

Summary

Objective

Use this guidance when identifying how to notify a client about a decision about support(s) relating to their claim.

- 1) When a written communication must be sent to a client
- 2) What a written communication is to specify
- 3) Types of written communication
- 4) Acceptance of late review when written communication not sent
- 5) Where to record decisions

Owner 9(2)(a)

Expert 9(2)(a)

Policy

1.0 When a written communication about a support must be sent to a client

- a The following business rule defines the circumstances in which we must communicate a decision relating to support(s) for a client in writing.

Written communication of a decision about support for a client

NOTE When is a written communication not needed?

When do I not need to send a written notification? When ALL of the following are true:

1. The client has NOT requested written communication
2. The decision is in the client's favour
3. The client has been notified by some other channel (call, text, MyACC)
4. The client does not need to know the specific details (e.g. entitlement amount) of the decision

2.0 What a written communication is to specify

- a The following business rule defines the information that we must include when we communicate a decision to a client in writing.

What a written communication to a client is to specify


3.0 Types of written communication

- a This business rule defines the accepted forms of communication we can use when notifying a client about a decision in writing.

Written communication of decisions


4.0 Acceptance of late review when written communication not sent

- a The following business rule defines what we must do if a client submits a late review application relating to a decision that was not communicated to them in writing.

 Acceptance of late review application when written communication not sent

5.0 Where to record decisions

a The following business rule defines where to record a decision and other relevant information relating to a client's claim.

 Recording decisions relating to clients

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Summary

Objective

An overseas claim is where a client already has cover for a personal injury and qualifies for support and now lives outside of New Zealand. Overseas claims do not apply to clients ordinarily resident in New Zealand who incur an injury while overseas and seek cover for their injury on their return to New Zealand.

1. Rules
2. Types of support
3. Short-term absences
4. Taxation and Double Tax Agreement (Australia)
5. Medical Certificate, Privacy and Information
6. Abatements

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

Policy

1.0 Rules


- a** Overseas clients include overseas visitors who have worked in New Zealand and who may need further rehabilitation after they've left New Zealand.

Overseas clients are required to continue to participate in their rehabilitation and may also be required to return to New Zealand at their own expense for assessments in order to maintain any weekly compensation payable.

2.0 Types of support

- a** Under current legislation we can continue to pay overseas clients weekly compensation or independence allowances/lump sums. The client must provide a medical certificate from their overseas medical practitioner confirming their inability to work as a result of their injury, unless Serious Injury certification exemption applies.

See Medical Certification for Serious Injury Claims

 Medical Certification for Serious Injury Claims

 Make an International Client Payment

b ACC can pay for or contribute towards client rehabilitation goods overseas where:

- the product is delivered in New Zealand and
— payment for the rehabilitation is made from a New Zealand bank account and
— ACC quality control requirements, for specific goods, are met.

This means that ACC may be able to pay the costs related to:



- overseas clients when they return to New Zealand for that rehabilitation (clients would be required to meet travel costs themselves) and then return overseas with the rehabilitation product, eg a client returns to New Zealand to be fitted with a new wheelchair
- overseas clients who have a New Zealand delivery address, when the products don't need to be fitted, eg stump socks and medical consumables

c ACC will usually not pay for or contribute towards client rehabilitation services where either the provider or the client is not in New Zealand at the time the service is provided. See section 128 of the Accident Compensation Act 2001.

This means that ACC will usually not pay for or contribute the costs related to:

- clients in New Zealand receiving rehabilitation from overseas providers, eg overseas surgeons who provide treatment for ACC clients in New Zealand
- services from a New Zealand-based provider to an overseas client, eg counselling and teacher aides via email, telephone and Skype. This excludes attendant care. See providing attendant care overseas for guidance.



Depending on the circumstances of the client, ACC may provide limited support to the clients. See the Overseas Claims Guidance document

-  Overseas Claims Guidance document
-  Assessing Overseas Clients For Non-contracted Care Service Page

3.0 Short term absences

a If a client is in receipt of weekly compensation and is on holiday or living overseas for less than three months:

- you must manage them as if they were on holiday within New Zealand.
- we'll only pay them weekly compensation or IALS. You must pay any amounts into a New Zealand bank account. See Payments to clients outside NZ
- we do not pay for any GP visits, treatment, rehabilitation or social rehabilitation. See Accident Compensation Act, Section 128.
- they're still required to participate in any vocational rehabilitation outlined in their Rehabilitation Plan, but at their own expense.

-  Payments to client outside NZ policy
-  Accident Compensation Act, section 128 - Payment for rehabilitation to claimant outside New Zealand
<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM101809.html>

4.0 Taxation and double taxation agreement (Australia)

- a Clients living in countries outside of New Zealand may also be subject to taxes in that country. They may also apply for a refund on taxes paid here in NZ and TS accounting can advise further on this.

Clients were asked to provide tax return information annually in 2018 and you will note it has been included in some action plans. This request cannot be enforced under non compliance (Section 72) if not provided without good and sufficient reason such as suspicion of other income but can however be requested.

The DTA is an agreement between New Zealand IRD and Australia ATO so that our clients residing there do not pay taxes in both countries. After six months living in Australia they are deemed as resident for taxation purposes. They should therefore file a tax return and declare ACC payments as 'Foreign Income'. This also assists ACC to determine if there are unknown earnings in Australia.

Those with tax exemptions should be monitored by IRD but this does not appear to be the case. Those who also work in Australia, should provide a copy of their tax return each year which should show both ACC and PAYE income. The Australian tax year runs from 1st July to 31st June and CM can supply a payment summary from Infact for this period.

If you have any questions about this, please contact the Technical Accounting Specialist (TAS) team.

5.0 Medical certification, privacy and information

- a Correct certification is essential for management of these claims. Please ensure the correct letter has been sent and send again if the medical certificate does not meet the certification requirements.

If the medical certificate does not meet ACC requirements, the client may need to return to their doctor to have the certificate amended. Technical Specialist (TS) advice in this situation is to add an extension of 4 weeks only to allow this to happen.

If the doctor supplies a letter in place of certificate, it must still include –

- Client's name, address, date of birth
- Date of injury
- Pre-injury role (unfit to perform)
- Diagnoses/symptoms
- Timeframe up to 13 weeks
- Treatment plan
- Details and signature of treatment provider
- Signature of client

This information is to ensure that the certifying treatment provider has a treatment plan, is aware of work type they are signing off as unable to perform and what the covered injuries are. This should not be provided just at client's request.

 Request Clinical Records

- b PRIVACY – The ACC6300 does not extend beyond New Zealand. Therefore, ACC cannot request information directly from treatment providers. Obtaining medical reports and information for ACC are the client's responsibility. This can be more difficult if they are being treated via a public health system. Requesting consultation notes from the doctor may also need a supporting letter from ACC as patients don't have the same access to these as we do in New Zealand. It is important that if you include that any cost for these are the client's responsibility on the letter.

Psychologist reporting is not objective based from overseas providers. One solution is to provide clients with ACC forms (ACC266/267/268) amended to remove CM approval and funding comments so their provider has an understanding of the information we require or may elect to use these.

Be sure to check the qualifications of the provider, as some are not psychologists but counsellors or social workers.

6.0 Abatements

- a Overseas earnings are abated using payslips.

Exchange rate information should be taken from the Crown Revenue website – <https://www.rbnz.govt.nz/statistics/b1>

The last day of the abatement period rate should be used as these vary over a week. As these are weekdays only, use most previous if working week ends on weekend.

Task is entered in comment box as – 15/3/19 – 21/3/19 20 hours \$400aud = \$429.12 .9521 (applicable exchange rate for 21/03/19)

Some have rolling abatements which is easier if their hours do not change significantly but a wash up is recommended if not amended when payslips available. Self employed abatement is as above but elect self employed as per standard practice.

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Summary

Objective

Since 2004, ACC has provided application packs and processed Independence Allowance (IA)/Lump sum entitlements with more urgency where a client's covered injury is recognised as imminently fatal.

Some conditions are more obvious than others. If you're unsure about a condition's likely impact, please refer to your Medical Advisor (MA), Clinical Services Directorate, or a Technical Specialist, for advice.

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1.0 'Rapid Assessment' IA/Lump sum application process

- a The IA/Lump sum team can prepare the claim(s) file records for the assessment process while the claim for cover is still being considered. This will reduce any delay between cover acceptance and the assessment outcome. While the cover decision is being finalised, the IA/Lump sum team can request a provider to complete (where possible) an assessment based on the medical documents, without the need to see the client in person. Sometimes this assessment can be carried out by an appropriately qualified MA.

See Assessments on medical records.

- Assessment
<https://go.promapp.com/accnz/Process/22af356b-1252-4f1c-9570-ff2e688c9701>
- Assessing lump sum or independence allowance for rapidly deteriorating terminal conditions

2.0 Eligible conditions

- a This rapid assessment process is relevant particularly in cases of work-related gradual process disease or infection (WRGPDI), asbestos-related diseases, eg mesothelioma, lung cancer, and where diagnosis is often very late in the disease's progression. However, it's not restricted to those conditions. Allowing an assessment prior to cover determination will protect the client's interests, without raising expectation that the cover decision outcome will be positive. Any injury condition, which has an obvious potential to be fatal, should be considered under the rapid assessment process. These Guidelines must be carefully followed.

