PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

ACC TREATMENT PROVIDER HANDBOOK

This is a living document and will be updated as required

Contents

While ACC has endeavoured to see that it's correct, the legal information contained in this document is a summary only. For any legal purpose, see the applicable legislation and regulations.

1. Overview

Welcome

ACC's role and our partnership with you

ACC's role is to ensure that people in New Zealand receive the rehabilitation they need to return to work or everyday life after injury.

Of course this isn't a role that we perform alone, but one that we carry out in partnership with you and other health professionals who provide treatment and rehabilitation services.

It's your expertise and dedication that are the main drivers of your patients' recovery. However, the funding and support available through ACC play an integral role in creating successful rehabilitation outcomes. Our partnership is therefore an important one, and it's vital to the wellbeing of the clients we serve.

This handbook has been created to help us work together as effectively as possible in this partnership. It gives you a thorough overview of what ACC is, how it works and, most importantly, the processes that need to be followed to ensure we work together in the best interests of our clients.

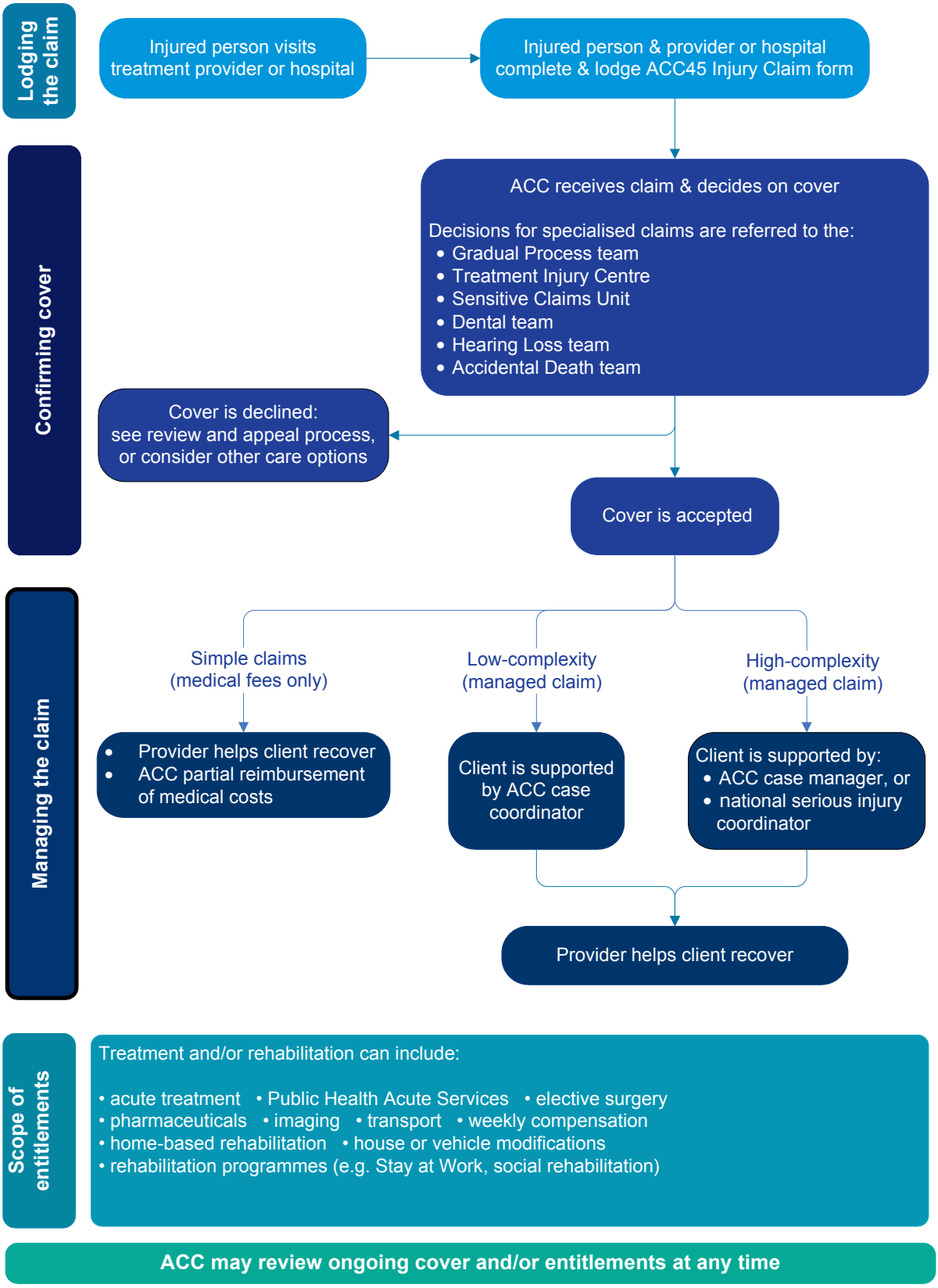
The handbook covers everything from your responsibilities as an ACC-registered treatment provider to details on how to lodge claims, order ACC resources and invoice us for your services. It also talks about the importance of our clients' rights to privacy and your role in this.

