers

ACC pays for providers' services under the costs specified by:

- service contracts
- agreements between ACC and the providers based on the treatment costs
- regulations, ie the:
  - IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003
  - IPRC (Ancillary Services) Regulations 2002
  - any later amendments ('the Regulations').

Payments under 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

If an ACC case manager requests services at an agreed cost, make sure you obtain a seven digit purchase order number from us. You must include this purchase order number when you invoice the requesting unit. For more information, phone the Provider Helpline on **0800 222 070** or email xxxxxxxxxxxx@xxx.xx.nz

Payments under Regulations

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 the provider examined, assessed and/or treated the client in person, for an injury or condition covered by ACC (for details see, Consultations/Visits p84).
- 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

The providers that ACC calls 'Specified Treatment Providers' (or 'Allied Providers') have a choice when working under the Regulations 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 (p92).

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 (p119).

How to find Regulations online

To view the Regulations online go to www.legislation.govt.nz and from the middle panel:

- select 'Regulations' next to 'Browse'
- select the letter 'I' from the dropdown menu under 'Title' and click 'Browse now'
- scroll down to find Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Note: Finding other legislation has the same steps, except that from the middle panel you select the 'browse' link next to, eg 'Acts'. You can then select, eg 'A' and scroll for the AC Act 2001, or 'H' and scroll for the HPCA Act.

Section 3 – Supporting quality

Resources for providers and clients

3

Resources for providers – best practice clinical resources

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 providers to compare their own practices on selected health issues with those of their 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 our work to support performance excellence. They are for both individual treatment providers and those who employ teams of providers.

  The reports summarise contract holders' clinical practices and in some cases compare them with peer or overall sector data. They aim to give contract holders a valuable opportunity to self-evaluate and consider their decision-making approaches for ACC clients. The reports are not designed for monitoring provider practice

- **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 health practitioners, 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 following leaflet series:

- **'Caring for your**…'

  This easy-to-understand information gives clients clinical tips on looking after their injuries.

- **'Knowing about your**…'

  These easy-to-understand brochures give clients profiles and rehabilitation details for specific injuries. They have simple anatomical illustrations and universally safe exercises that can be done at home.

The leaflets are available in tear-off pad form. To order printed copies, phone the Stationery Order Line on **0800 802 444**, option 0.

Research

Research involvement

ACC invests in ongoing research as part of our commitment to securing 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 us on which treatments, products and services we 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), information about the Research team, and details of current projects.

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 your 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 (p27).

Requesting your clinical records

People wanting to lodge claims for injuries can have complex or confusing presentations. 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.

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 your 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:

- if your practice undergoes one of our periodic audits
- by other agencies for other reasons, such as an adverse patient outcome or patient complaint
- for certain services invoiced for to ensure they are clinically justified (in this instance we do not cover the cost of you supplying us with the clinical records)
- by other treatment providers (you'll need patient consent for this)
- by your patients, and you should know how they can access them.

What we recommend for all clinical records

Because they're so important, we recommend that your clinical records for each patient:

- provide 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 rather than pencil
- record any tests or communication that influenced your diagnosis or treatment
- record any prescribed medications the patient is taking
- clearly show that you conducted each consultation/visit with skill and care
- 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
- can 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 don't:

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

Our recommendations for the initial consultations/ visits

- Detail the accident, how it occurred, and any mechanisms.
- Detail the injury's symptoms and its clinical significance.
- Record the reason for the presentation, or the main reason if the consultation/visit involves more than one condition.
- Record the history and examination findings, including important negatives.
- Record any relevant past history.
- Record any initial advice you've given the patient, eg about work fitness or injury-related restrictions.

Our recommendations for follow-up consultations/ visits

- Keep details of the patients' progress towards their rehabilitation goals.
- Demonstrate that your treatment meets the legislative requirements.
- Evaluate the effectiveness of previous treatment.
- Detail new aspects of history and examination, and the results of any new tests or investigations.
- Detail any restated or revised diagnosis.
- Record any subsequent advice given to the patient.
- Detail the reason for any change to an earlier treatment plan.
- Show progress towards the outcome.
- Provide an outcome report, where required.

Peer reviews

To ensure that we have the best possible information, we may sometimes approach colleagues in your clinical area for peer review. They will are usually be nominated by your professional body. Such reviews are coordinated by ACC staff with advice from medical advisors.

Audits, fraud control and monitoring

How a practice audit works

ACC's Practice Audit team is one of several responsible for a wide range of quality assurance and provider support initiatives.

Our practice audit programme was implemented under a protocol agreed between ACC and the New Zealand Medical Association and other provider groups. The legal basis for practice reviews are:

- 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.

All types of provider practice may be audited.

Objective

Practice reviews determine whether the goods and services you provide match ACC's requirements, and ensure that payments and contributions you initiate are valid and correct for covered clients and entitlements.

Audit details

A team of auditors conducts random practice reviews. These are designed to examine the strength of your practice control environment by looking at the arrangements for purchasing, implementing and monitoring ACC-related work.

Practice audits formally examine whether you or your organisation:

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

For more information see the ACC2135 Audit Protocol. This can be viewed online, or ordered online by entering the ACC number into the search field and selecting 'Order this publication', or ordered through the Stationery Order Line on **0800 802 444**, option 0.

