Clinical Services

Operational Guidelines

July 2016

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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.

> 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:

Code	Reason
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

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. A subsequent assessment can either be Simple or Complex.

Subsequent assessments (simple) – CS61

This assessment is expected to take **up to** 30 minutes.

Subsequent assessments (complex) – CS62

This assessment is expected to take **over** 30 minutes.

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.

Medical Case Reviews and Medical Single Discipline Assessments

Medical Case Reviews and Medical Single Discipline Assessments are used to obtain an opinion from a non-treating practitioner who is a medical specialist, when ACC is unable to get this from a treating practitioner. The provider (specialist) completing a Medical Case Review or Medical Single Discipline Assessments is able to order tests or investigations if this is necessary for them to be able to come to an opinion. They can also make recommendations for tests or investigations.

Referrals for Medical Case Reviews and Medical Single Discipline Assessments

Referrals for Medical Case Reviews and Medical Single Discipline Assessments may only be made by ACC. ACC will not pay for services where Clients self refer or are referred other than by a treatment provider as set out under Clause 4.2.2 within the Service Schedule.

Declining a referral

The provider may decline a referral if:

- The provider cannot meet timeframes as set out under Clause 7.1.3 within the Service Schedule; or
- The provider does not have an appropriate medical specialist available in relation to the injury; or
- The provider considers that the referral is more appropriately manage under the Vocational Medical Services contract because:
    1) It includes consideration of a Client's employment as a major factor of the assessments; or
    2) Assessment by an occupational medicine specialist of work restrictions, limitations, fitness for work, the ability to engage in employment or the ability to participate in vocational rehabilitation is required.

The provider must notify the referrer if the referral is declined.

Medical Case Reviews

A Medical Case Review (MCR) is used to obtain clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation. An MCR can be used to help determine cover and ongoing entitlements. MCRs can be purchased as either Standard or Complex, taking into account the complexity of the Client's presentation.

Medical Case Review (Standard) – CSM1

A Standard Medical Case Review is expected to take up to 3.5 hours.

Medical Case Review (Complex) – CSM2

A Complex Medical Case Review is expected to take more than 3.5 hours and less than 7.5 hours, as the Client's injury is of unusual complexity or there are co-morbidities that appear to be affecting the Client's recovery from injury; or the MCR will be undertaken in two parts whilst results of investigations are obtained.

Exceptional Medical Case Reviews

In rare cases where an MCR requires more than 7.5 hours, ACC may request the provider to undertake an Exceptional MCR. If on referral, the service provider believes the Client is exceptionally complex over and above the cost available under the Complex category, please contact ACC to discuss.

A complete definition for MCR services purchased under the Clinical Services contract is set out within the Services Schedule (Clause 7.2.2. to 7.2.6).

Medical Single Discipline Assessments

A Medical Single Discipline Assessment (Medical SDA) is used to obtain recommendations for the best onward treatment or rehabilitation. A Medical SDA cannot be used to determine cover and ongoing entitlements.

Medical Single Discipline Assessments (Standard) – CSA1

A Standard Medical SDA is expected to take up to 2.5 hours.

Medical Single Discipline Assessments (Complex) – CSA2

A Complex Medical SDA is expected to take more than 2.5 hours and less than 4.5 hours, as the Client's injury is of unusual complexity or there are co-morbidities that appear to be affecting the Client's recovery from injury; or the Medical SDA will be undertaken in two parts whilst results of investigations are obtained.

Exceptional Medical Single Discipline Assessments

In rare cases where an Medical SDA requires more than 4.5 hours, ACC may request the provider to undertake an Exceptional Medical SDA. If on referral, the service provider believes the Client is exceptionally complex over and above the cost available under the Complex category, please contact ACC to discuss.

A complete definition for Medical SDA services purchased under the Clinical Services contract is set out under Clause 7.2.7 within the Services Schedule.