If you're not familiar with any of the terms used in the handbook, please refer to the Glossary. You can also get more information by calling one of our toll-free enquiry numbers or sending us an email (see our contact details), or visiting our website.

I trust you'll find the handbook both helpful and easy to use, and I wish you well as we begin this important partnership together.

Scott Pickering
Chief Executive
ACC

How ACC cover works at a glance



Key ACC contacts for treatment providers

Provider Contact Centre	0800 222 070	providerhelp@acc.co.nz
Client Helpline	0800 101 996	claims@acc.co.nz
Urgent home help (fax numbers during ACC office hours)	Hamilton: 0800 222 891 Wellington: 0800 181 306	Christchurch: 0800 222 359 Dunedin: 0800 633 632
Provider eBusiness Support	0800 222 994 option 1	ebusinessinfo@acc.co.nz
Provider Registration	0800 222 070 04 560 5213 (fax)	registrations@acc.co.nz ACC, PO Box 30823 Lower Hutt 5040
Fraud Helpline	0800 222 372 (0508 ACC FRAUD) ACC online reporting fraud portal	collection.collation@acc.co.nz ACC, PO Box 1426, Wellington 6140
Medical Fees units for invoices, schedules, ACC32 treatment requests **North**: for regions north of New Plymouth, Gisborne and Taupo		auckland.acc32@acc.co.nz Waikato Mail Centre PO Box 952, Hamilton 3240
Medical Fees units for invoices, schedules, ACC32 treatment requests **South**: for regions south of New Plymouth, Gisborne and the South Island		dunedin.acc32@acc.co.nz Elective Service Centre PO Box 408, Dunedin 9054
Stationery Order Line (forms and brochures)		0800 802 444
Dental stationery		0800 226 440
Sensitive Claims Unit (sexual assault)		0800 735 566 option 1
Treatment Injury Centre		0800 735 566
Health procurement (for service contracts)		0800 400 503
ACC website		www.acc.co.nz

2. How the Scheme works and working with us

About the ACC Scheme

The ACC Scheme provides comprehensive, 24-hour, no-fault cover for all New Zealand citizens, residents and temporary visitors who sustain certain types of personal injury in New Zealand, generally those resulting from accidents. The Scheme is mandated by law, in particular by the Accident Compensation Act 2001 (the AC Act).

ACC is responsible for:

- helping to prevent the circumstances that lead to injuries at work, at home, during sport and recreation, and on the road
- providing cover for personal injuries, no matter who's at fault
- reducing the physical, emotional and social impacts of people's injuries by funding timely treatment and rehabilitation that gets them back to work or independence as safely and quickly as possible
- minimising personal financial loss by paying contributions to treatment costs, paying lump sum compensation and providing weekly compensation to injured people who can't work because of their injuries.

This handbook will help you work within the parameters of the Scheme and understand the legislation and regulations that govern what we do. The Glossary explains the terms we use in our policies and procedures for claims and treatment, and with providers. We haven't set out everything here and ask that, if in doubt and for legal purposes, you refer to our governing legislation and regulations that apply.