3

How ACC investigates and controls fraud

Definition of fraud

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 (eg 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:

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

Investigating fraud

Our Investigation Unit is responsible for 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.
- 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 xxxxx@xxx.xx.nz or by following the 'Reporting Fraud' link at www.acc.co.nz.

You may provide information anonymously.

How ACC monitors providers

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

Assistance we offer includes:

- working with providers in an educative and supporting role
- implementing 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.

Claims management category managers and staff around the ACC branch network work together to track compliance with services' monitoring plans, contracts and legislation.

Section 4 – Provider registration

Criteria and requirements for registering with ACC

4

About ACC's contracted services

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.

If you're interested in registering as an ACC health provider, your key initial contact will be the Health Procurement and Contracting team which negotiates and manages ACC contracting opportunities.

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.

The benefits of registering

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 ACC News and other 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	✓	✓	

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ACC's registration requirements

The qualification, registration and certification requirements that treatment providers must differ slightly between groups. For details for all the different invoicing arrangements see Invoicing and payments (p81).

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 (p92).

Counsellors

Counsellors work with ACC in a slightly different way. Reflecting these differences, they have a separate registration process. See Counsellor registration (p37).

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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 xxxxxxxxxxxx@xxx.xx.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 ACC number to an HPI number. Individual providers may already be using HPI – CPN, issued by their Registration Authorities.

Receiving your registration number

We will notify you 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 Registrations team on **04 560 5422**, to find the best solution.

Changing your details with ACC

If you've changed your name, postal or email address, or phone or fax number, we need to know about it. To update your details with us, phone the Provider Helpline on **0800 222 070** or email registrations@acc.co.nz (remember to include your provider number in the email).

We'll update your record, 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. Faxed or emailed copies are also accepted.

To check the details we currently have recorded for you, call the Provider Helpline on **0800 222 070** or email provxxxxxxxx@xxx.xx.xx

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 (p95).

Counselling services purchased by ACC

ACC purchases counselling services for clients with:

- sensitive claims
- mental injuries from physical injuries.

Our Sensitive Claims Unit 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.

For more information, see Mental injuries, sensitive claims and counselling (p56).

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

Required qualifications, skills and experience

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

The requirements include:

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

You can get more information on the required qualifications by:

- phoning the ACC Provider Registrations team on **04 560 5211**
- emailing xxxxxxxxxxxxx@xxx.xx.xx
- reading the FSCR01 Counsellor Registration Information fact sheet.

Applying for registration

To find out about the application process for becoming an ACC-approved counsellor, we recommend that you:

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

If you're a psychiatrist, psychologist or psychotherapist (professions covered by the HPCA Act 2003), you must provide us with a number of specific items. These include, among 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 must provide additional items, including certified copies of your academic and counselling qualifications. You must also arrange for your supervisor to provide details about you, and about their own membership of an appropriate professional body.

You can get a complete guide to the application and registration process by:

- phoning the ACC Provider Registrations team on **04 560 5211**
- emailing xxxxxxxxxxxxx@xxx.xx.xx

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.

Section 5 – Lodging claims

Lodging a claim with ACC or an Accredited Employer

Forms used to lodge claims

There are five main claim lodgement forms:

ACC45 Injury Claim form

Use the ACC45 Injury Claim form to lodge a claim. It has a unique number for security reasons, which we also use to monitor claims. See Completing the claim form (p41), for more information. If your patient requires 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 (p53).

ACC18 Medical Certificate

Use the ACC18 Medical Certificate if you're a medical practitioner and 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) (p72).

ACC42 Dental Injury Claim form

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

ACC1 Request for Assistance

Clients should phone us on the Client/Patient helpline on **0800 101 996** if they need help in addition to treatment costs, such as home help. If they can't phone (eg they have no phone or are unskilled in English), they can complete an ACC1 to ask for this additional help.

Other forms are listed on our website at For Providers > Lodge and manage claims > Lodge a claim.

Ordering new forms

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

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

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The claims lodgement process

When you lodge a claim using the ACC45 Injury Claim form 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 electronically with ACC > eLodgement
- see Working electronically with ACC (p98).

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 (p33) for a list of accepted providers, and visit our website at For providers > Lodge and manage claims for more information.
- Only medical practitioners can certify incapacity for work. For more information, see Medical certificates (ACC18) (p72).
- Dentists use a specialised version of the form, the ACC42 Dental Injury Claim form.
- Lodging a claim with an Accredited Employer (AE) is slightly different. For more information, see Lodging Accredited Employer claims (p44).
- 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 (p45) for details on how to lodge:
  - claims for mental injury caused by sexual abuse
  - claims for treatment injury (formerly medical misadventure)
  - claims for work-related gradual processes, diseases or infections
  - late lodgement claims.

The lodgement process might seem complex at first, so we encourage you to seek advice so you can help your patients in the best way possible. If you're not sure about lodging a claim with ACC, or if you have a question about a claim already submitted, call the Provider Helpline on **0800 222 070** or email provxxxxxxxx@xxx.xx.xx

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Completing the claim form

The process for filling out, signing and lodging a claim is detailed 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 (p43).