3.0 What to consider

- a If you're managing a claim for cover or managing a client for any other purpose, you need to ensure you consider the impact of the client's conditions (and any extended cover time frames), on the client's ability to apply and be assessed for entitlements.

When sending an acknowledgement, either by letter and/or phone, for cases that appear imminently fatal, you should include proactive reference to the other entitlements which may be available. Section 50 (1) (b) (ii) of the Accident Compensation Act 2001 requires the Corporation to "...facilitate the claimant's access to those entitlements".

NOTE: Great care must be taken to keep the client aware that the streamlined process does not presuppose the outcome of the application or the assessment. Letters of acknowledgement may need to be amended appropriately.

Client privacy is not breached if information is disclosed to a third party for the purposes of determining entitlements, even before cover is established.

4.0 How to arrange an application for IA or Lump sum

- a See how to generate an application.

Throughout the process the IA/Lump sum team will keep the current case owner updated on the progression of the application, assessment and decision.

 Generating an Independence Allowance or Lump Sum application

5.0 Deceased clients

- a Under ACC's legislation, a client must be alive when assessed for Lump Sum compensation. This has been confirmed by the District Court. See rules for Deceased clients. The rules for assessing the impairment for an Independence Allowance differ from those for Lump Sums.

6.0 Lump sum compensation

- a To be eligible for a lump sum, the deceased client must have been assessed prior to their death and all of the following must apply:

- the client suffered a personal injury for which they have cover
- the client survived the injury for no fewer than 28 days
- the assessment established that the client's injury resulted in a whole person impairment (WPI) of 10% or above.

Use of the streamlined 'rapid assessment' policy, doesn't impact on the way ACC makes its cover decisions on other claims, or on the way other entitlements are assessed.

 Lump sum eligibility requirements

Summary

Objective


When a client submits an application for a lump sum assessment or reassessment we must check their eligibility.

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1.0 Eligibility to a lump sum entitlement

- a** Clients may be eligible for a lump sum if their claim has all of the following:
 - an accepted cover decision
 - a whole person impairment rating of over 10%
 - a date of injury (or date of last event where relevant) is on or after 1 April 2002
- b** See the full list of lump sum eligibility criteria in the business rule below.
 -  Lump sum eligibility requirements
- c** See also the transitional provisions for impairment entitlements in the AC Act 2001, Schedule 1, part 3, clauses 54 and 55.

2.0 Impairment assessment and whole person impairment rating

- a** To determine the whole person impairment rating of a client, the client must have an impairment assessment.
- b** To be eligible for an initial impairment assessment, the client must meet the criteria listed in the following business rule, which includes having medical certification of a permanent and stable impairment.
 -  Eligibility to an initial impairment assessment
- c** An impairment assessment can only be completed by an impairment assessor who meets the criteria in the business rule below.
 -  Requirements for an assessor to perform an impairment assessment
- d** In some situations the whole person impairment rating must take into account any previous whole person impairment ratings. See the following business rule.
 -  Determining the whole person impairment rating by taking into account a previous rating


3.0 Medical certification of permanent and stable impairment

- a** A person must be considered to have medical certification of a permanent impairment for a lump sum entitlement if a medical practitioner supplies the relevant information to ACC. The relevant information is listed in the business rule below.
 -  Information needed to confirm medical certification of a permanent impairment for a lump sum entitlement
- b** The ACC554 Application medical certificate form is used to capture the relevant information needed.
 -  ACC554 LSIA Medical certificate

 ACC554 required method for supplying medical information for an impairment assessment

- c** You must decline the client's application if the information provided on the ACC554 does not meet the criteria for assessment.

See AC Act 2001, Schedule 1, part 3, clause 57.

 AC Act 2001, Schedule 1, part 3, clause 57.

https://www.westlaw.co.nz/maf/wlnz/app/document?docguid=Ibad19a8fe02e11e08eefa443f89988a0&isTocNav=true&tocDs=AUNZ_NZ_LEGCOMM_TOC&startChunk=1&endChunk=1

4.0 Client under 16 with a mental injury

- a** If a client is under 16 years of age and has cover for personal injury that is a mental injury, we must not assess their eligibility for lump sum compensation for the mental injury until the client turns 16, unless we are satisfied that there are compelling reasons for assessing eligibility earlier.

5.0 Reassessment

- a** See Lump sum reassessment.

 Lump sum reassessment Policy

<https://go.promapp.com/accnz/Process/e38cf259-ba39-4af3-8182-cf5058c855b2?force=False#>


6.0 Overseas clients

- a** Clients based overseas are eligible to have their impairment assessed or reassessed for a lump sum if:
- they meet the standard eligibility criteria
 - the medical practitioner completing the ACC554 medical certificate meets both the following criteria:

- holds registration in the country in which they practise


- holds a medical degree from a medical school approved by the New Zealand Medical Council. This includes universities listed in the WHO World Directory of Medical Schools.

- b** Financial help for an impairment assessment overseas or for travel to New Zealand for an impairment assessment must be approved by the Technical Services team and must be cost effective. See the following business rule.

 Impairment assessment extended discretion request

7.0 Deceased clients

- a** Estates may be eligible to receive payments for deceased clients. Different rules apply depending on when a client has died, the type of support applied for, and the stage in the request process. Information is available at: lump sum deceased clients

 Deceased client Policy

<https://go.promapp.com/accnz/Process/ceda722c-753b-424c-9bb3-432a7125d2aa>

Summary

Objective

Use this guidance to determine cover for Treatment Injury claims.

Background

The Accident Compensation Act 2001 was amended replacing the provision for medical misadventure with treatment injury. The treatment injury provisions apply to all claims lodged for the first time on or after 1 July 2005. For claims lodged before this date see Cover criteria for medical misadventure.

A treatment injury occurs when a person suffers a personal injury when undergoing treatment by a registered health professional (RHP). See Scenarios for treatment injury.

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Policy

1.0 Rules

a You must consider all of the following factors when making a treatment injury cover decision:

- the client must have suffered a personal injury
- the injury must have happened in the context of treatment
- there must be a clear causal link between the treatment and the injury
- the injury must not be a necessary part or ordinary consequence of the treatment
- the claim must not fall under any of the treatment injury exclusions from cover.


-  Cover criteria for personal injury Policy
<https://go.promapp.com/accnz/Process/d11b619d-e931-4005-8b5a-b3dad275184b>
-  context of treatment Policy
<https://go.promapp.com/accnz/Process/b7136db9-6a87-4714-96aa-42e5f68f50aa>
-  causal link Policy
<https://go.promapp.com/accnz/Process/9cfde804-0615-4533-a2bb-c1065c7027be>
-  Necessary part or ordinary consequence of treatment
<https://go.promapp.com/accnz/Process/bf28fd8e-acf3-4b57-affe-08e416e08a57>
-  Treatment injury exclusions from cover
<https://go.promapp.com/accnz/Process/2fddb171-3490-477c-a417-f7f41b63fd90>


2.0 Date of injury

- a** The date on which a person suffers a treatment injury is the date on which the person first seeks or receives treatment for the symptoms of that personal injury. This date applies, even if it was not known at the time the treatment was first sought or received for the symptoms, that previous treatment was the cause of the symptoms.

We determine the date that a client first sought or received treatment by taking the advice of the treatment provider and any other medical experts who lodged the claim. This date must be supported by clinical records.

See the Accident Compensation Act 2001, Sections 38 and 53.

 Accident Compensation Act 2001, Section 38, Date on which person is to be regarded as suffering treatment injury
<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100956.html>

 Accident Compensation Act 2001, Section 53, Time for making claim
<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100979.html>

3.0 Clinical trials


- a** We can accept cover for a treatment injury sustained during a clinical trial under either of these conditions:


- the client did not agree in writing to participate in the trial
- an ethics committee, which was approved by the Health Research Council of New Zealand or the Director General of Health, approved the trial and was satisfied that it was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled.

4.0 Third party infections

- a** When an original infection is covered as a treatment injury, we'll also accept cover when a person passes on their infection to anyone else.

See the Accident Compensation Act 2001, Sections 32(7) and 18A.

 Accident Compensation Act 2001, Section 32, Treatment injury
<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100934.html>

 Accident Compensation Act 2001, Section 18A, Partner (and partner in relation to deceased claimant)
<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100670.html>



Summary

Objective

Treatment injury claims being complicated claims, are subject to stringent timeframes for making cover decisions. If ACC does not keep to these timeframes the claim is accepted by default. See Timeframes to determine cover.

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Policy

1.0 Rules


- a We must have an additional claim registered for any mental injuries as a consequence of physical injuries. These are considered as uncomplicated claims.


We must determine a treatment injury claim within two months of lodgement, unless an extension is sought. For relevant timeframes and actions required, see Treatment injury claims and the information in the attached table.

-  Treatment injury claims (Lodgement & Reg)

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| If the claim will take... | Then... |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| less than 2 months (60 days) to process | Client permission is not required |
| More than 2 months (60 days to process | <p>You must:</p> <ul style="list-style-type: none"> • contact the client noting that an extension is required for a further 60 days, 5-10 working days before the cover due date expiry • send written notification of the extension via the client's preferred written contact method |
| More time than advised ion the 2-month extension letter (120-270 days) to process | <p>You must:</p> <ul style="list-style-type: none"> • Contact the client explaining the reason for the time extension beyond 120 days and get their agreement to the extension • Send written notification of the extension via the client's preferred written contact method |
| 9 months (270 days) or more to process | You must issue a decision at or within 9 months or the claim will be accepted by default |

 How to manage legislative timeframes table 1.png

 TI30 Time extension advise

 TI01- Acknowledge and Extension combined- claimant.doc

 TI31 Time extension request

2.0 Extension from 120 - 270 days

- a** For time extensions from 120-270 days you must obtain the client's permission for the extension.