ACC's governing legislation

The AC Act is ACC's governing legislation. It sets out what we're able to cover and ensures that our help to clients is of the required quality.

ACC's policy requirements

ACC has a number of policies and procedures to help us deliver the outcomes required by our legislation and ensure appropriate treatment and rehabilitation for our clients.

Our policies and procedures include:

- promoting current treatment protocols, guidelines and evidence-based practice
- encouraging providers to stay up to date with the latest developments in ACC policy
- requiring providers' clinical records to be of a standard acceptable to their relevant practitioner bodies and/or the Health Practitioners Competence Assurance Act 2003 (HPCA Act)
- expecting providers to deliver services that are culturally responsive to the needs of Māori and that recognise the Treaty of Waitangi by taking into account the social, economic and political values of Māori (see Services to Māori)
- promoting the Guidelines on Māori Cultural Competencies for Providers as a best-practice model when working with Māori
- monitoring appropriate outcomes for Māori

- requiring providers to deliver services in ways that are culturally appropriate and responsive for Pacific, Asian and other ethnic groups
- monitoring health care services
- assessing provider claims, both random and targeted
- investigating any concerns about the need for treatments, or the appropriate number, length or quality of treatments
- taking legal action if dishonest claims are made
- recovering any funding for claims that are charged for inappropriately.

Legislative and policy requirements for providers

When we ask providers to assist in the treatment of clients we're guided by three things:

1. Legislation and policy
2. Standards set by professional bodies
3. Major health sector frameworks such as the HPCA Act. The HPCA Act protects the public's health and safety by ensuring the competence of health practitioners for the duration of their professional lives. Having one legislative framework allows for consistent procedures and terminology across the many professions now regulated by the HPCA Act.

For more information, see the HPCA Act online or the Ministry of Health commentary on the Act.

Your partnership with ACC

Your role in our partnership

We work with injured people and their families/whānau in an extended partnership with you, our treatment providers, as well as other health sector professionals, employers and supporting groups.

Some of you will have occasional contact with patients who become ACC clients, while others of you may work with our clients daily.

As a health services provider seeking funding to treat clients with ACC-covered injuries, you'll have certain responsibilities. These include:

- complying with the AC Act, our policies and procedures and your professional standards when treating and making claims for ACC clients
- providing our clients with clinical treatment that meets the requirements of best practice and the standards of your professional body
- providing treatment and advice that assist ACC clients to return to work and/or independence
- following the ACC treatment profiles
- maintaining appropriate clinical records
- invoicing appropriately, especially if you are registered with more than one professional body.

We encourage you to get to know us. Feel free to make personal contact with us locally, e.g. through your local Supplier Manager or your local branch.

Supplier Managers – key contacts

Supplier Managers work in the community with our contracted and non-contracted suppliers in the following ways:

- providing education and support to treatment providers
- helping treatment providers work within ACC's policies and processes
- managing performance as well as relationships.

For more information about Supplier Managers, see Supplier Manager contact details.

What ACC covers

ACC cover

ACC receives about 1.9 million claims a year for personal injuries including mental injuries.

The most common injuries we cover are caused by:

- accidents at work, at home and on the road
- work-related gradual processes, diseases or infections
- treatment injuries
- sexual assault or abuse.

Advice on cover criteria

If you're unsure about advising patients on possible ACC cover, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz. Alternatively, ask your patient to get in touch through the Client Helpline on **0800 101 996** or by emailing claims@acc.co.nz.

Personal injuries

Personal injuries cover:

- physical injuries (including fatal injuries), which typically include:
  - wounds
  - lacerations
  - sprains
  - strains
  - fractures
  - amputations
  - dislocations
  - some dental injuries
- work-related gradual process injuries, diseases and infections, which cover a range of physical deteriorations caused over time by work or the work environment. Examples include:
  - asbestosis
  - work-related hearing loss
- treatment injuries, i.e. physical injuries sustained while receiving treatment from registered health practitioners.