Reporting requirements for Medical Case Reviews and Medical Single Discipline Assessments

ACC's expectations for each Medical Case Review and Medical Single Discipline Assessment report to include at least the following:

- The Named Provider's qualifications and statement of impartiality as a non-treating practitioner;
- Any facts and assumptions on which the opinions and recommendations of the Named Provider are based;
- A summary of the clinical history and examination the Named Provider has completed;
- Clear recommendations;
- Reasons for the opinions and recommendations made by the Named Provider;
- References to any literature or other material used or relied on in support of the opinions and recommendations expressed; and

- A description of any examinations, tests or other investigations that have been relied on in support of the opinions and recommendations expressed.

In addition, MCRs must include:

- A statement on the mechanism of injury used to assess causation in the specific case. If this differs from that obtained by ACC (as expressed in the referral document) an explanation of the difference must be provided;
- A statement on general causation with explanatory rationale. General causation requires a recognition by the scientific community that the mechanism of injury could cause the diagnosis/es - this might be with reference to the peer-reviewed literature and/or a statement on biomechanical plausibility;
- A statement confirming whether or not the specific Client and/or specific circumstances of this case would confer an exception to the general scientific understanding. If this is an exception, an explanatory rationale must be provided;
- A statement on specific causation with explanatory rationale. Specific causation requires an assessment as to whether the specified mechanism of injury caused the diagnosis/es in this particular case; and
- If there is evidence for general and specific causation, a statement as to why this explanation is considered more likely than alternative possible causes of the same condition, including it being idiopathic.

Where clarity about causation specific to a work-related gradual process, disease or infection is requested, statements as to the circumstances which caused the injury need to include:

- whether or not the personal circumstances of the client in relation to their employment led to exposure that caused the injury,
- circumstances of the property or characteristics of employment or non-employment activities that caused or contributed to the injury
- the risk of the client suffering this injury compared to others in the workplace undertaking and not undertaking the same employment tasks and to others who are employed in that type of environment.

In addition, Medical SDA reports must include:

- Specific recommendations for any further investigations, treatment and/or rehabilitation with explanatory rationale;
- Demonstration of clinical reasoning and a rationale for decisions reached.

Timeframes for submitting Medical Case Reviews/Medical Single Discipline Assessments report to ACC

Providers who undertake an MCR or a Medical SDA are required to provide an MCR or Medical SDA report within eight business days of the Specialist completing a consultation. A detailed timeframe for submitting an MCR or Medical SDA is set out under Clause 7.1.2 of the Clinical Services (Excluding In-room) or Clause 7.1.3 of the Service Schedule.

Referrals for clinics

ACC may make arrangements with a provider to visit a region (outside of the provider's area of domicile) to undertake a clinic. Where the clinic is in association with the Vocational Medical Services contract, travel and accommodation should be charged under the Vocational Medical Services contract. The ACC Branch will work with the provider to ensure arrangements are made for booking clients and meeting costs that are in addition to those available under the Clinical Services contract. This includes clinic room hire, travel, travel time and accommodation as appropriate.

Prioritising referrals

Please keep in mind, that referrals for MCRs will be used by ACC to help make decisions regarding ACC cover or entitlements which is a priority for ACC. Efforts by providers to prioritise MCRs are appreciated. Should a provider have spare clinics or capacity to see clients for MCRs, please make sure this is brought to ACCs attention.

Billing

The Supplier is responsible for billing under the Clinical Services contract.

Frequently Asked Questions (FAQ) for Medical Case Reviews/Medical Single Discipline Assessments

We have compiled a list of FAQs relating to MCR and Medical SDA and prepared responses to these questions. Copies are available in Appendix III.

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 accreditation against the **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
- YAG Laser Capsulotomy
- tympanostomy/myringotomy
- myringoplasty - simple +/- patch
- laser treatment – (for dermatologists and plastics only).

For more information on accessing these codes under the contract, 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 should 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 or ACC Surgery Line on free phone 0800 222 020.