Notes:

- If a person has claimed for their injury before, quote the ACC45 number they received for their original treatment. 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,

Completing the claim form – *continued*

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

- 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.
- 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.
- 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 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 (p42).
- If you think your patient could need help beyond ACC's contribution to treatment costs (eg further treatment, personal support or weekly compensation) please 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. There are also several places on the ACC45 Injury Claim form where you can specify a patient's additional needs. 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.
- **Important**: If a patient presents with a sexual abuse injury, please ask them whether they want mail from ACC or providers to be sent to a different address from the one on your records.

Managing 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 code only has 4 numbers it will end in a dot, which becomes its fifth character. For the most accurate injury diagnosis, you should ensure that each Read Code includes the dot, if necessary.

The full Read Code directory is available via Read Code browser software or the eLodgement service. The abridged ACC53 Read Code Quick Reference Guide covers the most used Codes.

When completing an ACC45 Injury Claim form, you need to record the Read Codes that best correspond to your diagnosis of your patient's injury. For multiple injuries, record the Read Codes for each injury.

If there's no Read Code to match your diagnosis, use Code Z (unspecified condition) and provide an accurate written diagnosis. An ACC staff member will complete the Read Code field, and may contact you to clarify and confirm your diagnosis.

Where to send the claim forms

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.

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 electronically with ACC

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 xxxxxxxxxxxx@xxx.xx.nz. You can also check via the eLodgement system.

We can decline claims, or place them on hold pending further information. We don't usually pay for these unless they are work-related gradual process claims (p51), or sensitive claims (p57).

Invoicing

For information on invoicing ACC and AEs:

- see Invoicing ACC or AEs (p83)
- 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 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 AC 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 Care Advantage, CRM, Injury Prevention Management Services, 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.

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How to lodge an AE claim

Send all documentation for your AE patients (ie 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.

Section 6 – Treatment cover

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 also Glossary (p105)).

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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.

If you diagnose the need for acute treatment and/or admission you must ensure the treatment is provided by:

- a publicly funded provider, or
- a provider that is not publicly funded, if:
  - ACC agrees beforehand, or
  - for reasons of clinical safety, treatment by a publicly funded provider is not 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 DHBs on behalf of ACC. You can find more details in the publication 'Accident Services – A guide for DHB and ACC staff'.

Note: This book is currently unavailable online and will be republished when updating is completed.

Further treatment: Referring clients via the ACC32 form

Who can lodge referrals for further treatment

ACC only pays for claims lodged within the parameters of the provider claim lodgement framework (see Glossary (p105)), which shows providers which types of claim they can lodge. If you're not appropriately qualified, you'll need to refer your patient to an appropriate provider.

There are no special requirements for referring a client for further treatment. If their injury needs to be treated by another treatment provider, follow your usual clinical practice and ensure your clinical notes clearly show the reason for the referral.

Types of acute referral

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 needs acute medical help in addition to radiology for their injury, refer them to the nearest public hospital.

MRIs

- Acute MRIs for ACC clients are provided as part of PHAS. If your patient needs an urgent MRI, refer them to the nearest DHB MRI facility.
- 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 xxxxxxxxxxxx@xxx.xx.xx

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 staff supported by medical advisors will be able to confirm cover and coordinate services for clients and providers.

Using the ACC32

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

- anticipate that you'll need prior ACC approval for additional treatment funding
- want to add a diagnosis
- want to change a diagnosis
- want additional splinting costs.

6

Further treatment and costs

Prior ACC approval for further treatment

Prior ACC approval is required when either:

- it's been more than 12 months since the client last received treatment from a specified treatment provider, or
- the trigger number for the covered injury has been reached.

Note: Each Read Code allocates a number of treatments (trigger numbers) before you need prior ACC approval to fund further treatment.

- When completing an ACC32 request for prior approval of treatment it's important to specify the date of the injury(s), 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 xxxxxxxxxxxx@xxx.xx.nz

Adding or changing a diagnosis

Adding a diagnosis

In the course of providing treatment for a covered injury, you might identify an additional injury(s). We can only fund treatment for that additional injury site(s) if we have made a cover decision.

> **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 under this claim.

Changing a diagnosis

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

- an administrative error (ie a claim was lodged for the incorrect body site)
- a change from an International Classification of Disease (ICD) code to a Read Code
- an error in the original diagnosis.

What to include in the ACC32

Currently, different treatment provider types need to submit different information on the ACC32. Please refer to your contract for details.

Physiotherapists:

All physiotherapists and hand therapists must include both an 'outcome measure' report and their 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, current records of treatment given to the dates of application (see What we recommend for all clinical records p27).

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 three 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 enhance quality.

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

If an ACC32 has been submitted by a provider from a different discipline and the client then comes to you for treatment, you need to submit another ACC32.

Using the ACC32 to refer a client to a different provider type is not equivalent to using the form to get ACC prior approval for further treatment. So another ACC32 will need to be submitted for that purpose. Please attach the referral letter or form to your ACC32 request.

If a client has been referred to you by another provider who operates in 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

Send the ACC32 form and all relevant information to your nearest Medical Fees Unit. We aim to either issue a decision or advise you of any delay within five working days of receiving the documents.

