Clinical Services

Service Schedule

Operational Guidelines

August 2011

This is a living document and will be updated as required

Contents

Introduction

The following information is designed to help providers interpret the ACC Clinical Services contract which:

- is used to fund specialist assessment services
- provides funding for some procedures to be completed in specialists' rooms.

Important:
If there are any inconsistencies between this document and the contract, the contract takes precedence.

To ensure that all specialists are aware of the process for funding assessments, the services are clearly outlined in this document. ACC supports best practice for the assessment of all clients.

There are two distinct groups of assessment codes. Those exclusively for anaesthetists and the general use codes.

The information in this document is tailored to cover:

- anaesthetists, and
- specialists from other defined scopes of practice.

However, all providers will use each section of information.

Who can hold this contract

The contract holder (the supplier) is any medical specialist within a relevant vocational scope of practice, eg an anaesthetist, cardiologist, or surgical specialist (20 currently covered). The contract can be held by either a group of specialists or an individual. If an individual holds the contract they are expected to have access to:

- a nursing team led by registered nurses, and
- a sufficient range of diagnostic and assessment services, and
- staffing arrangements for a multi-disciplinary approach.

ACC also allows suppliers such as private or public hospitals to hold the contract and requires them to name the individual service providers (medical specialists) who will work under the contract so that ACC can name them on the service schedule. A specialist can be named on more than one Clinical Services contract, eg if they work in both public and private hospitals. The supplier is responsible for managing the contract and disseminating information to the named providers.

The Clinical Services contract is for specialist assessment in the above skill areas. Service must not be provided at a higher level of expertise than needed. While this applies to all services and is aimed at promoting appropriate delegation of tasks within the wider health care team, it is particularly important if multiple providers work within the same premises. For example within a primary care clinic, eg integrated family health care centre, medical centre, or Accident and Medical (A&M) clinic, the GP level clients and A&M level clients should not be treated by the vocationally registered medical specialist. Referrals to the medical specialist should only be made if the injury requires assessment or treatment that is within the scope of practice of the specialist and outside the scope of practice of the primary care provider.

Anaesthetist Specific Assessments

If a surgical application has not been approved before these assessments are performed, ACC will decline payment.

All clients must complete an anaesthetic assessment form. Any client who is classified as an ASA 3 or greater, no matter what procedure they are having, must be formally assessed by an anaesthetist. This initial assessment may be by phone if the client lives in a rural environment or is remote to the clinic and cannot access the clinic. If necessary this is followed up with a face-to-face consultation, and must be done before the day of admission. The codes listed below are used for pre-operative assessments by an anaesthetist.

Procedures with risk factors

There are 46 major procedures that have been identified as having significant risk for anaesthetists and the management of clients. They are:

- AFT72
- ELF10
- HIT01-05
- KNE09-12, KNE14-15
- SHU13-15
- SKP10
- SPN101-102, SPN106-107, SPN110-113, SPN115-116, SPN119-SPN121, SPN125-131, SPN133-134, SPN 135-138
- WAH25-27.

Required assessments

The anaesthetist should carry out the:

- CS250 - Pre-operative anaesthetic assessment – simple, or
- CS260 - Pre-operative anaesthetic assessment - complex.

Pre-operative anaesthetic assessment - simple: CS250

The simple pre-operative anaesthetic assessment is used for:

- clients whose co-morbidities are likely to pose anaesthetic risk
- non-core complex/unpredictable procedures if the client is expected to need Intensive Care Unit care post-surgery
- clients who have been identified with significant anxiety about anaesthesia.

After this assessment the anaesthetist must inform the surgeon of the post-operative plan.

Pre-operative anaesthetic assessment - complex: CS260

The complex pre-operative anaesthetic assessment is used when the client:

- has a personal injury of unusual complexity
- needs a more complex level of investigation than required for a simple pre-operative assessment, and
- the assessment is expected to take over 45 minutes.

After the assessment the anaesthetist informs the surgeon of the post-operative plan.

Other possible pre-operative assessments

Important note:
The following four codes are by no means exhaustive. They **may** need a pre-operative assessment for the following reasons:

AFT70	This is a major joint replacement
AFT71	Some clients needing this treatment may have had a cerebral injury leading to spasticity
SHU16	This may turn into a major procedure
HIT06	This may turn into a major procedure

Long-distance anaesthetic consultation – CS70

A long-distance consultation is a phone call to a client who lives in a rural environment or is remote to the clinic when there is a need to get further information, clarify their health status, or identify the need for further investigations or specialist input before surgery.

Use this code when a consultation is done by phone, regardless of whether an additional consultation occurs face-to-face at a later stage.

A long-distance consultation is not a substitute for the clinical examination of a client to determine anaesthetic status. Nor is it a simple introductory phone call. The purpose of this item is to improve the service to clients who live some distance from the treatment hospital.

