Confirming existing cover decision

Latest update 25/3 Step 4 of Decide if physical injury caused by accident amended to refer to setting the outcome status of Injury Code field to 'approved' if claim meets criteria of Step 2.

Claims management staff (CMS) use this process to review or confirm an existing cover decision at any stage during the life of a claim. Cover must be reviewed whenever you receive new information or a request for an additional entitlement.

The process map replaces the swimlane previously used in Manage Claims. You can see that swimlane by clicking here: Confirm cover decision (40K)

Contact [redacted] Last review 25 Mar 2014 Next review 25 Nov 2014

Click on a shaded box for instruction details

Show all instructions

Review documents

Responsibility

Claims management staff

When to use

Use this instruction when you:

- are asked to confirm an existing cover decision
- receive new information regarding the circumstances of the accident or injury
- receive a request for an additional entitlement.

Instruction

Step 1

Review the claim documentation received. You may find new information about the claim in the following documents:

- ACC18 Work capacity certificate (medical certificate)
- ACC2018 Alcohol and other drug assessment report and treatment plan (251K)
- ACC054 Application form for lump sum / independence allowance (125K)
- letter from an advocate or client
- medical notes or assessments
- a Rehabilitation assessment.

Step 2

If the claim...	then...
is for an additional injury on an existing claim	• go to Determining cover for an additional injury or change in diagnosis • this process ends
has a change in diagnosis	
is for a new injury caused by a new accident	• go to Making cover decision at cover assessment • this process ends
is none of the above	go to **Decide if injury is a covered personal injury**

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Decide if injury is a covered personal injury

Responsibility

Claims management staff

When to use

Use this instruction to confirm whether an injury is a personal injury that is covered by ACC.

Instruction

Step 1

Check whether the client's injury meets the criteria for a personal injury. See:

- Cover criteria for personal injury
- Cover criteria for pre existing conditions

You may also need to check the following policies:

- Criteria for ordinarily resident in New Zealand
- Criteria for injury occurring outside New Zealand
- Cover for visitors to New Zealand.

Step 2

Contact the client's medical practitioner for more information about the client's injury, if needed. Add any contacts in Eos.

Step 3

Decide if the injury meets the cover criteria for a personal injury

If the injury is...	then...
a personal injury	go to step 4
not a personal injury	go to Revoking cover
excluded from cover	

Step 4

Determine if the personal injury is physical or mental. See.

- Cover criteria for physical injury
- Mental injuries

If the personal injury is...	then...
physical	go to **Decide if physical injury caused by accident**
mental	go to Assessing cover for mental injury cover

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Decide if physical injury caused by accident

Responsibility

Claims management staff

When to use

Use this instruction to determine if the physical injury was caused by accident when you receive new information.

Instruction

Step 1

Check that the physical injury meets the cover criteria. See:

- Cover criteria for personal injury
- Definition of accident

Step 2

Check the claim and medical documentation to make sure the claim meets all the criteria for the claim type. If needed, contact the client or their medical practitioner to get more information.

If the physical injury is caused by...	then the claim must meet all of the following criteria...	and see...
force or resistance	• the injury was the result of a specific event or series of events • there was an external force or resistance associated with the specific event or series of events • this force or resistance was external to the human body	Definition of accident
inhalation	• the client breathed a substance into their lungs or air passages • the substance was inhaled on a specific occasion, although not necessarily in a single breath • the injury was caused by the inhalation ingestion	Cover criteria for inhalation or oral ingestion
ingestion	• the client ingested a solid, liquid, gas, fungus or foreign object • the substance or object was swallowed on a specific occasion • the injury was caused by the ingestion	
absorption	• there was a specific chemical involved • this chemical was absorbed through the skin, rather than being injected, ingested or inhaled • the chemical was absorbed through the skin over a period of one month or less • the injury was caused by this absorption	Cover criteria for absorption
exposure to the elements	• the exposure occurred over a period of time not greater than one continuous month • medical certification confirms that the resulting disability lasted continuously for more than one month	Cover criteria for burn or exposure
burn or exposure	• the cause of the injury was a burn or exposure to radiation or rays of any kind • the burn or exposure occurred on a specific occasion	
anaphylactic reaction (shock)	caused by one specific event	• Cover criteria for anaphylactic reaction pre June 2005 • Cover criteria for allergies and allergic reactions