Mental injuries

Cover for a mental injury is provided if it was caused by:

- a physical injury
- a specific event in the workplace
- sexual assault or abuse.

Mental injuries caused by physical injuries

Some mental injuries are caused by physical injuries already covered by claims with ACC. If a person suffers a mental injury of this kind that can be covered by ACC, it's treated as part of the original physical injury claim, with the same injury date as the physical injury.

Mental injuries caused by witnessing a traumatic event at work

ACC provides cover for mental injuries caused by traumatic events in the workplace if certain conditions set out in the AC Act are met.

Mental injuries caused by sexual assault or abuse

Mental injuries arising from this type of criminal offence are called sensitive claims. For more information, see Schedule 3 of the AC Act 2001 or the Glossary.

Mental injury is a complex area and it can sometimes be difficult to determine cover. Decisions are made in each case on the basis of diagnosis and evidence provided by a psychiatrist or psychologist in their report to us. In order to receive cover, the information provided in the report needs to prove that the patient's physical injury, the traumatic event at work or the sexual assault or abuse was a direct and significant cause of the mental injury.

For more details about the assessments used to determine treatment options for mental injuries, see Mental injuries, sensitive claims and counselling.

What ACC is unable to cover

ACC isn't able to cover:

- injuries to teeth arising from their natural use, e.g. biting a boiled sweet
- cardiovascular or cerebrovascular diseases, unless they're a result of treatment injuries or work injuries involving effort that is 'abnormally applied' or 'excessively intense'
- gradual process injuries that are not caused wholly or substantially by work-related gradual processes, diseases or infections
- personal injuries caused wholly or substantially by the ageing process (if medical opinion confirms that the injuries wouldn't have happened without the ageing process)
- personal injuries caused by illness
- the emotional effects of injuries such as hurt feelings, stress or loss of enjoyment, unless they result from mental injuries
- injuries caused by coughing or sneezing, or other internal forces.

Limitations to entitlements

In some cases a person's injury will be covered but we'll be unable to provide some entitlements, e.g. in some instances of self-inflicted injury or criminal disentitlement. If you're treating a patient with a claim of this nature, please encourage them to contact the Client Helpline as soon as possible on **0800 101 996**.

Who ACC covers

Three categories of people are covered by ACC:

- all New Zealanders, 24 hours a day, whether or not they're earning an income
- New Zealanders who are injured overseas (with certain criteria)
- visitors to New Zealand (with certain criteria).

Code of ACC Claimants' Rights

All ACC claims are managed under the Code of ACC Claimants' Rights. These rights are covered in the pamphlet ACC2393 *Working together to resolve issues*.

The pamphlet explains what clients can do if they're unhappy with the service they receive and outlines what they can expect from ACC in their dealings with us.

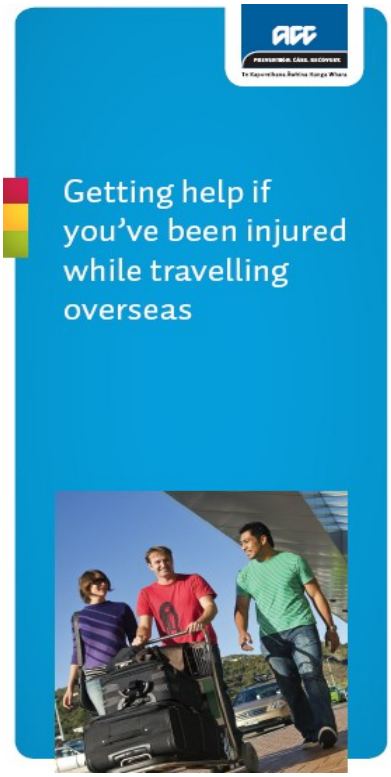
For more information, see Code of ACC Claimants' Rights: respect, culture and values.

Cover for Kiwis injured overseas

New Zealanders may also be able to receive support back in New Zealand if they were injured overseas. They just need to meet ACC's 'ordinarily resident' criteria.