General Assessments

General assessments are carried out by appropriately qualified medical practitioners who are registered with the Medical Council of New Zealand and who hold a vocational scope of practice in one of the areas listed in the Service Schedule. See Medical Council of NZ > Registration > How to become a registered doctor > Vocational scope.

Referrals

Referrals for assessment and/or treatment will contain the following:

- client name
- ACC claim number
- date of injury
- injury diagnosis
- list of any previous known treatment and/or tests on this claim, and
- the rationale for requesting the specialist's opinion.

If the referral does not meet this criteria the Supplier can decline the request.

Initial assessments

The specialist will ensure that the initial assessment takes place within 6 weeks of receiving the referral. If the specialist cannot meet this obligation they must refer the client to another specialist who has capacity to meet this requirement.

If 5 or more subsequent assessments are expected, there will be a treatment plan in the clinical notes that details the expected rehabilitation outcome. This will be submitted electronically to ACC on either a clinical letter/report or by using the Clinical Services Assessment Report and Treatment Plan template at the back of this Guideline.

Clients will receive clinic-based procedures, that do not need prior approval, within 28 days of the assessment that determined the need for the procedure(s).

Simple assessment (initial) - CS100

Also known as an initial assessment, this is used when a specialist sees a client for the first time to assess an injury. **It can only be claimed once per specialist for that injury.**

- Anaesthetists will use the code **CS250**.

Complex assessment (initial) - CS200

This assessment is done when a more complex level of investigation is needed and a simple assessment will not be sufficient. This is direct client time and does not include report writing, or reviewing scans and referrals when the client is not present. The increased time is justified in the clinical notes. It will take over 45 minutes to complete. **It can only be claimed once per specialist for that injury.**

- Anaesthetists will use the code **CS260**.

Second opinion assessments

Second opinion assessment (simple) - CS400

This assessment is done when a second opinion is needed from an anaesthetist or other specialist while a client is being assessed or diagnosed, and/or having their ongoing care options considered. A second opinion may be requested regardless of whether the initial assessment recommended surgical or non-surgical care. All vocational scopes of practice can refer for second opinions.

Second opinion assessment (complex) - CS900

This is as above but is to be used when the assessment is long, generally over 45 minutes. This is direct client time and does not include report writing or reviewing scans and referrals when the client is not present. The increased time is justified in the clinical notes.

Payments for second opinions

This type of assessment will be paid under:

- this agreement if the second specialist is a named specialist, or
- the appropriate regulations if the second specialist is not named in any current Clinical Services contract with ACC.

Overall responsibility for Clinical Services ARTP in the event of second opinions

The initial specialist remains responsible for providing the Clinical Services Assessment Report and Treatment Plan (ARTP) to ACC, and for including in it any recommendation made by the second specialist.

Subsequent assessments – CS600

Subsequent assessments **cannot take place on the same day as the initial assessment**. They are used for assessments or consultations where specialists discuss the results of tests or interventions with the client and explore the resulting treatment and rehabilitation options. It is also used to provide necessary on-going management and/or conservative treatment, or if the client has not reached the outcomes predicted in the initial ARTP and needs a subsequent assessment or consultation.

If 5 or more subsequent assessments are expected a treatment plan must be submitted to ACC electronically at Clinical.notes@acc.co.nz

Reassessment – CS500

Reassessments **cannot occur within 12 months of the initial assessment**. They are used for subsequent face-to-face simple or complex assessments by the provider who carried out the initial assessment. The client must have been discharged from the care of the provider and a new referral is required before a reassessment can occur.

Tests and treatments

There is a list of tests which can be done without prior approval under the Clinical Services contract, eg neurophysiological consultation. This list is reviewed yearly and additional tests may be added.

Pre-operative tests

Pre-operative tests are used to determine 'fit for surgery' status and must all have an approved surgical request before being undertaken. These tests cover:

- echocardiogram
- stress echo
- respiratory spirometry
- exercise treadmill
- electrocardiogram.

Note:
If a surgical application has not been approved before these tests are performed, ACC will decline payment.

Clinic-based Surgical Procedures Needing Prior Approval

The following procedures need prior approval:

- lid /adnexa – lid surgery - minor
- laser treatment
- orthoptic assessment
- fluorescein angiography
- revision of scar(s)
- minor finger surgery (stump revision/cyst)
- excision post-traumatic inclusion cyst(s)
- tympanostomy/myringotomy
- myringoplasty - simple +/- patch.