You must also inform the client that if they don't agree to an extension, the claim decision will be made on the information available and this may be a decision to decline the claim.

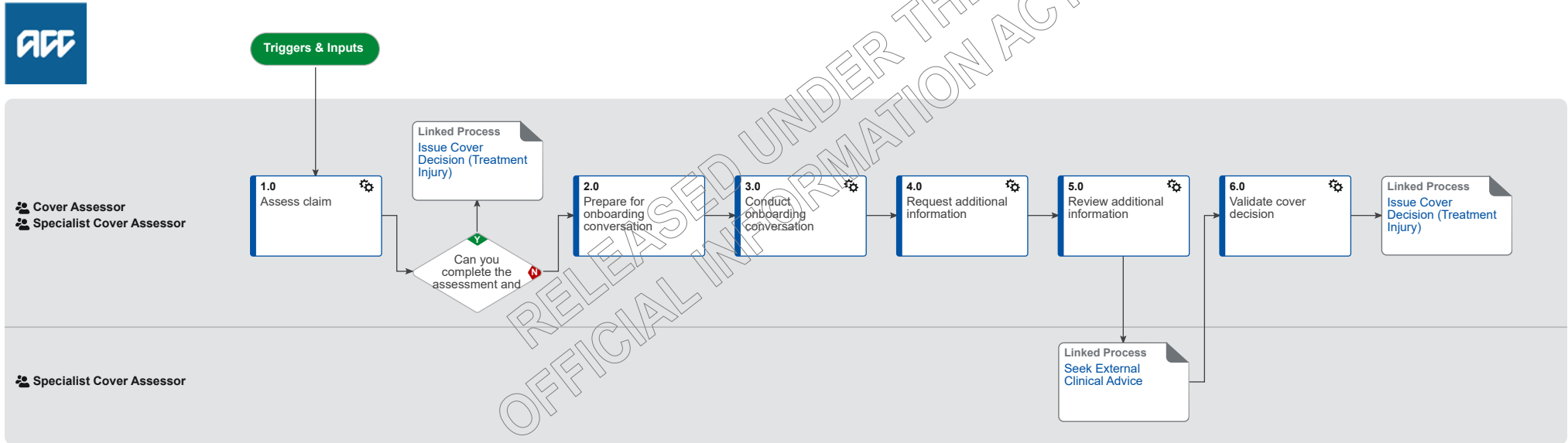
The client must can agree to the extension verbally or by returning the ACC109 form attached to the T131 letter. If they don't return this form you must call them and ask for verbal confirmation of the extension agreement.

Document conversation agreement or non agreement regarding extension of time frame in Eos contacts.

- b** See attached table for direction on the records in Eos.

| If the claim will take... | Then... |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Agrees to the extension | <ul style="list-style-type: none"> • Update the 'General' tab in EOS • Edit the cover decision due date with the date 9 months after the date of lodgement |
| Agrees to the extension but with less than 150 days | <ul style="list-style-type: none"> • Update the 'General' tab in EOS • Edit the cover decision due date with the date 9 months after the date of lodgement |
| Cannot be contacted and does not return the ACC109 | <ul style="list-style-type: none"> • Attempt to contact the client again to get verbal confirmation of their agreement to the extension • If the client cannot be contacted issue the cover decision based on the information you have at hand • Add a 'Contact' in Eos of all action taken |

 How to manage legislative timeframes table 2.png



Summary

Objective

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

Background

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

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Procedure

1.0 Assess claim

Cover Assessor, Specialist Cover Assessor


a Consider Risk of Harm questions.

 Risk of Harm Guidance 1.0.pdf

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

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

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

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

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

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

1. Ensure that an ENT05 Cover decision pending letter is sent out to the client. This letter advises the client that as cover is yet to be determined, we are not able to consider an application for entitlement, unless cover is awarded on their claim. Ensure that you forward date the task associated with the request to the legislative date on the claim.
2. Create 'Follow-up cover' task and add in the description [Complex claim, please assess].
3. Set priority on the task as 'high' if:
 - a) the client requires a critical decision,
 - b) the client needs more than a week off work,
 - c) there is an ARTP on file,
 - d) the claim is on the complex list,
 - e) we determine the client needs some sort of other urgent assistance
4. Change the target date of the task to the lodgment date
5. Transfer 'Follow-up cover' task to TIC-Case Ownership."

c Generate ACC2184 Cover decision tool if required.

NOTE When is ACC 2184 is required?

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

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

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

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

DATE OF INJURY:

ACC 45

ACC 2152

BACKGROUND

ANALYSIS

ADVICE

RESEARCH

d Confirm this is a newly lodged claim.

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

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

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

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

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

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

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

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

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

 Cover criteria for medical misadventure Policy


NOTE What if the claim is a duplicate?

Go to Identify and link duplicate claims.

 **PROCESS** Identify and Link Duplicate Claims :: Treatment Injury

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

Refer to Consequential Injury Claims Policy

 **PROCESS** Consequential Injury Claims Policy

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

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

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

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

NOTE What should be written in the contact?

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

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

f Determine whether the client has suffered a personal injury.

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

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




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

NOTE What if the claim is for a mental injury?

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

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

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

-  Mental Injury Because of a Physical Injury Policy
-  Statutory timeframes for mental injuries Policy
-  Treatment injury mental injury Policy


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

-  Context of Treatment Policy

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

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

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

 **PROCESS** Assess Claim for Cover :: PICBA

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

-  Causal Link Policy

NOTE What if there is no direct causal link?

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

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

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

-  Necessary Part or Ordinary Consequence of Treatment Policy

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

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

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

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

-  Treatment Injury Exclusions from Cover Policy

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

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

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

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

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

-  Next Generation Case Management landing page

m Updating Eos with relevant information

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

Ensure that with any work that you have completed on the claim that you are recording this in the contacts section of the clients claim with the heading stating: CLAIM UPDATE.



Can you complete the assessment and issue cover decision?

Cover Assessor, Specialist Cover Assessor

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

NO... Continue

2.0 Prepare for onboarding conversation

Cover Assessor, Specialist Cover Assessor

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

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

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

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

 NG GUIDELINES Obtain Verbal or Written Authority

NOTE When is a ACC6300 required?

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

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

NOTE What if the client is deceased?

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

NOTE What if verbal consent is appropriate?

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

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

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

Refer to the process below for more information.

 **PROCESS** Obtain Client Authority to Collect Information


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

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

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

NOTE What if the client requires an Authority to Act?

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

 **PROCESS** Obtain Authority to Act (ATA)

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

NOTE When should you request ACC2152?

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

NOTE What if you require an audiology assessment?





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

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

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

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

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

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

3.0 Conduct onboarding conversation

Cover Assessor, Specialist Cover Assessor

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

NOTE How many contact attempts should be made?

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

- Two attempts to contact client by phone, on different days/times, if unsuccessful send TI73.
- Request clinical notes from lodging provider
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

Claim lodged with ACC45 and ACC2152 or additional clinical notes

- Two attempts to contact client by phone, on different days/times, if unsuccessful send TI73.
- If we have been provided with sufficient information as to who provided the treatment on the lodging documents, it would be reasonable at this stage to request the clinical notes from those providers.
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

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

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

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

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

 TI Onboarding conversation

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

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

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


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

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

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

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

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

 NG GUIDELINES Managing Threat of Self-harm Calls

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

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


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

Work claims: insurerliaison@acc.co.nz
Non work claims: TPAsupport@acc.co.nz


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

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

This process ends here.

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

 Accredited Employer List

 Participating Accredited Employers (Non-work claims only)

d Complete outstanding actions.

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

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

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

 Referral for New Claim Lodgement

4.0 Request additional information

Cover Assessor, Specialist Cover Assessor

a Follow the appropriate process below for requesting additional information.

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

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

 **PROCESS** Re-open claim


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

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

 **PROCESS** Request Clinical Records for Treatment Injury

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

Refer to the 'Clinical questions guide'.

 Clinical questions guide

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

Please go to 'Seek Internal Guidance' process.

 **PROCESS** Seek Internal Guidance


NOTE What if you require external clinical advice?

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

 **PROCESS** Seek External Clinical Advice

NOTE What if you require an archived physical claim file?

Go to 'Retrieve Archived Physical Claim Files' process.

 **PROCESS** Retrieve Archived Physical Claim Files

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

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

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

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


Attach the ACC612 document to the task

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

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

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


 ENT memorandum.docx

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if a mental injury assessment is required?

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

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


 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Psychiatric assessment memorandum template

 Psychiatric assessment memorandum example

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

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

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

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

 How to manage legislative timeframes Policy

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

Go to 'Extend Cover Decision Timeframe' process.

 **PROCESS** Extend Cover Decision Timeframe

c Updating Eos with relevant information

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

Ensure that with any work that you have completed on the claim that you are recording this in the contacts section of the clients claim with the heading stating: CLAIM UPDATE.

5.0 Review additional information

Cover Assessor, Specialist Cover Assessor

a Review new information to make a cover decision.