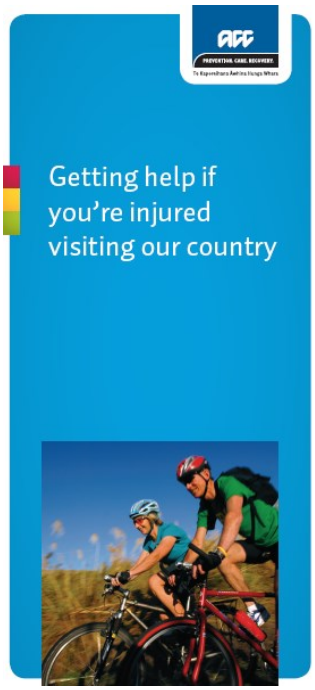
Eligible New Zealanders may also receive payment for overseas treatment if they've suffered work-related personal injuries overseas. ACC isn't able to reimburse New Zealand providers for treatment given overseas (e.g. when accompanying sports tours). Providers can only receive payments when they're working in New Zealand.

See the information sheet ACC593 *Getting help if you've been injured while travelling overseas*. You can order this online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC593).



Cover for visitors to New Zealand

Visitors to New Zealand are covered for personal injuries, and ACC can help to pay for treatment while they're in New Zealand once their claims have been accepted. We're not able to reimburse visitors for rehabilitation or treatment costs in their home countries, or for loss of income.

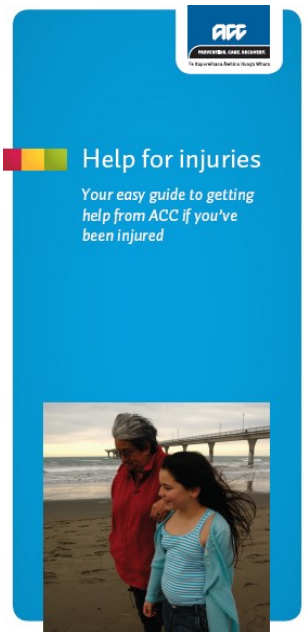


The information sheet *ACC592 Getting help if you're injured visiting our country* can be ordered online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC592).

The brochure is also available in Māori, Samoan, Tongan, Cook Island Māori, Chinese, Hindi and Korean. You can select the brochure in the language you want at our website.

Cover for Kiwis in New Zealand

The information sheet ACC583 *Help for injuries* explains for clients how the claim process works in New Zealand.



You can order this online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC583).

Terminology: clients and patients

ACC uses the word 'clients' to describe patients whose claims have been accepted for cover and have therefore become ACC clients. The term is used throughout this handbook to reinforce the importance of lodging claims in order to access entitlements for people. We recognise, however, that you may prefer to use alternative terms.

Cultural services

The Cultural Services team

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

Code of ACC Claimants' Rights: respect, culture and values

All ACC claims are managed under the Code of ACC Claimants' Rights.

The pamphlet ACC2393 *Working together to resolve issues* explains what clients can do if they're unhappy with the service they receive and outlines what they can expect from ACC in their dealings with us.

You can order this online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC2393).

For more information, see the legislation covering ACC claimants' rights.

Māori cultural guidelines

The ACC booklet ACC1625 *Guidelines on Māori Cultural Competencies for Providers* can be viewed online. It was created to help you give appropriate advice, care and treatment to Māori clients.

You can order this online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC1625).

The booklet comes with a DVD and is available as:

- an A4-size document with the code number ACC1625, or
- a shorter version with the code number ACC1626.

Please quote the ACC number and your provider number when ordering.

Treaty of Waitangi

In line with our Treaty of Waitangi obligations for Māori and recognising the cultural and ethnic diversity of New Zealand, ACC obtains input from Cultural Services for appropriate service delivery and to ensure these clients have positive experiences of our service.

Services to Māori

ACC is committed to ensuring that appropriate services are delivered to all who meet our entitlement criteria. However, we know that Māori make significantly fewer claims than New Zealand Europeans.