The requests are processed by claims officer treatments and, if necessary, assessed by clinical advisors.

We'll write to both you and the client with our decision. If we've declined the request, we'll also try to contact the client to advise them of our decision verbally.

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. However, it's up to the client to dispute the decision formally. 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, but this can be extended if a situation beyond their control prevents the client from applying within that timeframe.

Approving requests – criteria

If you're requesting treatment only and we approve your request, we'll fund up to six treatments and (as long as you invoice ACC in the order that the services are delivered) this will be in addition to the treatment profile trigger.

We can approve more than six treatments in the case of a serious injury and where it is clinically justified.

Declining requests – criteria

Our typical reasons for declining ACC32 treatment requests include the following.

No causal link

To get ACC funding for additional treatments, you must clearly show how the client's ongoing condition has been caused by their injury. This link must be supported by medical evidence, as a condition may be similar to but not caused by an injury.

Not injury related

The client has a condition not related to their injury so that condition is not eligible for ACC cover.

Not 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.

Injury site doesn't match the covered

We can only fund treatment if the injury is covered. If you're unsure about whether your patient's injury is covered please contact the Provider Helpline on **0800 222 070**.

Surgery not funded by ACC

We can't fund post-operative rehabilitation treatment when we haven't funded the surgery.

Gradual process

We can't fund treatment for a gradual process injury unless we've accepted cover for that injury as a work-related gradual process condition.

Treatment plus cover, or cover only

If you submit an ACC32 to add an injury, we need supporting medical information. As cover and entitlement are two different decisions, we may or may not approve cover while determining treatment.

Lodging 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.

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 (eg 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.

   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 (ie '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.

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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 (eg by a physiotherapist) before the patient has seen a GP or medical specialist will not be 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 (eg 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:

- 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. Details of the patient's clinical history and your examination findings will speed up the cover decision process for them.
- If you're documenting aspects of workplace 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

The Act describes treatment injury 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 will 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.

Which treatment providers are and are not covered

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
- podiatrist
- medical laboratory technologist
- occupational therapist

Several other provider groups qualify as ACC treatment providers but their treatment can not be the subject of a "treatment injury" claim.

However, the affected patients who receive injuries from their treatment may still be covered under the wider ACC personal injury claim provisions.

The treatment providers not covered for 'treatment injuries' are:

- acupuncturist
- counsellor
- speech therapist
- audiologist
- osteopath

Lodging a treatment injury claim

Treatment injury claims are lodged on the ACC2152 Treatment Injury Claim form, along with an ACC45 Injury Claim form, or ACC42 Dental Injury Claim form. The ACC2152 is available on the For Providers site. Payment for the submission of the associated ACC45/42 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:

- The best person to lodge an ACC2152 may be the registered health professional involved in the treatment that caused the injury. They could be different from the treatment provider who lodges the ACC45 Injury Claim form.

  Exceptions: Registered health professionals whose treatment could give rise to a 'treatment injury' claim but who can't lodge a treatment injury claim are:

  - clinical dental technicians
  - dental technicians
  - medical radiation therapists
  - midwives
  - pharmacists.
- If you're helping a patient but were not involved in the original treatment, you can complete the ACC45 Injury Claim form and the ACC2152 if you have enough information. Otherwise you should complete only the ACC45 Injury Claim form, ticking the 'Treatment Injury' box and, as a minimum, providing the place of treatment, the name(s) of the person(s) who provided the treatment that caused the injury, and 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're not obliged to first ascertain the exact cause of the injury. This is especially relevant with older injuries, or when the records that you have access to are incomplete.
- If possible you should advise your patients that we assess all claims and may ask for more information about the injury and the events that led to it, including from other treatment providers involved in the case. This means that it could take a few weeks or more to reach a decision on their treatment injury claim.

Note: Legislation gives us up to nine months to make a decision after a treatment injury claim has been lodged.

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 suffered complications. We don't 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 it receives the ACC45 Injury Claim form, along with an ACC2152 Treatment Injury Claim form and/or supportive medical records. If only an ACC45 Injury Claim form is received, the claim process will be delayed while we obtain the ACC2152 or other records.

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

Once it has made a cover decision, the Centre informs the client and advises them to let their health professional know about it (it doesn't contact the health professional directly). If the claim is accepted, 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. We accept about 66% of all treatment injury claims.

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 ACC News, and 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 that is diagnosable and requires treatment'. ACC covers only the effects of the injury/event, not the event itself.

Client eligibility

ACC funds counselling for:

- mental injuries arising from physical injuries or a work place event
- sensitive claims, ie 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 a sexual abuse crime, they can lodge their claim through either a medical practitioner or an ACC-registered counsellor.

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Mental injury caused by physical injury

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

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

After receiving the treating medical practitioner's report, we consult an ACC medical advisor who makes a detailed referral to obtain a psychiatric or psychological assessment, with the aim of learning more about the injuries clinical significance and getting 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. Their 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

A report's recommended treatment options can include referral to a counsellor, psychotherapist, psychiatrist or psychologist for treatment or counselling. We can only contribute to the funding of treatment if they are registered with us (that is, either they are registered with ACC as providers of counselling services under the Regulations, or they are psychiatrists or psychologists who have entered into ACC service contracts).