NOTE What if you need more information?

Go back to activity 4.0 Request additional information.

NOTE How do you review the ENT assessment?

Refer to the guide below.

 Review ENT assessment

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

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

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

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

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

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

Go to 'Extend Cover Decision Timeframe' process.

 **PROCESS** Extend Cover Decision Timeframe

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

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

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

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

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

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

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

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

c Updating Eos with relevant information

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

6.0 Validate cover decision

Cover Assessor, Specialist Cover Assessor

a Review 'Claim validation framework guide'.

 Claim validation framework guide

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

NOTE What if you're unsure of the decision?

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

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

 **PROCESS** Seek Internal Guidance

RELEASED UNDER THE
OFFICIAL INFORMATION ACT



Triggers & Inputs

Cover Assessor
 Specialist Cover Assessor

1.0
Generate cover
decision
documents

2.0
Update Eos
records

3.0
Inform client of the
decision

4.0
Finalise Eos
records

Linked Process
[Match Claim to
Recovery Team](#)

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Summary

Objective

To notify the client about the cover decision.

Background

When cover assessment is completed, ACC must let the client know about the decision. This process covers two main scenarios - when ACC accepts the claim (injury) for cover and when ACC declines the claim (injury) for cover.

For each scenario, staff need to make sure they have clearly documented the rationale and updated the records, so they can clearly communicate the decision to the client. Staff always communicate our decisions to the client in writing and, if applicable, verbally. This helps the client to understand why we made a certain decision and gives them an opportunity to ask questions.

Once the decision to accept or decline the claim (injury) has been made, staff can determine the next appropriate steps in the client's recovery.

Owner 9(2)(a)

Expert 9(2)(a)

Procedure

1.0 Generate cover decision documents

Cover Assessor, Specialist Cover Assessor

- a Update the ACC2184 Treatment injury cover decision tool if required.

NOTE When is ACC2184 is required?

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

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

NOTE What if ACC2184 is not required? (If the claim does not meet the above criteria use the below template)

In Eos, update the 'Contacts' tab by adding a contact to explain rationale for cover decision made. Include the following:

- self-validation - ACCEPT or DECLINE (delete one) - (state the injury being accepted)
- DATE OF INJURY (Accepted claim)
- ACC45
- ACC2152
- Background - name, age and gender.
- Analysis
- Advice - short summary
- Research (if applicable) - short summary of events or evidence

NOTE What if it is PICBA?

In Eos, update the 'Contacts' tab by adding a contact to note 'Clinical information assessed - not treatment injury but meets PICBA criteria.'

- b Generate appropriate cover decision letter.

NOTE What if it is PICBA?

Generate TI60 Decline claim - treatment injury.


If you approve claim for cover, CVR40 will auto-generate and be posted to the client by completing the note in 4.0a.

NOTE What if there is a claim for mental injury?

• If you accept cover for physical injury, Supported Recovery Team will assess mental injury caused by physical injury.

• If you decline cover because there is no personal injury, you'll need to discuss with the client and seek the client's permission to re-open the declined mental injury claim. Once re-opened, you will assess it as treatment injury mental injury claim (TIMI)

Ensure that all lodged injuries are declined and that the letter references that the mental injury has been previously declined on the separately lodged claim.

 **PROCESS** Assess Claim for Cover (Treatment Injury)

NOTE Consolidated Treatment Injury Letters

• TI51 and TI69 have been retired in CMS and have been consolidated into TI50

• TI68, TI72, TI61, TI62, TI64 have been retired in CMS and have been consolidated into TI60


-  TI50 Approve claim Treatment Injury consolidated TI51 and TI69
-  TI67 Approve claim - treatment injury (for employer)
-  TI80 Approve claim - fatal treatment injury
-  TI82 Approve claim - fatal consequential injury caused by treatment
-  TI85 Approve claim - treatment injury mental injury
-  CVR49 Claim approve - review decision - claimant
-  TI60 Decline claim - Treatment Injury - consolidated TI68, TI72, TI61, TI62, TI64.
-  TI63 Decline claim - withdrawal
-  TI65 Decline claim - no new information (Med Misadventure legislation)
-  TI81 Decline claim - fatal treatment injury
-  TI83 Decline claim - fatal consequential injury caused by treatment


2.0 Update Eos records

Cover Assessor, Specialist Cover Assessor


a In Eos, in the 'Medical' tab, check the injury codes are correct.


b In Eos, in the 'Medical' tab, open the injury code, set the 'Outcome status' to 'Approved' or 'Declined', update the 'Outcome date' to the date you made a decision and add in the 'Comments' the exact injury being covered.

 Injury outcome status definitions

 Assign an outcome status and an outcome date to an injury code

c In Eos, in the 'Treatment Injury' sub-tab under the 'Injury' tab, update Injury Details, Treatment Context and Cover Decision sections. You must complete all mandatory fields.

 Treatment Injury tab in Eos - Data fields guide

 Data tables for Eos fields.pdf

 Risk of Harm Questions for Cover Specialists

NOTE What if it is re-assessment?

In Eos, in the 'Treatment Injury' sub-tab under the 'Injury' tab, update Injury Details, Treatment Context, Cover Decision and Reassessment sections.

NOTE What if it is PICBA?

In Eos, in the 'Injury' tab, update 'Accident' sub-tab.


d In Eos, check all treatment injury and cover related tasks are closed.

e What if the claim is accepted for cover?

NOTE Determine if the client require any assistance/support.

If client, require any assistance/support - create NGCM - Client Welcome Conversation Task (if cancelled previously) then add a brief description for Recovery Team.

NOTE Determine appropriate recovery team.

 **PROCESS** Match Claim to Recovery Team

NOTE What if the client does not require any assistance/support from ACC?

Transfer claim to TIC - Actioned Cases

3.0 Inform client of the decision

Cover Assessor, Specialist Cover Assessor

a Call the client if cover is declined or partially declined or if you think its is appropriate. Make sure you check client's identity.

NOTE How many call attempts do I have to make?

Two attempts to contact client by phone, on different days and times. Then send the decision letter by email or post.

NOTE What do you need to cover during your conversation with the client?

Clearly communicate

- why you're calling
- cover decision made
- rationale for decision
- review rights (if applicable)
- confirm the preferred method of communication for the decision letter
- discuss client's recovery needs (if applicable)
- what happens next (ie letter to be sent, transferring claim to another team, medical certificates required etc.)

 Identity Check Policy

NOTE What if the client requests a copy of their information?

- If the request is for one document, send a copy to the client directly.
- If there are multiple documents requested, go to 'Complete Client Information Requests' process.


 **PROCESS** Complete Client Information Requests

b Update the decision letter if applicable.

NOTE Update 'What happens next'.

Enter appropriate recovery team for transfer of claim.

c Enclose Treatment Injury or Consequential Injury Report if required.

 Treatment Injury Cover Assessment Centre: Style writing guide

NOTE When do you need to enclose the Treatment Injury or Consequential Injury Report?


You need to enclose the Treatment Injury or Consequential Injury Report if

- it is a decline (regardless of claim's complexity)
- it is a complex claim.

- d Set the letter's status to 'Complete'.
- e Upload appropriate information sheets on the claim.

NOTE What are the mandatory information sheets?

- Kōrero mai - Working together

 ACC255 Kōrero mai - Working together

NOTE What are the non-mandatory information sheets/attachments?

Determine if attaching the following would help client understand our decision or decide on the next steps:

- Copy of external or internal clinical advice
- Report from treating provider

 Privacy Check Before Disclosing Information Policy


NOTE What if you find information that needs to be redacted?

Send an email to Recovery Administration (recoveryadmin@acc.co.nz) and include the document to be redacted plus your specific redaction instructions, before adding the redacted document to the document group.

- f In Eos, at the Party level in Contact Details, check the client's preferred method of contact.


- g Privacy check and send the decision letter via the client's preferred method of contact.

 NG GUIDELINES Sending Letters in NGCM

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if the client's preferred method of communication is by post with a verified and valid postal address?

- 1) In Eos, go to 'Add Sub Case' and Select 'Recovery Plan'
- 2) From Recovery Plan Select 'Add Activity'. Then select 'Choose Activity' type 'NGCM - Send Letter'
- 3) In the task description enter: list the title of the letter, information sheets and other relevant attachments that need to be printed out and included with the letter
- 4) Review "When to use 'high' priority indicator on the tasks sent to Recovery Administration" rules to determine priority of the task. Change the priority indicator to 'high' if your scenario meets the rules.
- 5) Close
- 6) Open 'NGCM - Client Welcome Conversation' task then select 'Cancel' button.

 When to use 'high' priority indicator on the tasks sent to Recovery Administration

NOTE What if the client's preferred method of communication is by post but postal address is not verified but a valid address?

Send the decision letter (attempt to verify is best practice) - add into the Send Letter task instructions along the lines of can send to this valid unverified address. This is not say that you would never obtain verification if there is a need to do so.

- 1) In Eos, go to 'Add Sub Case' and Select 'Recovery Plan'
- 2) From Recovery Plan Select 'Add Activity'. Then select 'Choose Activity' type 'NGCM - Send Letter'
- 3) In the task description enter: Address valid but unverified - cover decision letter - please send
 - a) address valid but unverified - cover decision letter - please send
 - b) list the title of the letter, information sheets and other relevant attachments that need to be printed out and included with the letter
- 4) Review "When to use 'high' priority indicator on the tasks sent to Recovery Administration" rules to determine priority of the task. Change the priority indicator to 'high' if your scenario meets the rules.
- 5) Close
- 6) Open 'NGCM - Client Welcome Conversation' task then select 'Cancel' button.