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

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.

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 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.

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.

Appendix I

Frequently asked questions (FAQs) about Clinical Services

Q1. What is a simple initial 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 initial 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 II

Useful contact numbers

ACC Provider Helpline	Ph: 0800 222 070	Email: providerhelp@acc.co.nz
ACC Client/Patient Helpline	For general enquiries, the Client Helpline will answer your call and refer you for further assistance. Ph: 0800 101 996	
Provider registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Fax: 04 560 5213	Post: ACC, PO Box 30 823, Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994, option 1	Email: ebusinessinfo@acc.co.nz
Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team: Email: health.procurement@acc.co.nz Ph: 0800 400 503	
Supplier managers	Supplier managers can help you to provide the services outlined in your contract. Contact the Provider Helpline for details of the supplier manager in your region.	
ACC website	For more information about ACC, please visit: www.acc.co.nz	

Appendix III

Frequently asked questions (FAQs) on Medical Case Reviews and Medical Single Discipline Assessments

Q Can a General Practitioner refer directly for a MCR or Medical SDA?

A A General Practitioner can refer for a first or subsequent specialist appointment under the Clinical Services Contract but is unable to refer for a MCR or Medical SDA.

Q How will outliers be managed for MCR referrals (i.e. rare cases which take for example 16 hours to complete the review)?

A There is an exceptional process available which is negotiated on a case by case basis with the ACC case owner.

Q Can I continue to provide MCRs and Medical SDAs outside of the Clinical Services Contract?

A Frequent providers of MCRs and Medical SDAs will need to hold the Clinical Services Contract. ACC may purchase MCRs or Medical SDAs through a letter of agreement outside of the Clinical Services Contract on rare occasions for one-off assessments required by specialists who do not hold the Clinical Services Contract; for example where an immunologist, or tropical diseases specialist assessment is required. The terms and conditions and price paid when a letter of agreement is used are the same as the Clinical Services Contract.

Q Does Clause 4.2.4(c) of the Clinical Services Contract mean referrals to occupational physicians should be re-directed to the Vocational Medical Services contract?

A No, this clause means that where a medical specialist receives a referral they think would be more appropriately managed under the Vocational Medical Services contract, they have the option to decline the referral. Occupational physicians are included in the Clinical Services Contract. This means occupational physicians should accept referrals for MCRs where the primary reason for referral relates to diagnosis or causation; and should accept referrals for Medical SDAs where the primary reason for the referral is to provide advice on onward treatment or rehabilitation. In cases where diagnosis or injury cause is not in question; and the client is no longer employed; and a rehabilitation plan needs to be developed requiring an occupational physician's expertise, this is more appropriately referred under the Vocational Medical Services contract.

Q I cannot not see any provision for payment of travel related costs in this Clinical Services contract. Occupational Medicine Specialists currently travel to provincial areas to conduct MCR & Medical SDA assessments where there is no such resident specialist. Please advise.

A Travel and accommodation costs are not able to be charged under the Clinical Services Contract. However, an ACC Branch Manager can approve travel and accommodation costs to be paid separately where they have requested a clinic be held in their province. In this situation, the actual delivery of the MCR or Medical SDA services is paid under the Clinical Services contract and travel and accommodation costs is invoiced separately as

instructed by the ACC Branch Manager.

Q If I am asked to undertake a clinic out of region to complete MCRs and Medical SDAs for ACC, how is travel, accommodation and clinic fees reimbursed as there is no provision in the Clinical Services Contract?

A If ACC **requests** that you undertake a clinic out of region, then there are provisions available for travel, accommodation and clinic room hire which are paid separately to the Clinical Services Contract. There is a set fee available for accommodation and other expenses incurred for clinic room hire and travel incurred at cost.

Appendix IV

Clinical Services Assessment Report and Treatment Plan (CSARTP)

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 ☐

This form was completed on [date]

1. ACC DETAILS

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.