You can play a key role in helping to address disparities. For example, if you're filling out the ACC24 Application for ACC Health Provider Registration form, you can indicate both your capacity to offer services in a range of languages and your ability to work respectfully with clients whose cultural backgrounds might make extra demands of providers. This lets us offer your treatment services to clients in need of such providers.

Alternatively, you can contact the ACC Provider Registration team by phoning **0800 222 070**, emailing registrations@acc.co.nz or writing to ACC Provider Registration, PO Box 30823, Lower Hutt 5040.

For our contracted services, ACC's Standard Terms and Conditions include clauses that outline suppliers' obligations to provide services that comply with the Treaty of Waitangi and will meet the cultural needs of Māori, Pacific and Asian clients and clients of other ethnicities.

Treatment and rehabilitation entitlements – overview

Managing rehabilitation

The aim of rehabilitation is to help restore a client's pre-injury health, independence and participation in society as much as possible. Returning injured people to work and independence is ACC's role and we engage with a range of providers to enable rehabilitation.

If a client's rehabilitation requirements are complex, their claim is managed in a branch by a case owner who has access to a panel of experts. Typically these will be a clinical advisor, a branch psychologist, a technical advisor and a team manager with a rehabilitation focus. These experts will help the case owner to direct rehabilitation.

For more information on rehabilitation, see Rehabilitation.

Managing treatment

Treatment includes:

- physical rehabilitation
- cognitive rehabilitation
- examinations or assessments for the purpose of providing a certificate to ACC (such as a medical certificate for time off work, or assessments to help determine treatment plans).

ACC supports clients' treatment by contributing to:

- client consultations/visits and procedures delivered by treatment providers, according to the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 and amendments (the Regulations). See also How ACC pays
- treatment services such as elective surgery and hand therapy, usually under contract

- pharmaceuticals prescribed for ACC-covered injuries (see also Pharmaceuticals)
- bulk funding to the Crown for emergency department, acute inpatient and follow-up medical outpatient services, and some associated ancillary services.

Increasingly, multiple interventions are used alongside treatment, including 'non-clinical' tools such as exercise programmes and education for clients.

We encourage you to participate in early planning and discussions with clients, and may also pay for you to attend case conferences where multiple parties, including families/whānau and employers, can be represented.

What help clients can receive

ACC clients can receive a range of treatment and rehabilitation services and may also be eligible for compensation. The AC Act forms the legislative base for most of ACC's activities and outlines what clients with approved cover may be entitled to receive.

This includes:

- weekly compensation while a client is unable to work
- lump sum compensation for permanent impairment
- support for survivors in the event of accidental death
- rehabilitation, which covers:
    - treatment
    - social rehabilitation (support in everyday activities)
    - specialised rehabilitation
    - vocational rehabilitation (support in maintaining or obtaining employment)
    - pain management services
    - associated ancillary services.

Details of these entitlements follow in the sections below.

Weekly compensation

Clients may be eligible for compensation for lost earnings if they need to take time off work because of their injuries.

Only medical practitioners and nurse practitioners can certify time off work for ACC clients. The exception is for the first week off work after a work-related personal injury. In this case the client's employer can nominate and pay a registered health professional, such as a nurse, occupational therapist or physiotherapist, to complete the certificate.

For more information, see Medical certificates (ACC18s).

Lump sum compensation

Lump sum compensation is generally available for clients whose injuries lead to permanent impairment. The type of compensation available is based on claim type.

You can get more information through the Provider Contact Centre on **0800 222 070** or by emailing providerhelp@acc.co.nz. Your patient can get more information by calling the Client Helpline on **0800 101 996**.

The information sheet *LSIAIS01 All about lump sum payments and independence allowances* also gives details on lump sum compensation calculation procedures.

Social rehabilitation

The aim of social rehabilitation is to help clients achieve as much independence as possible. Social rehabilitation is available to support clients whose injuries have moderate or significant impacts on their lives. It supports the clients' rehabilitation through the provision of:

- home and community support services, e.g. home help, child care and attendant care
- equipment based on the clients' assessed needs, e.g. wheelchairs, shower stools and walking frames
- modifications to clients' homes or vehicles
- needs assessment services
- post-acute rehabilitation delivered by district health boards (DHBs) and some trust hospitals.