NOTE What if the client's postal address is not valid and not verified?

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

NOTE How many contact attempts should be made?

- Two attempts to contact client/ATA by phone, on different days/times.

NOTE What if unable to verify an invalid client's postal address?

Do not send the decision letter. Document this on Contact tab – 'Decision letter not sent as postal address not valid and not verified'.

NOTE What if the client/ATA provided us with a returned/signed ACC6300 or client/ATA contacted ACC following response to TI73?


It would be reasonable at this stage to change or Update Client Address to verified. Then send decision letter.

 **PROCESS** Update Client Address

NOTE What if the client's preferred method of communication is by email?

Must be a verified email address.

Follow 'Send an email with an Eos document' system steps.

 Send an email with an Eos document (Eos Online Help)

4.0 Finalise Eos records

Cover Assessor, Specialist Cover Assessor

a In Eos, in the 'General' tab update Cover Status, Cover Status Reason and Accident Date & Time.

NOTE What if it is PICBA?

- In Eos, in the 'General' tab, in Cover Details section, update Cover Status and Cover Status Reason. If claim is accepted, set the Send Auto Accept Letters to 'Yes'.
- In Eos, in the 'General' tab, in Claim Type section take the tick off 'Treatment Injury'. Then fund code will change to 'Non-Earners' or 'Earners' depending on how the 'Employment' tab has been set.

NOTE What if the claim is withdrawn?

- In Eos, in the 'General' tab, in Cover Details section, update Cover Status and Cover Status Reason.
- In Eos, in the 'Injury Details' tab, sub tab 'Injury Diagnosis' and 'What treatment gave rise to the injury' tab - write Claim withdrawn.
- In Eos, in 'Treatment Context' tab, sub tab 'Treatment Context', 'Event' and 'Primary Injury' tabs – write Unknown/lack of information.
- In Eos, in the 'Cover decision' tab, sub tab 'Cover status - Personal Injury' – select 'Unknown'. In 'Cover Decision Details' tab, sub tab 'Describe how you arrived at your decision...' – write 'Claim withdrawn'. In 'Cover Decision' sub tab – select 'Declined – Withdrawn'.

b In Eos, in the 'Contacts' tab, add a contact to note any key points from the conversation with the client if applicable.

c In Eos, check the documents have not been left 'incomplete'. All documents must be completed prior to transfer.

d In Eos, check all cover related tasks are closed.

e Go to 'Match Claim to Recovery Team' process.

NOTE What if the claim is declined?

- transfer claim to TIC Actioned Cases department.

NOTE What if there are open tasks for support and or entitlements?

- Request for Nursing Services - Forward the task to the 'Elective SC – TMT Assessment dept' queue.
- Request for dental treatment - Forward the task to the 'Dental Claims' department queue.
- Request for hearing loss treatment or aids - Forward the task to the 'Hearing Loss Claims' department queue.
- Request for elective surgery - Forward the task to the 'Elective SC – Surgery Triage' department queue.
- Request for Independence Allowance/Lump Sum - Forward the task to the 'Hamilton SC – IA/Lump Sum' department queue.
- Request for orthotics - Forward the task to the 'Hamilton SC – Orthotics' department queue.
- Request for reimbursement costs
 - Travel costs - Forward the task to the 'Hamilton SC Transport' department queue
 - Pharmaceuticals - Forward the task to the 'Elective SC – Claimant Reimbursements' department queue.


 Move claim to actioned cases (Eos Online Help)

NOTE What if the claim is a staff claim?

Transfer the claim to the Staff Claims Unit department queue

NOTE What if it is a fatal claim (as the client has died as a result of their injuries)?

- transfer claim to the Accidental Death Claims department queue
- give the department a call to notify.

 Accidental death team - contact details

NOTE What if the client's condition is rapidly deteriorating and the client is eligible for Independence Allowance/Lump Sum?

- 1) In Eos, create 'General task'
- 2) Add in the task description [Rapidly deteriorating client]
- 3) Set the target date to the current date
- 4) Set priority as 'High'
- 5) Send the task to 'Hamilton SC- IA/Lump Sum' queue

NOTE What if there is a previously declined mental injury related to the physical injury you have assessed?

If there is a previously declined mental injury, and you have accepted the physical injury for cover:

- 1) In Eos, generate 'Follow-up cover' task on the declined mental injury claim
- 2) Add in the task description [re-assessment required for mental injury, physical injury caused by treatment has been accepted for cover]
- 3) Set priority as 'High'
- 4) Send the task to Supported Recovery Team

If there is a previously declined mental injury, and you have declined the physical injury for cover:

- 1) Re-open the declined mental injury claim (you'll need to discuss with the client and seek the client's permission to re-open the declined mental injury claim. Once re-opened, you will assess it as treatment injury mental injury claim (TIMI)
- 2) Go to 'Assess Claim for Cover (Treatment Injury)' to assess Treatment Injury Mental Injury

 **PROCESS** Assess Claim for Cover (Treatment Injury)

 **PROCESS** **Match Claim to Recovery Team**
Cover Assessor, Specialist Cover Assessor

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Summary

Objective

A treatment injury is a personal injury arising from treatment that meets ACC's Cover criteria for treatment injury.

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

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

Policy

1.0 Treatment injury claim identification

a A treatment injury claim may be identified by any of the following:

- text on the ACC45 ACC Injury claim form (ACC45) stating the client has an existing physical injury claim, and while receiving treatment for this injury, incurred a further injury
- the key words 'treatment', 'medical', 'hospital', 'surgery', 'physiotherapy', 'chiropractor' or 'doctor' appearing on the ACC45
- a tick in the 'Is this claim for treatment injury?' box on the ACC45 or the 'Medical misadventure' box on older ACC45s
- material accompanying the ACC45, eg the ACC2152 Treatment Injury Claim (123K) form and any medical notes.

 ACC2152 Treatment Injury Claim

2.0 The difference between consequential injury and treatment injury

a The key point in the difference between a treatment injury and a consequential injury is understanding what the treatment is provided for, that gives rise to the claimed new injury:


- if the treatment is for an underlying condition and the person suffers new injury from the treatment provided by a registered health professional, it is considered under the treatment injury provisions (s32 of the AC Act 2001)
- if the treatment is for a covered ACC injury and the person suffers new injury from the treatment, it is considered under the consequential injury criteria (s20(2)(d) & (h)) – TI delegation to determine cover
- if the person has a covered ACC injury and that injury through gradual process, disease or infection develops into another injury, this is a consequential injury that the branch has delegation to determine cover [as there is no intervening treatment that gives rise to the additional injury] (s20(2)(g)).

3.0 Lodgement date

- a** A claim for treatment injury must be lodged within 12 months of the later of:
- the date the registered health professional (RHP) first considered the personal injury to be a treatment injury
 - the date the client suffered the injury as determined under the AC Act 2001, Section 38.

4.0 Late lodgement

- a** ACC must not decline a claim on the grounds that it was lodged late, unless the claim's lateness prejudices the ability of ACC to determine cover. See Eligibility of late claims.

 Eligibility of late claims Policy

5.0 Transitional claims

- a** If a client lodges a claim for the first time on or after 1 July 2005, apply the treatment injury rules. The rules for medical misadventure apply to claims lodged before 1 July 2005.

 Cover criteria for medical misadventure Policy

6.0 Exception

- a** We can consider a claim under the treatment injury provisions if it was lodged on or after 1 July 2005 and previously declined under the medical misadventure rules if no personal injury was established at the time, but a personal injury arises after the claim was declined from that past incident. The personal injury could arise before or after 1 July 2005.

NOTE Example

After a period of hospitalisation before 1 July 2005, a client is diagnosed with Methicillin Resistant Staphylococcus Aureus (MRSA) but they have no symptoms at the time. Some time after 1 July 2005 they develop a serious infection. A personal injury becomes present so their claim can be considered under the treatment injury provisions.

7.0 Forwarding treatment injury claims


- a** When you receive a treatment injury claim, you must capture the details as a new claim and forward any hard copy materials to the Treatment Injury Centre. This includes any material accompanying the ACC45, eg the ACC2152 Treatment Injury Claim (123K) form and any medical notes.

Specialist staff in the Treatment Injury Centre assess the claim and make the cover decision.

You must:

- refer any enquiries about treatment injury claims to the Treatment Injury Centre
- ensure any material that accompanied the ACC45, eg the ACC2152 and clinical notes, is clearly marked with the claim number or ACC45 number.