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 (p37), or contact the Provider Registrations team on **04 918 7782** or by emailing xxxxxxxxxxxxx@xxx.xx.xx

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 of the claims' confidential and personal 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 that collected on an ACC45 Injury Claim form. Therefore it can take longer to determine cover for these claims than for less complex injuries. The ACC 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.

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**.

If you'd like to be kept informed of news and training updates for ACC sensitive claims providers, contact your local Relationship & Performance Manager.

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 (eg doctors or GPs) 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.

Note: If you are a counsellor and believe your patient needs counselling support 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. 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.

Lodging a sensitive claim – *continued*

Notes:

- **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.
- 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 give the most useful information to help us determine cover. Use a DSM-IV diagnosis, an ICD code or a Read Code.
- At the various stages of seeing the patient, you should always check whether their contact details need updating.
- **Important**: Owing to the nature of these claims, check with the patient that we can contact them at their given address and phone number to ensure their ongoing safety and privacy rights. This is particularly important for clients aged between 13 and 16, for whom we prefer confirmation of caregiver and family/whānau involvement where possible.
- 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 on their behalf. If any other person signs we can't register the claim. If there is no signature, we'll have to send the ACC45 Injury Claim form back to you.
- Make sure that you complete the section of the form relating to whether the patient is working. This is another mandatory field and if it's not done the claim registration will very likely be delayed.

Dealing with challenging behaviour

Situations that can cause problems

Dealing with a violent or aggressive 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 but others, owing to injury or debilitation, take out their frustrations on treatment providers and blame the broader accident compensation and rehabilitation system.

Patient violence against providers is rare in New Zealand. However, some individuals exhibit behaviours that can range from verbal abuse to physical assault. There may or may not be a direct connection between the 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 liaise with us about any violent and/or aggressive patients. 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 determine the appropriate entitlements, eg psychiatric evaluations and therapy or psychologist referrals. In these cases our staff can be crucial in working with you to rehabilitate the patient and improve and consolidate 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, our staff can offer pain management options. This type of support could help you and your patient to achieve a return to everyday life and work for them. For more information, see Managing pain (p67).

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 the management cornerstones in dealing with violent and aggressive patients.

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.

When we help with costs

When clients are prescribed medication to help them recover and rehabilitate, we may be able to contribute to the prescription costs. However, there are some specific rules for reimbursing a client's costs, including a form they need to fill out and send to us (incomplete forms will be returned to them).

The ACC249 Request for Reimbursement of Pharmaceutical Costs is both a form to request reimbursement and an information sheet that covers the rules, eg the types of receipts and invoices that we need to see before reimbursing a client's costs.

It would also help if you or your colleagues could explain to clients the basis on which they can expect to be reimbursed for some or all of their prescription costs.

How we decide to reimburse

Those who prescribe and dispense pharmaceuticals should comply with all appropriate legislation, service agreements and standards. 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 information to support a reimbursement request is incomplete, we may ask for more information. We will decline the request if there's no valid entitlement for the covered injury or if the pharmaceuticals do not meet all of the above criteria.

What we won't reimburse

We won't reimburse any:

- administration charges added by the prescriber or dispensing pharmacy
- the cost of substances that area not 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 an pharmaceutical costs if the contract price covers pharmaceuticals.

By reimbursement

We reimburse clients or pharmacies:

- for co-payments on community pharmaceuticals
- for part-charges for partly subsidised community pharmaceuticals
- a reasonable cost for 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 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 clients' 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, you should record the ACC45 Injury Claim form number against each item. Record a Ministry of Health identifier for all medical illness scripts to distinguish between accident and medical cases.

When prior ACC approval is needed

You need prior-approval from us 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.

Please seek funding approval from us before prescribing the pharmaceuticals. If you prescribe them without our prior approval, you should tell the client 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.

The following checklists provide useful information on when ACC can and can't contribute to the cost of typical non-subsidised medications.

- ACC1173 Tramadol – Prescriber Checklist: Guidelines for ACC contribution to cost
- ACC2530 Cox 2 Inhibitors – Prescriber Checklist: Guidelines for ACC contribution to cost
- ACC2531 Anticonvulsants (non-subsidised) for Neuropathic Pain Management – Prescriber Checklist: Guidelines for ACC contribution to cost.

Things to note when prescribing

When prescribing, please ensure that you:

- typically 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, eg 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.

Section 7 – Rehabilitation

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
- support to maintain employment
- support to obtain employment
- support to regain or acquire 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. So we've 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 benefit them most.

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

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.

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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 (eg via the Stay at Work service p68)
- helping clients to find new work in the same field
- 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.

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.

The 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 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 2 and 3 services are longer term, cover more complex needs and require progress reports from providers. These can outline whether clients need additional support, such as a Physical Fitness for Work and Independence programme, to increase their fitness or mobility.

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 Reed Groups' Medical Disability Guidelines (MDG) database
- the ACC2360 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.

Using the medical disability guidelines (MDG)

The MDG database gives information on the expected durations of incapacity for various injuries. It can be a useful reference tool to complement and support your medical expertise. ACC staff also use the MDG for guidance on rehabilitation durations for our clients.