If the physical injury is caused by...	then the claim must meet all of the following criteria...	and see...
damage to dentures or prostheses	only if being used for the purpose of replacing part of the human body	Cover criteria for dentures and prostheses

Step 3

Refer the request to one or more of the following to determine if the injury is still covered:

- medical advisor (MA)
- team manager (TM) or technical claims manager (TCM)
- quality assurance manager (QAM)
- clinical advisor (CA)
- Workwise.

Step 4

If the claim...	then...
meets the criteria in step 2	• confirm cover for the personal injury, as its cause meets the definition of an accident • set the outcome status of the 'Injury Code' field in Eos to 'approved' • add a 'Contact' in Eos confirming that the cover decision has been reviewed and confirmed
doesn't meet the criteria in step 2	go to Revoking cover

What happens next

This process ends. Continue with the relevant claim management process.

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Determining cover for an additional injury or change in diagnosis

When you receive an additional injury or change in diagnosis request, use this process to review the information and determine whether to accept cover for the additional injury or new diagnosis.

Contact [redacted] Last review 08 Jan 2014 Next review 08 Jan 2015

Click on a shaded box for instruction details

Show all instructions

Assess the request

Responsibility

Claims Management staff

When to use

Use this instruction when you receive new information about a claim, to decide:

- what action is needed to determine cover for an additional injury or change in diagnosis
- which unit should manage the claim.

Before you begin

See Timeframes to determine cover.

New information may come via:

- an ACC32 Request for prior approval of treatment
- an ACC18 Medical certificate
- an ACC2018 Alcohol and other drug assessment report and treatment plan (251K)
- an ACC054 Application for lump sum / independence allowance (126K)
- a letter from an advocate or client
- an enquiry to the provider help line or the Inquiry Service Centre (ISC)
- a rehabilitation assessment
- an additional ACC45 Injury claim form.

Instruction

Step 1

Assess the claim documentation received.

If the claim is for...	then...
an injury caused by a new event	• go to Making cover decision at cover assessment • this process ends
an additional injury or change in diagnosis	go to step 2

Step 2

Decide which unit will manage the claim.

If...	then...
the claim has a case owner	transfer the request to the case owner
the claim was previously managed in a branch or short term claims centre (STCC)	transfer the request to the previous managing site
the claim is a sensitive claim or treatment injury claim	• transfer the request to the Sensitive Claims Unit (SCU) or the Treatment Injury Centre (TIC) • this process ends
the claim relates to an additional diagnosis for an independence allowance or lump sum claim	transfer the request to the Independence Allowance Lump Sum (IALS) unit
all of the following: • the claim has no case owner • the request is on an ACC32 Request for prior approval of treatment • the request is for the same body site	transfer the request to the ACC32 Processing team
the claim has no case owner and the request is on an Assessment Report & Treatment Plan (ARTP) 2012/13 (251K)	transfer the request to the Elective Surgery Assessment team
the claim has no case owner	transfer the request to the Claim Lodgement and Cover Assessment team

What happens next

The staff member or business unit responsible for making the cover decision goes to **Review information and make cover decision**.

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Review information and make cover decision

Responsibility

Claims Management staff

When to use

Use this instruction when you receive a request to make a cover decision on an additional injury or change in diagnosis.

Before you begin

If you're not sure whether it's appropriate to approve additional cover or a change in diagnosis, consult with one or more of the following:

- a medical advisor (MA)
- a team manager (TM) or technical claims manager (TCM)
- a quality assurance manager (QAM)
- a clinical advisor (CA)
- Workwise.

Instruction

Step 1

Add the additional injury or new diagnosis to the 'Medical' tab of the claim and set the 'Outcome Status' indicator to 'Investigating'.

Step 2

If the request is for an additional diagnosis, check the claim to ensure a decision has not already been made, particularly if the claim has previously been managed by an accredited employer.