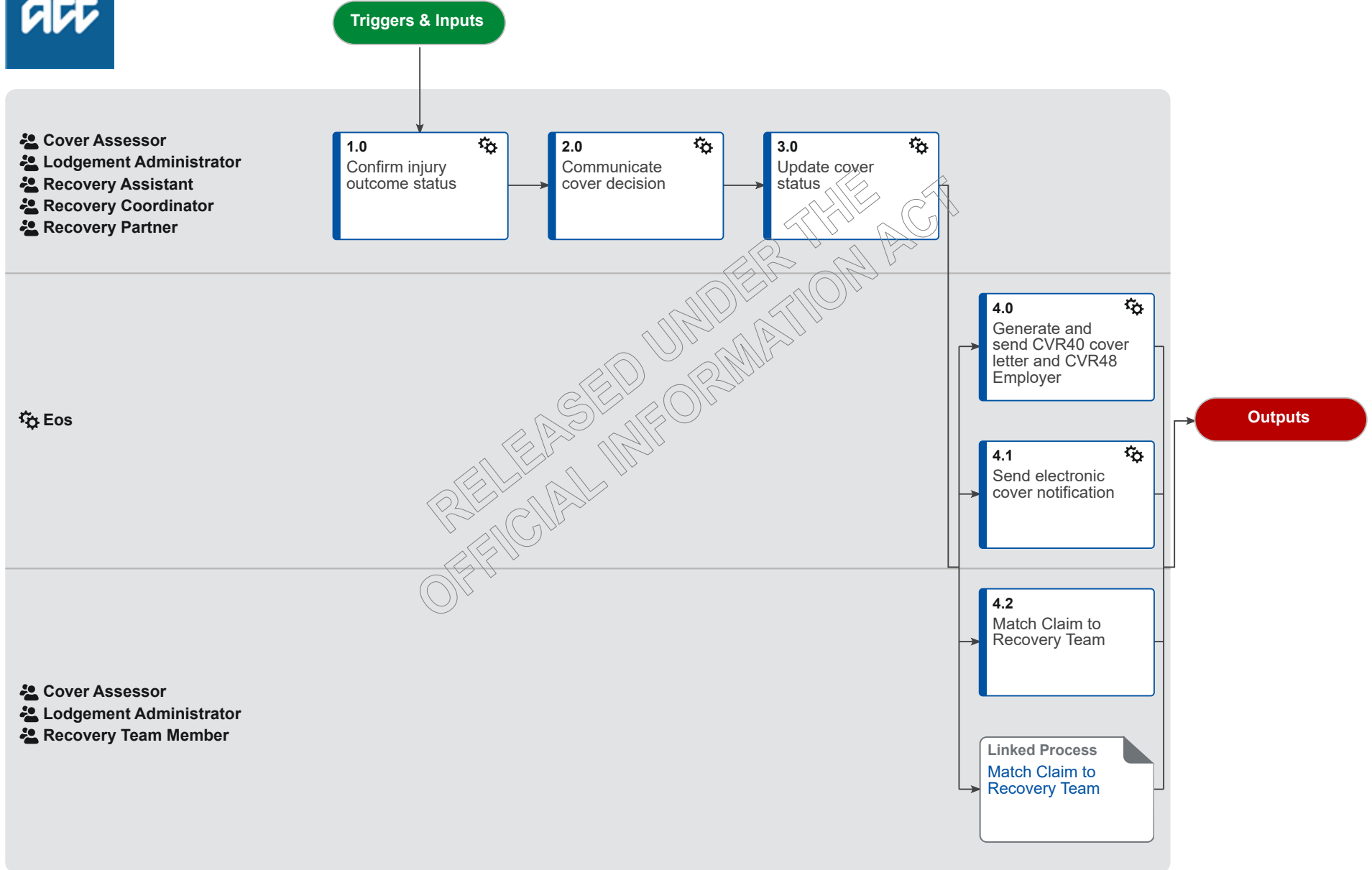
See Receiving and streaming treatment injury claim for further information.

 Receiving and streaming treatment injury claim Policy

8.0 The Accident Compensation (Definitions) Regulations 2019 and determining treatment injury cover

- a** The Accident Compensation (Definitions) Regulations 2019 moved the key definitions of 'registered health professional' and 'treatment provider' and associated definitions from the Accident Compensation Act 2001 to standalone regulations.
 - b** The Accident Compensation (Definitions) Regulations 2019 took effect on 01/10/2019.
 - c** When assessing cover for Treatment Injury, we need to determine the date of injury based on when a person first seeks treatment for the signs or symptoms of their injury. So a claim may be lodged after 1/10/2019, but have an earlier date of injury.
 - d** The relevant date to consider whether someone was an RHP is the date of the treatment. If a client claims after 01/10/2019 for an event occurring earlier the amendment does not apply. The changes are not retrospective.
-

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Summary

Objective

To advise a client that we've accepted their claim. This process addresses accepting PICBA claims only, it does not include accepting specialist claims.

Background

A staff member has investigated a claim and determined that it meets criteria for cover and can accept it.

Owner 9(2)(a)


Expert 9(2)(a)

Procedure

1.0 Confirm injury outcome status

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner


- a Review the outcome status of the injury or injuries in Eos and update if necessary. The default outcome status is Provisional however this should be updated to Approved or Declined in certain scenarios. See the Injury outcome status definitions guide below.

 Injury outcome status definitions

NOTE What if ACC is accepting some of the injuries but declining others?

Leave the outcome status for the accepted injuries as Provisional and update the outcome status for the injuries you're declining to Declined.

NOTE: If you've received medical records that confirm the injury or injuries being covered, then you must change the outcome status for the accepted injuries to Approved after you've created the CVR43 cover letter. This is because Eos will only populate the details of the accepted injuries in the letter when the outcome status is Provisional.

 Assign an outcome status and an outcome date to an injury code

2.0 Communicate cover decision

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine which cover letter should be sent to the client using the guide below.

 Cover Letter Quick Reference Guide

NOTE What if the guide says you should send the automatic CVR40 letter?

- Ensure the Send Auto Accept Letters radio button is set to Yes.
- Go to step 3.0 to update the cover status in Eos.


NOTE What if the guide says you should create and send a letter that is not the automatic CVR40 (ie CVR43, CVR45, CVR47, CVR70, WSI02 or CVR41)?

- Ensure the Send Auto Accept Letters radio button is set to No.

- b Generate the relevant accept cover letter in Eos that you identified using the guide above.

NOTE What if the claim is for a mental injury?

Go to the Issue Recovery Decision process

 **PROCESS** Issue Recovery Decision

 Upload an Incomplete Electronic Document

NOTE What if the client's address is not verified? - FOR CLAIMS ASSESSMENT

- If the address is verified but not valid, it is okay to send a letter to the client. However, if speaking with the client as part of the assessment process, please ensure the address details are verified.

- If the address is not verified and not valid, add a note in the contact for the document stating: 'Letter not sent to client as address is invalid.' Send a copy of the accept cover letter to the provider who lodged the claim instead.

NOTE CLIENT ADMINISTRATION - when working on sending information for Claims Assessment. Continue to send to unverified addresses.


NOTE What if the client address is not verified - FOR RECOVERY TEAM MEMBERS

-If an address is verified the letter can be sent regardless of whether the address is valid or invalid

-If an address is not verified the letter cannot be sent regardless of whether the address is valid or invalid. Add a note in the contact for the document stating: 'Letter not sent to client as address is invalid.' Send a copy of the accept cover letter to the provider who lodged the claim instead.

c Print and sign the letter.

d Add the Working Together information sheet.

 ACC255 Kōrero mai - Working together

e Complete a privacy check to ensure you are only sending information to the client that is relevant to this claim.

NOTE Do I have to complete the privacy check myself?

In some business units a separate team will complete this privacy check. Ask your manager if this is the case for your team. If there is not a separate team responsible for privacy checking you will need to complete the check yourself.

NOTE What if I'm only accepting some of the injuries but declining others?

Now that you've created the CVR43 cover letter, you can update the injury outcome status for the accepted injuries to Approved if you've received medical records that confirm the injuries. If you haven't received medical records that confirm the injuries then leave the outcome status for the accepted injuries as Provisional.

3.0 Update cover status

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Eos, change the cover status to Accept and update the cover status reason to Criteria for Cover are met.


NOTE What if the claim is for a wilfully self-inflicted injury (WSI)?

Include the following statement in the cover status change reason:

Cover accepted for physical injuries - if entitlements sought must be investigated for wilfully self inflicted by managing department.

 Update Cover Status

b Add a contact to the claim explaining your cover decision rationale.

 Add a client contact

c Close the Confirm Cover Decision task.

 Close a Task

NOTE What if I've received a Notification Decision task?

You've received this task because the claim has a specialist claim type (WRGPDI, Hearing Loss, Mental Injury, Work Related Mental Injury, Treatment Injury, Dental). In general, it's good practice to send the automatic electronic notification to the client informing them that their claim has been accepted. However in some instances it might not be necessary, for example you may have just confirmed cover over the phone with them.

- If you want to send notification, close the Notification Decision task and select Send Notification when prompted.
- If you don't want to send notification, close the Notification Decision task and select Discard Notification when prompted.

Note that Sensitive and Fatal claim types will never be sent automatic notification, and electronic notification is automatically sent for PICBA claims.

NOTE Why does a new Confirm Cover task get created?

Before you can successfully close the Confirm Cover task all Information Required tasks need to be actioned and closed. You also need to change the Cover Status on the General Screen to "Accept". If you close the Confirm Cover task before these steps have been undertaken a new Confirm Cover task will be created.


4.0 Generate and send CVR40 cover letter and CVR48 Employer Notification letter (if applicable)

Eos

- a** If the Send Auto Accept Letters radio button is set to Yes and the cover status has been updated to Accept, then the CVR40 cover letter will be automatically generated. Eos transfers the letter data to an external mail house who print and send the letter to the client.
- b** If the claim is accepted and is a work-related injury, then the CVR48 Employer Notification letter will be automatically generated. Eos transfers the letter data to an external mail house who print and send the letter to the client's employer.