The disability duration figures are based on statistically significant data covering more than 3.5 million workplace absence cases, including data from ACC. The duration tables are physiologically based. They reflect actuarial experience and provide guidelines on the length of the recovery process consistent with a person's injury and work type. We use this data for provider education material and monitoring purposes.

Arranged by injury, illness, or treatment name, the MDG present disability duration tables with minimum, optimum, and maximum duration expectations based on work type. See Work type details sheets.

Supporting information on the MDG gives recommendations on rehabilitation therapies, frequency and duration of treatment, co-morbidities and other factors that may affect the duration of a client's disability. It also contains suggestions for returning to work including appropriate work restrictions, work environment alterations and/or living alterations.

Note: If a client is a non-earner and their rehabilitation aims to restore their level of independence in daily life, the MDG can still give useful guidance on the expected duration of incapacity for specific injury types.

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Factors that influence disability duration

Disability durations are 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. The values expressed in the MDG tables do not represent absolute minimum or maximum times but rather indicate key points in time for review and/or other decisions.

The **minimum** figures indicate the minimum recovery time most people 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.

The **optimum** is the time 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.

The **maximum** is the 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.

MDG example

Here is an example of incapacity durations for epicondylitis.

Duration in days			
Work type	**Minimum**	**Optimum**	**Maximum**
Sedentary	0	7	28
Light	1	10	28
Medium	7	21	56
Heavy	14	28	56
Very heavy	14	28	56

Reed P (ed), "The Medical Disability Guidelines", 6th Edition, Colorado, USA; Reed Group; 2010. See also, www.rgl.net

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.

We encourage that you use the spaces provided on the form, as well as other communication methods, to give us your views on clients' 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 (eg GP or emergency department doctor) 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 change a diagnosis. If you do, we'll need a new Read Code along with the supporting clinical evidence or rationale for the change.

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
- which 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.

How to fill in an ACC18 Medical Certificate – *continued*

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 (ie 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, eg 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.

How to fill in an ACC18 Medical Certificate – *continued*

The clients 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 (p79), 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.

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 or fax: 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.

The fastest method for paper forms is by fax:

- Christchurch Service Centre **fax - 0800 222 359**
- Dunedin Service Centre **fax - 0800 633 632**
- Hamilton Service Centre **fax - 0800 222 890**
- Wellington Service Centre **fax - 0800 181 306**.

Sustained return to work

How you can help clients return to work

Returning to work after an injury has to be sustainable if it's to be successful. Communicating with the employer is one way you can help to achieve this. If you're unable to liaise with the employer, talk to the client's ACC case manager, who may have already contacted the employer.

You can find a lot more 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. It describes the increasing evidence on the benefits of getting injured people back to an active life, not least the psychosocial benefits.

You can contribute to a more efficient return to work by:

- understanding the specific demands of the client's job
- identifying any barriers to returning to work and advising ACC
- troubleshooting the barriers.

Analysing the demands of the client's job

'Work type detail sheets' specify tasks for various work categories. See For Providers > Work type detail sheets and scroll to the bottom of the page for the list of work categories. You can use these to identify a client's work tasks (eg sitting, standing, climbing a ladder, lifting heavy loads, or working on a keyboard most of the day), which can help you to assess the client's ability to return to work.

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 a client's fitness to return to full, partial or graduated work activities. Vocational/Occupational providers may need to consult the client's treatment or rehabilitation provider on the following issues.

Disability and physical impairment

Residual impairments can stop a client returning to work fully. It's important to diagnose these and get 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

How to identify return-to-work barriers – *continued*

graduated approach.

Individual factors

Individual factors include the client's beliefs about their injury and symptoms, eg their fear of pain from movement (p78). 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 the client to ensure they're using the them 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 do a return-to-work plan with a client, see Appendix 3 (pg 105) of the ACC2360 Return to Work Guide.

Advising us of a client's barriers

When a client has ongoing restrictions or specific limitations, please tell us so we can liaise with the 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 the client can still do become the temporary focus of their work
- a graduated return to work, where the client does 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 gives the client 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, eg significant fatigue or serious medication side-effects. See Lifestyle substitution (p78).

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

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Dealing with return-to-work barriers

Fear of pain from movement

If there are no specific safety concerns, the client's activity levels should be based on time rather than pain. The client 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 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 the client to experience the benefits of work while avoiding the lifestyle pressures associated with working longer hours.

To change this pattern, ask the client 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 the client's case manager and/or their employer (manager or supervisor). If this fails, 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.

The client'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

This table gives basic information on some of our most common assessment, service and/or rehabilitation programmes. In almost all cases the providers who run the programmes do so under contract, and the provider criteria in the table give an indication of the contract type.

Service	Purpose	Provider criteria
Comprehensive Pain Assessment	Assesses and recommends the appropriate management options for a client with stable but persistent pain (lasting more than 12 weeks). This is a gateway to other pain services.	ACC and GP using multidisciplinary team as needed
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
Physical Fitness for Work and Independence	A tailored exercise and activity programme with education, if needed, to focus on restoring function and managing pain	Exercise rehabilitation professional with GP agreement

Continued over...