Step 3

Review the request and determine whether you have enough information to make a decision. Consider:

- the description of how the injury happened
- the body site of the injury
- the time elapsed since the initial injury
- any differences between the initial injury and the additional injury and why
- what has contributed to the original injury and additional injury
- whether the additional injury is due to disease or the aging process
- whether the additional injury is due to a gradual process, disease, or infection
- whether the change in diagnosis can be plausibly caused by the described accident on the original ACC45
- whether it's realistic that the additional injury is related to the original injury.

Step 4

If there is...	then...
enough information to make a decision	go to step 5
not enough information to make a decision	• contact the relevant party by phone or letter to request more information • repeat this step

Step 5

Review all the information received and the past history of the claim, including:

- the claim
- any party records
- the date of the injury
- the total number of treatments allocated on the 'Treatment Regulated' tab in Eos and/or the previous treatment history in Medical Fees Processing (MFP)
- any other relevant documents or comments attached to the claim, or any other relevant claim, or the request.

Step 6

Determine if it's appropriate to approve the additional injury or the change in diagnosis. See Definition of accident and Cover criteria for personal injury.

What happens next?

Go to **Finalise request and issue decision letter**.

Back to process map ↑

Finalise request and issue decision letter

Responsibility

Claims Management staff

When to use

Use this instruction when you've decided whether to accept or decline an additional injury or change in diagnosis.

Instruction

Step 1

Generate and send the appropriate decision letter to the client and their treatment provider.

Step 2

Update the 'Medical' tab to reflect the cover status of the additional injury or changed diagnosis.

Step 3

Update the 'Injury Code' screen with the additional information.

What happens next?

This process ends.

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When to review cover and entitlements

Contact [redacted] Last review 10 Feb 2014 Next review 10 Feb 2015

Introduction

Case owners are responsible for regularly reviewing the scope of ongoing cover and whether entitlements are still linked to the covered injury. Case owners are also responsible for the checking the initial fund code on a file when it is allocated to them. See Confirming existing cover decision.

Rules

Each time a new entitlement is requested or considered, or further medical information is received for a client, you must confirm the link to the covered injury.

You must also review cover:

- if it was granted incorrectly
- if the diagnosis changes
- if there is doubt around the causal link between current incapacity and the effects of the injury originally covered by ACC.

Check that the fund code is correct and include evidence to support this.

Paying entitlements when claim is being investigated

If a client has requested an entitlement and ACC needs to confirm responsibility for this, it is reasonable not to pay entitlements until a decision has been made.

Example:

Susan sustained a lumbar sprain lifting a heavy box and ACC granted cover for this. Nine months later Susan applies for weekly compensation (WC) as she is unable to work because of back pain. Due to the nature of the injury and the length of time between the original accident and the application for WC, it is reasonable for ACC to investigate the causal link between the covered lumbar sprain and the current inability to work, before paying WC.

However, if a client is currently receiving entitlements, ACC must continue to pay these while investigating the claim.

Example:

Adam fell off his tractor and hurt his knee. Cover was granted for a knee sprain and ACC started to pay WC based on Adam's inability to work as a farmer. Three months later he is still struggling with the injury and hasn't returned to work. Adam is referred for an MRI scan on his knee, which shows a cyst that is likely to have been there for some time. The specialist considers this is now the cause of Adam's pain and inability to work. ACC must keep paying entitlements until we receive all the medical evidence and a formal decision can be made whether to cease entitlements.

Change of diagnosis

If the client's diagnosis changes, you must consider the new diagnosis and whether ACC should still be responsible for cover. Eos needs to be kept up to date and cover letters reissued if the new diagnosis is accepted by ACC. Sometimes the provider will lodge the original claim with a working or suspected diagnosis, and this is updated when further information is received. To ensure ACC has accurate records, the diagnosis should be updated with relevant evidence. This is important because ACC cover is linked to ongoing liability for that injury in the future.

Example:

Manju fell while playing netball and hurt her knee. She sees her GP who lodges the claim as a knee sprain. ACC accepts cover for a knee sprain. Later, it is confirmed that Manju sustained a meniscal tear and she will need surgery to repair this. Once ACC has appropriate medical evidence, the injury on Eos is updated as meniscal tear, and a fresh cover letter issued to the client.