NOTE What if the employer is noted as being Proxy, and we receive updated details?

Review Identify Clients Employer - Step 2.0

 **PROCESS** Identify Client's Employer

4.1 Send electronic cover notification

Eos

- a** An electronic notification is automatically sent to the client that confirms their claim has been accepted. Note that there are some situations where this notification is prevented, for example if the claim type is Fatal or Sensitive, if the client is a minor or deceased, if the claim is managed by the Remote Claims Unit or Te Ara Tika (previously Wellington Central Branch), if the client has a Safe Contact on their party record, if the Stop Notifications attribute on the client's party record is set to Yes etc.

4.2 Match Claim to Recovery Team

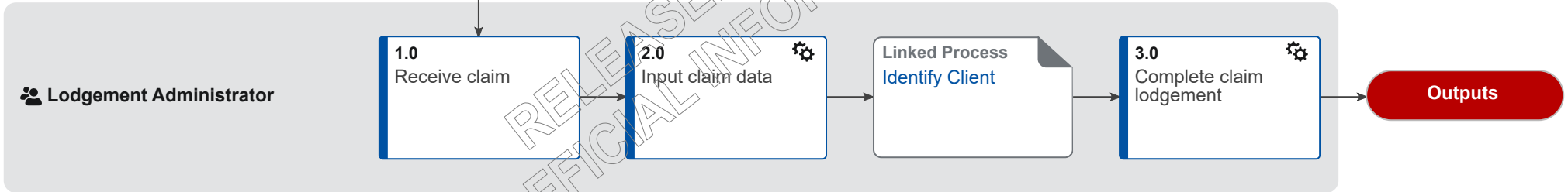
Cover Assessor, Lodgement Administrator, Recovery Team Member

- a** Use this process to determine the appropriate team to manage the client and their recovery.

 **PROCESS**

Match Claim to Recovery Team

Cover Assessor, Lodgement Administrator, Recovery Team Member





Summary

Objective

To capture ACC45, ACC46 and ACC46N manual claim forms received via email into Eos on behalf of the provider and then prepare the forms for further document management. This can also include forms that a Provider faxes to ACC which are received as an email.

Background

A Provider has submitted a claim form to ACC manually by emailing it directly to ACC.

Emailed manual claims are completed in a priority order of:

- 1) FataIs/Accidental Death Unit (ACC21)
- 2) Early Cover (ACC7422) and Urgent
- 3) Pre-1982 claims
- 4) Treatment Injury (ACC2152) & Sensitive Claims
- 5) Assistance Required/Time off (ACC18s)

Owner 9(2)(a)

Expert 9(2)(a)

Procedure

1.0 Receive claim

Lodgement Administrator

- a Filter the Registration Inbox to prioritise the processing order.
- b Read the email content and attachments.

NOTE What if the email has no attachments?

Respond to the email and/or request the claim form from the sender.

NOTE What if it's a returned Accredited Employer claim?

Go to Action Returned Accredited Employer Claim. This process ends.

 **PROCESS** Action Returned Accredited Employer Claim

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NOTE What if the email is from MFAT (Ministry of Foreign Affairs & Trade) or an Embassy?

If the email is from a staff member posted overseas, we still need to register their claim.

We will also register claims on behalf of their family members – usually the email will still come from the MFAT staff member

- Lodge the claim using a dummy number

- If there is insufficient information on the email from the client regarding their personal details (eg. Date of birth, Middle name etc.), Please respond to the email and get clarifying details.

If the client has not attached enough information about the accident – please clarify this, this could be done by requesting a medical certificate or doctors notes to show they have sought treatment.

If the client has supplied an address, then please update their details otherwise leave all information as it is.

- Let the claim stream to Cover Triage for assessment and suppress the letters

NOTE What if I'm unable to resolve the email without gathering further information?

Contact the relevant party to gather the necessary information, to update the next person in the team who may pick up the follow up action on the email edit the email adding the reason it is flagged so it's clear about what action was taken and why. Steps to edit the email are: Open email (double click) > Actions > Edit email > Write and highlight reason email is flagged > Close. Once the email has been processed and completed repeat previous steps but erase comment added. This process then continues.


NOTE What if we have received a ACC2152 (Treatment Injury) with no ACC45/42 form attached?

Please respond back to the email/task sender to request a copy of the ACC45/42 as we cannot lodge a treatment injury claim without this.

c Go to step 2.0 Input claim data if the email has an attached ACC45, ACC45+ACC18, ACC46 or ACC46N.


NOTE What if it's an ACC18 Medical Certificate only?

Go to Complete ACC18 Medical Certificate Request process.

 **PROCESS** Complete ACC18 Medical Certificate Request


NOTE What if it's an ACC42 Dental claim form?

Go to Receive and Input Manual Claim: Dental process variation.

 **PROCESS** Receive and Input Manual Claim :: Dental

NOTE What if it's an Early Cover request (ACC7422 Early cover application form)

Go to Receive and Input Manual Claim: Early Cover process variation.

 **PROCESS** Receive and Input Manual Claim :: Early Cover

d Go to step 3.0 Complete claim lodgement if the email has an attached ACC2152.


2.0 Input claim data

Lodgement Administrator

a In Eos, attribute the client (if you can), using Identify Client process.

 Identify Client

b Enter the remaining information on the claim form into the relevant fields.

 Complete claim intake form

NOTE What if you can see information or inconsistencies on the claim form that you can correct now so that they don't trigger an IR?

Correct the information when you're entering it in Eos.

Corrections can include:

- when the diagnosis side isn't selected - but the injury description makes it clear what the selection should be.
- if the formatting of the address is wrong, (eg St used instead of Street) or address information has been entered in the wrong fields in the form.

NOTE What if there is no accident description listed on the claim form?

This will not drop out as an Information Required Task.

Please follow up with the provider or the client at the time of registration as we need to know how the accident occurred.

If this has been picked up with another IR task then please confirm before completing the outstanding IR.

NOTE What if the claim form was lodged with ACC (ie received) prior to the date of claim intake?

Amend the date of lodgement in the claim intake form to the date that the claim form was received by ACC.

NOTE What if the answer to "Is this a work-related gradual process, disease or injury?" is Yes?

Add 'WRGP' to [Additional Injury Comments] to ensure that it matches to the Gradual Process team.

NOTE What if the Provider hasn't signed the claim form? (eg they've stamped the form instead)

Tick the 'Claimant/representative has not signed the form' box to No and leave the Provider ID field blank.

Even though this tick box is typically used for when clients do not sign the form, this will raise a Missing Signature IR as opposed to a Provider Invalid for Registration IR.

NOTE What if the Provider has signed the form, however there are no other provider details?

We must investigate who the provider is as we need to check for provider competencies.

Leave the Provider ID field blank and push through as this will raise a Provider Invalid for Registration IR and then try the following:

- Check inFact reporting to check the batch numbers to see if we can see a provider trend/match signature
- Check claim numbers before and after your claim to see if the provider details are the same
- Call the client to confirm where they were seen

NOTE When is it appropriate to use the Default Provider (J99966) ID?

- When it is a Sensitive Claim/Sensitive Engagement Form
- When it is a Treatment injury but there isn't any additional information as to where they were seen
- When it is an Additional Claim for Lodgement.
- Helicopters - with the appropriate vendor ID in the vendor ID box.
- Prisons – make a registration note on the general screen with the prison and provider that the client was seen by (eg: Christchurch Men's Prison, Dr John Smith).

NOTE What if more than one ethnicity has been selected on the claim form?

Please select all ethnicities listed on the ACC45/ACC42 form

C Click [NEXT] on the claim intake form to save the changes.

NOTE What if the ACC45 is for a Sensitive Claim?

The date of accident should be the date of consultation.



PROCESS

Identify Client

Lodgement Administrator

3.0 Complete claim lodgement

Lodgement Administrator

a Check there is no Missing Information for Cover task once the claim has progressed through automation.

NOTE **What if there is a Missing Information for Cover task?**


Resolve the information requirements in the task using the relevant Validate Claim processes.

b Close out of the Eos screen and out of the PDF attachments.

c Determine what to do with the email.

NOTE **How do you determine what to do with the email?**

- For ACC45/ACC42 attachments only, forward email to dmthamilton@acc.co.nz.
- For ACC2152 attachments (email may also include ACC45), forward email to vcfduinedinscanunitti@acc.co.nz.
- For ACC18 requests, go to Complete ACC18 Medical Certificate Request process.

 **PROCESS** Complete ACC18 Medical Certificate Request

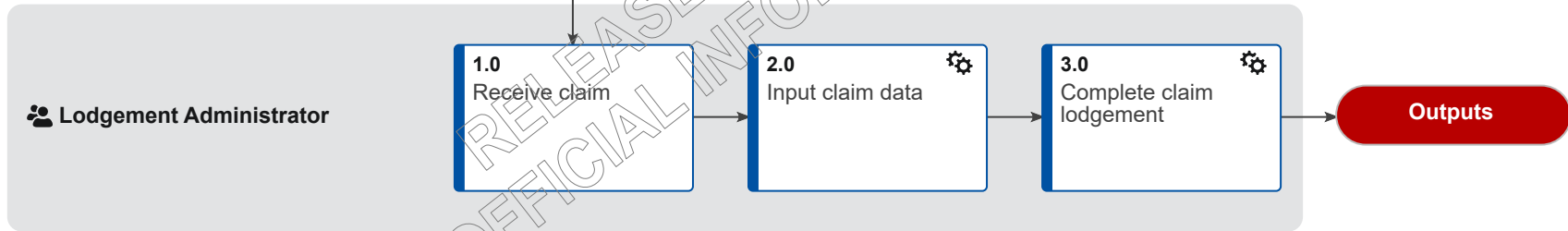
NOTE **What if the claim number of client party details aren't clear in the body of the email or attachment that you're forwarding on to be processed?**

To assist with ease of processing, please add these details to the body of the email which you forward on.

d Move email into Completed [current year] sub-folder in the Registration Email Inbox.