The following procedures can only be done by suppliers who have satisfactorily completed the self audit tool for **New Zealand Standards 8165:2005 Rooms/Office-based Surgery and Procedures:**

- flexi cystoscopy
- flexi cystoscopy (with dilatation)
- flexi cystoscopy (with 300 units botulinum toxin)
- supra pubic catheter insertion
- supra pubic catheter change
- removal of foreign bodies (not eye (under local)
- revision of scar(s) <5cm
- revision of scar(s) 5cm -10cm
- revision of scar(s) 10cm -20cm
- minor finger surgery (stump revision/cyst)
- repair/reconstruction of nail bed
- excision post traumatic inclusion cyst
- lid/adnexa - lid surgery – minor
- removal foreign body – eye
- tympanostomy/myringotomy
- myringoplasty - simple +/- patch
- laser treatment – (for dermatologists and plastics only).

For more information on completing the self audit tool please contact health.procurement@acc.co.nz.

Providing Treatment

Completing a surgical Assessment Report and Treatment Plan (ARTP)

This ARTP is completed when requesting surgery. All requests are sent to the Elective Services Unit (ESU) in Dunedin. These can be sent electronically to ARTPS4ESU@acc.co.nz.

The Elective Surgery ARTP can be accessed under For Providers > Publications and forms > ACC Publications page by scrolling down to select Surgery. Complete it with as much detail as possible and then send it to the ESU. At times more information may be requested and will need to be provided in order for ACC to make a thorough assessment of the request.

Checking on the approval process

For information on where the approval process is up to, contact the ACC Provider Helpline on free phone 0800 222 080. The Provider Helpline may also be able to give you a copy of the decision letter 'ES03 Accept request for non-contracted services'.

Contracted surgery (elective surgery)

A provider who holds a contract with ACC can request elective services treatment to provide the required surgery. This is the standard method of applying for surgery approval. Fees are provided from allocated budgets for contract holders (suppliers). There is a nationally agreed price which covers the surgical treatment and six weeks of post-surgery care after the client is discharged from hospital. This includes the subsequent assessments, short-term equipment hire, and most pharmaceuticals required.

Regulation (non-contracted) surgery

All payments under regulation surgery cover the same period of treatment as contracted surgery. If the application is for surgery that ACC must pay or contribute to, a surgical ARTP needs to be completed and sent to the ESU. **On the ARTP you will need to indicate that this is a regulation request.**

For information on ACC's liability to contribute see also, Regulation 18 of the Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

This is accessed from www.legislation.govt.nz by selecting:

- browse: Regulations,
- 'I' from the drop down menu under Title and clicking 'browse now', and
- scrolling down to find Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Informing the client of their options

Clients must make the decision regarding the choice of regulation surgery. To do that they **must** have all the information available, **including the amount that ACC will contribute to the surgery costs**.

ACC is required to inform the client that surgery can be performed by a contracted provider at no cost to the client. This information is given directly to the client in the decision letter 'ES03 Accept request for non-contracted services'. The client must sign the letter and return it to ACC to demonstrate understanding and consideration of all of the options available.

The discussion about options must take place after surgery is approved so that all information is available. This will lead to a second consultation regarding surgical options.

Anaesthetic consultation on admission

When the client is admitted on the day of surgery, or the night before, there must be a normal pre-operative consultation visit by the anaesthetist. This is included and paid for as part of the package of care for the surgery.

Elective Surgery Agreement

The Elective Surgery agreement is usually held by hospitals (or in a few instances by surgeons) and pertains to the surgical treatment of the injury.

The anaesthetic pre-assessment, and the surgical Assessment Report and Treatment Plan (ARTP) must be completed for prior-approval of surgery and are covered under the Clinical Services contract. Click on Assessment report and treatment plan (ARTP) to download the report. This is located under For Providers > Publications and forms > ACC Publications page by scrolling down and selecting Surgery in the right hand column.

Note:
Under Clinical Services, if the client has co-morbidities the supplier needs to ensure they are seen by a vocationally registered anaesthetist (preferably the anaesthetist who will attend the surgery). If the co-morbidities are identified as needing services outside the normal scope for this type of surgery, the provider should complete the relevant surgical ARTP section for a Non-Core Procedure.

Example:
A client needs invasive monitoring, HDU, or ICU. The supplier needs to invoice for the extra services required. After assessment, the anaesthetist believes the client should not have surgery in the proposed hospital due to significant clinical risk. They discuss this with the surgeon, inform them of their assessment outcome, and jointly decide to move the surgery to a hospital that can provide the extra support.

Specific clauses within the Elective Surgery contract

There are clauses within the Elective Surgery contract which are influenced by the Clinical Services contract. When this occurs the supplier should advise specialists of their specific responsibilities.

Example: The Elective Surgery contract '5.5 Resources' states:

> "The supplier must have a multidisciplinary team which includes ... an Anaesthetist who will ensure that pre-assessments are undertaken on all clients using a pre-anaesthetic assessment form, and who will make final recommendations on HDU/ICU access for those clients deemed to need that level of care."