Vocational rehabilitation services – ***continued***

Service	Purpose	Provider criteria
Employment Maintenance Programme	Uses interviews, visits and an individual time framed plan for a client to work through vocational or injury barriers.	Vocational practitioner and rehabilitation professional
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	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.	Rehabilitation professional
Multi-Disciplinary Persistent Pain Programme	Intensive, multi-strand therapy programme that aims to modify a client's response to pain through self-management, coping and goal-setting skills.	Pain management contracted provider
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
Work Preparation Programme	Detailed personal programme of rehabilitative vocational and psychological elements for a client who no longer has pre-injury employment.	Multidisciplinary, including registered psychologist
Work Ready	Supervises a client who can demonstrate work readiness and will participate in a work trial with monitoring.	Vocational practitioner

Section 8 – 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:

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

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

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 tests including 'necessary', 'appropriate' and 'of the quality required' are being met, and that all providers are supporting the treatment given with auditable clinical records. For more information on monitoring, see Audits, fraud control and monitoring (p29).

8

Invoicing

You can invoice ACC:

- under the IPRC (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003, and amendments
- through a contract arrangement (see your particular contract for details of your invoicing process)
- by refunding against a purchase order the cost of the treatment or service agreed by you and ACC.

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 xxxxxxxxxxx@xxx.xx.nz

See also, Electronic invoicing: eSchedules (p100).

Invoicing under Regulations – key points

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

ACC and AEs pay, or contribute to, costs at the rates and/or amounts specified in these Regulations or later amendments. These contributions cover basic treatment provider costs, while a Schedule to the Regulations specifies amounts that can be paid for specific treatment and procedure types.

The Regulations allow invoicing for:

- a consultation/visit relating to an injury or condition covered by ACC. A number of procedures are included as part of a consultation fee (see Consultations/Visits p84).
- 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.

Clients must be eligible for the service you provide, before you can invoice us for payments. If a procedure is minor it's often covered in the consultation/visit fee and can't be invoiced separately. 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 (p119).

8

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 PMS.

AEs

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 TPA. For more information see Lodging Accredited Employer claims (p44).

8

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.

A consultation/visit includes providing claim-related advice, completing prescriptions, making referrals and issuing any certificate to ACC that results from the consultation/visit. It does not include insubstantial medical services for which clients wouldn't normally pay, eg 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 and minor dressings (eg small gauze or non-stick dressings) to small burns or abrasions
- cleaning and minor dressings (eg plaster strips) to 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 (p119).

When appointments are missed

You can only invoice us for missed appointments or cancellations 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 claim, 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, eg 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 can't 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
- a second practitioner from your practice assesses a client after X-ray.

If you have any enquiries, call the Provider Helpline on **0800 222 070** or email xxxxxxxxxxxx@xxx.xx.xx

Tell us why

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.

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Medical practitioners' treatment costs

Medical practitioner's 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 slightly higher rate for clients under six years old than we do for all other clients.

- Any 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.

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.

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	$15.00	@ 50% = $7.50
Treatment/Procedure B	$45.00 (highest-cost procedure)	@ 100% = $45.00
Treatment/Procedure C	$7.00	@ 50% = $3.50
Consultation/Visit	$33.53	$33.53
	Invoice Total	$89.53
Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.		

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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 higher amount.

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

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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 the client's age and is specified in the Regulations.
- Any 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 wishing 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 (p86). 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 higher amount.

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

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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 slightly higher rate for clients under six years old than we do for all other clients.
- Any 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 any treatment
- the individual treatment costs specified for a nurse 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 number
Treatment/Procedure A	$15.00	@ 50% = $7.50	Nurse
Treatment/Procedure B	$45.00	@ 100% = $45.00	Medical practitioner
Treatment/Procedure C	$7.00	@ 50% = $3.50	Nurse
Consultation/Visit	$36.67	$36.67	Medical

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			Practitioner
Invoice Total		$92.67	
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 rules for dual treatments apply, contact the Provider Helpline on **0800 222 070** or email xxxxxxxxxxxx@xxx.xx.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	$15.00	@ 50% = $7.50	Nurse
Treatment/Procedure by nurse A	$23.00	@ 100% = $23.00	Nurse
Treatment/Procedure by medical practitioner B	$33.00	@ 100% = $33.00	Medical practitioner
Treatment/Procedure by medical practitioner B	$12.00	@ 50% = $6.00	Medical practitioner

Consultation/Visit	$36.67	$36.67	Medical practitioner
Invoice Total		$106.17	
Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.			

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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 instructions specified in the contract.

The following descriptions apply 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.

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

We will not back pay any services when you request a change to your invoicing option. 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 treatment. For more information visit our website at For Providers > Invoicing and payment or contact the Provider Helpline by phoning **0800 222 070** or email xxxxxxxxxxxx@xxx.xx.xx

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Invoicing per hour

If you're invoicing on an hourly rate we pay the appropriate proportion of the rate that applies. If you provide 'direct treatment' for less than one hour, we calculate the payment in increments of five minutes, eg if your treatment takes 28 minutes, we pay for 30 minutes of the hourly rate (ie half 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
- applying direct hands-on treatment.

It doesn't include, for example, applying a preparation treatment to one patient at the same time as you work on others.

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.