For details on the assessment criteria for social rehabilitation, see Social rehabilitation assessment.

Specialised rehabilitation

The aim of specialised rehabilitation is to help clients achieve the best possible outcomes by providing early, intensive rehabilitation and community support. Specialised rehabilitation is available to support clients whose injuries have significant long-term (or lifelong) impacts on their lives. It supports the clients' rehabilitation through services such as:

- 'training for independence' programmes
- community-based services
- disability support services
- education support
- residential rehabilitation services
- transition services.

For details on specialised rehabilitation, see ACC's Contracts and services.

Vocational rehabilitation

Vocational rehabilitation is available to help clients recovering from significant injuries to maintain or obtain work, or to regain vocational independence. Generally it's best for clients to stay in their pre-injury jobs where possible. Together with suppliers and providers, we can help them to do this by:

- reviewing their working environment and discussing ways to help them do all or some of their work tasks as their rehabilitation progresses
- providing equipment to help them at work.

In some cases clients start in Stay at Work (SAW) programmes before they return to work and while they're rehabilitating. Employers are asked to take all practical steps to help injured employees to rehabilitate, including when their injuries aren't work related.

We have a range of tools to help clients who are unable to return to their pre-injury jobs. These include:

- initial occupational assessments, which identify the types of work that may be suitable for them
- initial medical assessments, which identify whether those types of work are medically sustainable and if any further rehabilitation is required
- Work Readiness programmes, which include pre-employment preparation and/or strengthening programmes and can include work trials.

Following rehabilitation, we may ask a client to have their vocational independence assessed by an occupational assessor and a medical assessor. This is to ensure that the full extent of rehabilitation has been provided and we've addressed any injury-related barriers to employment or vocational independence. The assessments help to determine whether the client can return to work full time or whether further alternative rehabilitation is necessary.

For details on vocational rehabilitation see Work and rehabilitation.

Pain management services

Pain management services aim to reduce clients' pain through exercise activities and education. Early screening can determine when a client will need further assessments to establish if they have an increased risk of disability.

A pain management programme works best for the client when the programme clearly and specifically targets getting the client back to independence. This means:

- the programme sets client-specific goals to restore independence for pre-injury activities, e.g. vacuuming and getting in and out of a truck
- the client can continue the programme once the formal supervision has finished, if they choose to do so
- the client must be confident that there are no other reasons for their pain, i.e. red flags have been dismissed.

ACC has a range of tools to help clients identify, manage and recover from pain. These include:

- Functional Reactivation Programme
- Progressive Goal Attainment Programme
- Pain Management Psychological Service
- Pain Disability Prevention Programme
- Comprehensive Pain Assessment
- Activity Focus Programme
- Multi-disciplinary Persistent Pain Programme
- Interventional Pain Management

For details on vocational rehabilitation, see Pain management services.

Accidental death – help for families/whānau

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

- a funeral grant (to the maximum amount set by the Regulations)
- a grant (for the spouse, children and other dependants)
- weekly compensation for the dependants if the deceased person was in employment at the time they died (the spouse can apply to convert this into a lump sum)
- payments to cover child care for the deceased's children.

Ancillary services

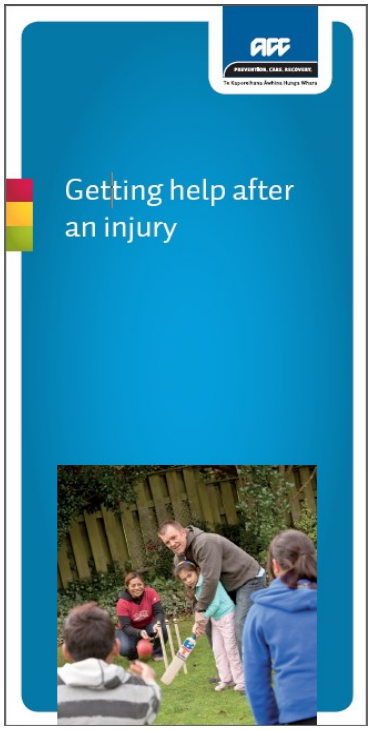
Ancillary services help clients to access treatment and rehabilitation. They include:

- pharmaceuticals and laboratory services
- emergency transport by ambulance, and transport to treatment
- transport to and from certain types of vocational and social rehabilitation
- travel for support people in specific situations
- help with accommodation for clients and/or their support people.