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Receive and Input Manual Claim - New claim lodgement with no claim form :: No claim form v14.0



Receive and Input Manual Claim - New claim lodgement with no claim form :: No claim form v14.0



Summary

Objective

To capture new claims requested by internal staff into Eos and file the relevant information

Background

In certain circumstances it's necessary to create a new claim In these cases, there will be no standard ACC claim form so the information must be provided another way

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

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

Procedure

1.0 Receive claim

Lodgement Administrator

a Open the Registration Email Inbox and access the new claim request.

b Read the email content and any attachment(s).

NOTE What if the email doesn't have all the information I need?

Reply to the email and request the information from the sender.

c Confirm that the request meets the criteria for a new claim to be lodged

NOTE What's the criteria for a new claim to be lodged?

A new claim may be lodged only if all of the following are true:

- The client has consented to the new claim being lodged via any of the following methods:

- o verbally
- o in writing

- and at least one of the following is true:

- o the date of accident of the new claim is different from the date of accident of the claim that the client is currently being treated for
- o the accident description of the new claim is different from the accident description of the claim that the client is currently being treated
- o the claim contains at least one of the following types of claim:

- complicated claim
- non-complicated claim

 Non-complicated claim definition

 Complicated claim definition

NOTE What if the claim doesn't meet the criteria for a new claim?

Return the request to the requestor for them to gather more information or cancel the request

d Confirm that you have all the information you need to register a new claim

NOTE What information do I need to register the claim?

A request for a new claim must contain all of the following information relating to the client:

- Person ID
- First name of client
- Surname of client
- Date of birth of client
- NHI number of client
- Fund code of new claim
- Accident description of new claim
- Date new injury identified
- Provider name
- ACC provider number
- Full name of the person submitting the request for a new claim
- Title of the person submitting the request for the new claim
- Date the request for a new claim was submitted
- The name of the ACC business unit submitting the request for a new claim
- The ACC45 number of the original claim, if there is one
- The name of the staff member if the new claim needs to be transferred to a specific person
- At least one of the following for the new claim:
 - o read code
 - o injury description
 - o injury diagnosis
 - A copy of at least one of the following:
 - o Document where the injury is recorded
 - o Clinical notes with the relevant page number noted
 - o Instruction from the Technical Services team
 - o Medical Advisor comment

NOTE A request for a new claim may be on the Referral for new claim lodgement form

 Referral for New Claim Lodgement

NOTE What if the email doesn't have all the information I need?

Reply to the email and request the information from the sender.

NOTE What if the email is from MFAT (Ministry of Foreign Affairs & Trade) or an Embassy?

If the email is from a staff member posted overseas, we still need to register their claim.

We will also register claims on behalf of their family members – usually the email will still come from the MFAT staff member

- Lodge the claim using a dummy number

- If there is insufficient information on the email from the client regarding their personal details (eg. Date of birth, Middle name etc.), Please respond to the email and get clarifying details.

If the client has not attached enough information about the accident – please clarify this, this could be done by requesting a medical certificate or doctors notes to show they have sought treatment.

If the client has supplied an address, then please update their details otherwise leave all information as it is.

- Let the claim stream to Cover Triage for assessment and suppress the letters


2.0 Input claim data

Lodgement Administrator


a In Eos, open the client's party record. See the Client Searches guide below.

 Client searches

b Turn off notifications.

 Stop notifications

c Request a Dummy ACC45 number using the Request Dummy 45 tool.

 Request Dummy 45 spreadsheet

d In the reason for request box in the Request Dummy 45 tool, type: 'Referral for new claim lodgement'

e In Eos, enter the new claim information into the relevant fields.

NOTE **What if it's been identified that it's a work related gradual process, disease or injury?**

Add 'WRGP' to Additional Injury Comments to ensure that it streams to the Gradual Process team.

f In Part E, enter the default provider number (J99966) so that the claim receives a Held cover status.

g Click NEXT on the claim intake form to save the changes.


h Reopen the new claim and action any information requirements.

i Once the claim has a 'Registration Complete' status, remove the default provider and replace with the actual provider from the ACC45.

NOTE **What if the claim has been streamed to a specialist department?**

Transfer the claim to your queue (or contact the relevant department to ask for it to be transferred to your queue if you're not able to transfer it yourself).

j In Eos, upload any documents that came with the request to the claim.

 File an inbound email

NOTE **What document type should I use in Eos?**

- Miscellaneous claims: VCF011 Internal document
- Sensitive claims: SC VCF011

NOTE **What information should I include when I'm uploading and where?**

- Contact details: Referral for new claim lodgement
- Status: Received
- Direction: Internal
- Reason: Contact with Internal Party
- Description: Referral for new claim lodgement

k Confirm cover status

- If meant to be Held, then transfer to relevant person or team.
- If meant to be Accept, then amend cover status to Accept and suppress auto accept letter.

l Open the client's party record and turn notifications on.

m Confirm to the requestor that you've created the new claim and advise of any changes or default info you had to use.

3.0 Complete claim lodgement

Lodgement Administrator

a Close out of the Eos screen and any related documents.

b Move email into Completed [current year] sub-folder in the Registration Email Inbox.

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Your claim number is **[Claim number auto]**

Date auto

Client Title Auto Client Full Name Auto
Additional Recipient Reference Auto
Address Line 1 Auto
Address Line 2 Auto
Suburb Auto
Town Or City Auto Post Code Auto

Dear Client Title Auto Client Surname Auto

We need more time to consider your claim

[Option 1] We're still working on getting [information] from your [source of information]. It's important we have this information as it will help us assess your claim.

We'll be in touch with you as soon as possible and advise that we are required to make a decision by [date - 4 months from lodgement].

[Option 2] We're still working on getting the following information from your [source of information]:

- [information]
- [information]

It's important we have this information as it will help us assess your claim.

We'll be in touch with you as soon as possible and advise that we are required to make a decision by [date - 4 months from lodgement].

[Option 3] We have received the following information from your [source of information]:

- [information]
- [information]

However, we're still working on getting the following information from [source of information]:

- [information]
- [information]

It's important we have this information as it will help us assess your claim.

We'll be in touch with you as soon as possible and advise that we are required to make a decision by [date - 4 months from lodgement].

We're happy to answer your questions

Please call me on [CONTACT_DETAILS] if you would like to talk about this letter. I'll be able to help you faster if you have your claim number (LEGACY_CASE_ID auto) ready.

Yours sincerely

[Staff_Name auto]

[Job Title auto]

Telephone: [CONTACT_DETAILS]

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OFFICIAL INFORMATION ACT

| | |
|--------------------------|-----------------------|
| Your claim number | LEGACY_CASE_ID |
|--------------------------|-----------------------|

1 July 1974

CLM_TITLE Claimant_First_Name Claimant_Surname
Claimant_Line1
Claimant_Line2
Claimant_Line3
Claimant_Line4

Dear CLM_TITLE Claimant_Surname

We need your agreement for more time to consider your claim

[Option 1] We're still working on getting [information] from your [source of information]. It's important we have this information as it will help us assess your claim.

[Option 2] We're still working on getting the following information from your [source of information]:

- [information]
- [information]

It's important we have this information as it will help us assess your claim.

[Option 3] We have received the following information from your [source of information]:

- [information]
- [information]

However, we're still working on getting the following information from [source of information]:

- [information]
- [information]

It's important we have this information as it will help us assess your claim.

Why we need your agreement

The law gives ACC a limited period of time in which to assess claims. If we need longer than this, we must ask for your agreement.

Although we will try to make a decision on your claim as soon as possible, we are asking for your agreement to have until [9 months from lodgement date] to give us enough time to collect all the information we need.

If we don't have this information, we will have to use the information we currently have to make a decision on your claim.

What happens now

If you agree to give us more time, please fill out the attached *Time extension to determine cover* form and return it in the enclosed reply-paid envelope by [date].

We're happy to answer your questions

Please call me on [CONTACT_DETAILS] if you would like to talk about this letter. I'll be able to help you faster if you have your claim number (LEGACY_CASE_ID) ready.

Yours sincerely

Staff Name

Job Title

Telephone: CONTACT_DETAILS

Encl. *Time extension to determine cover (ACC109)*, reply-paid envelope

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Request for time extension

"Use this form to agree or disagree to a time extension for ACC to make a decision on your claim"



Please read the statements below and tick one box.

I agree to an extension of time from [from date] to [to date]. This will enable ACC to gather required information to enable a decision to be made on my claim.

Or

I do not agree to an extension of time. I ask ACC to make a decision based on available information.

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Signed

Date/...../.....

CLAIMANT FULL NAME

Claim number: LEGACY_CASE_ID