Note that we'll follow up any invoicing patterns outside clinical norms. For more information on provider monitoring and other quality assurance functions, see Audits, fraud control and monitoring (p29).

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 (ie invoice us for a total of one hour of your time).
- You can't invoice us for an hour for each client (ie invoice us for a total of six hours for one hour of your time).

Note: Your records still need to demonstrate that your clinical input is necessary and appropriate. See Supporting quality (p23).

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 client's 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 number of treatments for different injuries (ie the sum of different Read Codes) to give an aggregated number of treatments.

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

Example 4	Injury	Trigger number of treatments
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.

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 (p46).

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 (p56).

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 xxxxxxxxxxxx@xxx.xx.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.

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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 myelograms and arthrograms.

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 (p46).

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, eg 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, ie 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 Relationship & Performance Manager or by phoning the Provider Helpline on **0800 222 070** or emailing xxxxxxxxxxxx@xxx.xx.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.

Completing and sending a bulk-billing schedule

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.

Instructions 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

Send your schedule to the Medical Fees unit for your area, see Key ACC contacts for treatment providers (p4).

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

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Section 9 – 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 (p99).

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 electronically 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, ie 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 (p98).
3. A compatible 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
    - ACC23L Organisation Application for eBusiness

    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 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 (p99) – 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 (ie 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 (p102), 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.

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Querying payment delays

We usually decide on cover for a claim within 24 hours as we have enough information. However, some claims (eg 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 xxxxxxxxxxxx@xxx.xx.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.

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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 should 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.

Section 10 – Glossary

Introduction

Glossary covers definitions relating to the Regulations

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

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. 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 update/add a diagnosis.
ACC32 Request for Prior Approval of Treatment form	This form is completed by a Specified Treatment Provider: • to alter or add 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.
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 funding approval and should be completed by a provider and submitted to ACC before they prescribe a non-subsidised pharmaceutical item for a client. ACC can reimburse some or all of the costs involved. Approvals are for a limited time. Other related forms and checklists are detailed on p64.

Term	Meaning
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) guides 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.
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.
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.

Term	Meaning
Ancillary services	These are services that are 'ancillary' to a client's rehabilitation (ie 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 (eg 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 (eg 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.
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 authorises 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.
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: • consultation/visit in detail on p84 • Section 11 – Consultation/Visit and procedure costs and codes: Guide to invoicing for medical practitioners and nurses starting on p119. 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.
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).
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.

Term	Meaning
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.
Hauora Māori – Cultural Competency	All contracts between ACC and providers include an organisational quality standard, a Hauora 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.
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.
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).

Term	Meaning
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.
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) function. 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 an 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.
Lifetime rehabilitation plan	This is a detailed support and rehabilitation plan developed with a client who has long-term or lifelong support needs owing to a serious injury (ie 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.
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 Disability Guidelines (MDG)	The Medical Disability Guidelines are published, systematised tools that give general benchmarks to guide the minimum, optimal and maximum durations of incapacity (ie time off work) for a client based on their injury and type of work.

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Term	Meaning
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. 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.
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.

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 • 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.
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, 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).
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.

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Term	Meaning
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 (eg Medical Council of New Zealand). A practitioner must practise within any conditions imposed by their registering authority.
Self-harm	ACC has to decide if any wilfully self-inflicted injury or suicide was the result of an existing covered mental injury. If not, we may withhold entitlements other than treatment. We will only disentitle a client if investigations confirm that they did not have an existing mental injury.
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 help, child care, attendant care, equipment and aids for independence, training for independence, modification of vehicles or home, and education support.
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.

Term	Meaning
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).
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.

Term	Meaning
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.
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.

Term	Meaning
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.

Section 11 – 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 effective 1 October 2010.

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:
  - removing sutures
  - removing a non-embedded foreign body from eye, mouth, auditory canal or other site (excluding rectum or vagina) without incision
  - re-dressing wounds that don't require significant dressings
  - performing a plaster check
  - removing casts/splinting
  - removing packing of nose, or packed abscesses or haematomas
  - cleaning and minor dressings (eg small gauze or non-stick dressings) to small burns or abrasions
  - cleaning and minor dressings (eg plaster strips) to small, open wounds
  - managing minor sprains that don' involve significant splinting
  - completing clinical records.

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What a consultation/ visit does not include

A consultation/visit does not include:

- informal encounters
- 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 (eg 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.

Invoicing criteria for each MB code - *continued*

MB3 - Treatment of significant abrasions less 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.

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'.

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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 Relationship & Performance 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 Relationship & Performance Manager).

Invoicing criteria for each MF code

The general invoicing criteria cover all MF 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.

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.

Invoicing criteria for each MF code – *continued*

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.

Invoicing criteria for each MF code – *continued*

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.

Invoicing criteria for each MF code – *continued*

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.

Invoicing criteria for each MF code – *continued*

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.

Invoicing criteria for each MM code – *continued*

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.

Invoicing criteria for each MM code – *continued*

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.

11

Open wounds

General invoicing criteria

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.

Eligible – all MW 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.

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.

Invoicing criteria for each MW code – *continued*

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.

11

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.

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Invoicing criteria for each MT code – *continued*

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.

Invoicing criteria for each MT code – *continued*

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.

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