Invoicing

Payment processing centres

There are two units that handle invoices relating to the Clinical Services contract:

Address	Service area covered
Northern Processing Centre: PO Box 90-347 Auckland Mail Centre Auckland	This unit processes all invoices in the upper half of the North Island. The boundary line is from Gisborne in the east, through Taupo, and across to New Plymouth.
Elective Service Centre, Dunedin: PO Box 408 Dunedin	This unit processes all other invoices.

Electronic billing

ACC's method of invoicing for services is electronic billing which makes the process faster, easier, and more efficient. For more information on working electronically with ACC, see For Providers > Set up and work with ACC > Work electronically with ACC.

The Provider Helpline will answer queries relating to invoices and ARTP progress: free phone 0800 222 070.

How do I get paid?

The e-Schedule should be sent to the relevant processing centre depending on your location. Payment by ACC is usually made **15 days after receiving the invoice**. ACC needs the completed documentation before paying for the surgery provided.

The payment will be made to the supplier who holds the contract. If you are a provider named on a supplier's contract you will need to discuss with the supplier how they will forward the payment to you.

Invoicing for specialist tests

Please send invoices directly to the processing centres and not to the client service staff or branch. However, if the specialist test is not listed in the Clinical Services contract or the Cost of Treatment Regulations, then the specialist would need to contact the client service staff member for a purchase order number. This number can then be quoted on their invoice and sent directly to the relevant processing centre.

APPENDICES

Appendix 1: Frequently asked questions (FAQs)

Q1. What is a simple assessment?

A. As a general guide a simple assessment is an initial assessment that takes less than 45 minutes. This can only be used once per claim for each specialist. A more detailed description can be found on page 9 of the contract.

Q2. What is a complex assessment?

A. A complex assessment is an initial assessment that takes over 45 minutes to complete. This can only be used once per claim for each specialist. A more detailed description can be found on page 9 of the contract.

Q3. Can I charge a co-payment?

A. No. The price for each clinical service is the amount chargeable and no additional amount may be charged.

Q4. Where do I send the ARTP?

A. All clinical services and surgical ARTPs are sent to ARTPS4ESU@acc.co.nz.

Q5. How do I find out more information on sending my invoices electronically?

A. Please contact the e-business team 0800 222 994 (option 1), or email ebusinessinfo@acc.co.nz.

Q6. The treatment I need to provide is not listed in this contract. What can I do?

A. Additional intervention assessments are available. Many of these need prior approval by a client service staff member, therefore it is best to contact ACC to discuss this. If the patient does not have a client service staff member, contact the Inquiry Service Centre on 0800 101 996.

Q7. My patient does not have a case manager and needs more help from ACC. Who do I contact?

A. Contact the Inquiry Service Centre on 0800 101 996.

Appendix 2: Useful contact numbers

Provider Helpline
Ph: 0800 222 070
providerhelp@acc.co.nz

The Provider Helpline staff can help with queries relating to provider numbers, ARTP updates and general enquiries.

Elective Service Centre
Fax: 0800 222 463

Health Procurement
Ph: 0800 400 503
health.procurement@acc.co.nz

Health Procurement can provide advice regarding appropriate documentation in relation to the application for contracts.

Inquiry Service Centre (ISC)
Ph: 0800 101 996

For general enquiries, ISC will answer your call and refer you for further assistance if required.

CLINICAL SERVICES

Clinical Services Assessment Report and Treatment Plan (CSARTP)

Te Kaporeihana Āwhina Hunga Whara

Please complete the form and sign the declaration. Keep this form for your records and send a copy along with any supporting documents to ACC, email: **artps4esu@acc.co.nz**

Please tick box to indicate if this is an:

Initial Plan ☐ Updated plan ☐

1. ACC DETAILS

This form was completed on [date]

Email address: ARTPS4ESU@acc.co.nz

2. SUPPLIER DETAILS

Supplier name:	Supplier number:
Specialist's name:	Date of consultation:

3. CLIENT DETAILS

Client's full name:
ACC Claim number:

4. CONSULTATION DETAILS

Injury details (including date and history of the injury, the initial and current diagnosis, and relevant medical history)	

5. TREATMENT RECOMMENDED

ACC procedure code		N/A
ACC procedure name		N/A
Date of proposed treatment		N/A
Activity modification (eg light duties)		
Proposed plan		
Review date (anticipated or known)		

6. ATTACHMENTS

Please list and attach copies of any documents that support your recommendations

7. SPECIALIST DECLARATION

I certify that, on the date shown, I personally examined and/or treated the client. I have discussed their treatment options with them and advised why the recommendation is the appropriate treatment in this case. The client (or their representative) has authorised me to provide this information to ACC on their behalf.

Signature: **Date:**

Specialist name:

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.