When a client's care is being funded under the Public Health Acute Services (PHAS) agreement, the DHB provides their ancillary services.

Helping clients understand what help they can receive

Our clients often ask their treatment providers about what help they can get from ACC and how ACC works. While we don't expect treatment providers to understand all the ins and outs of the Scheme, the brochure ACC2399 *Getting help after an injury* covers the basics of how we can help.



You can order free online or by phoning the Stationery Order Line on **0800 802 444** option 0, and quoting the ACC number in the title (ACC2399).

For detailed information you can direct clients to www.acc.co.nz. Under 'Making a claim', they can click on What support can I get? They can also call the Client Helpline on **0800 101 996**.

If you have any questions about entitlements, please contact the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

How ACC pays

Criteria for covering costs

ACC pays for, or contributes to, the costs of treating covered personal injuries. See also Invoicing and payments and Online claims lodgement: eLodgement.

ACC makes decisions according to the AC Act and the Regulations, which state that treatment must:

- be necessary and appropriate
- meet the quality required
- be given the appropriate number of times, and 'in person'
- be given at the appropriate time and place
- be reasonably required to facilitate treatment (for ancillary services)
- normally be provided by your type of treatment provider, and you must be qualified to provide that treatment
- have prior approval (if required).

In deciding whether these points apply to a client's treatment, the AC Act says that ACC must take into account:

- the nature and severity of the injury
- generally accepted treatment for the injury in New Zealand
- other treatment options available in New Zealand for such an injury
- the cost in New Zealand of both the generally accepted treatment and the other options, compared with the benefit to the client of the treatment.

Requirements for providers seeking payment

Providers seeking payment from ACC for services or treatment must ensure that:

- the services provided and invoiced for include clinical records that meet ACC's recommendations
- their clinical records meet their professional bodies' standards
- their clinical records demonstrate that the treatments provided meet the legislative requirements (listed above)
- the treatments provided and the clinical records can withstand scrutiny through peer review, an audit (medical or financial) or a medico-legal challenge
- the dates of appointments are the same on the invoices as recorded in any clinical notes.

Our policy on treating yourself or your family

ACC agrees with the Medical Council of New Zealand, which states that "other than in exceptional circumstances you shouldn't provide medical care to yourself or anyone with whom you have a close personal relationship". ACC considers this to be relevant to all types of treatment provider and includes the treatment of work colleagues.

We generally consider it unacceptable and unethical for providers to claim payments from ACC for treating those who are close to them. In these cases we'll only consider paying for treatment in exceptional circumstances.

Exceptional circumstances include:

- acute treatment provided in an emergency situation where, in your reasonable judgement, the need for treatment is urgent given the likely clinical effect on the person of any delay in treatment
- situations in rural areas where there is no other appropriately qualified treatment provider available to give the required treatment.

We're unable to fund:

- treatment provided in a non-emergency situation
- emergency treatment that would ordinarily be provided by a family member who isn't a provider.

The provider claim lodgement framework

To enable us to verify claims lodged on behalf of patients, we've worked with professional bodies to incorporate 'scopes of practice' into our frameworks.

The 'provider claim lodgement framework' covers various injury types. It refers to common Read Codes to show those injuries for which a provider may complete an ACC45 Injury Claim form and provide initial treatment. If an injury is within a provider's scope of practice we can decide to cover it.

If an injury isn't within a provider's scope of practice (as defined in the provider claim lodgement framework), the provider can give initial treatment and initiate the completion of an ACC45 Injury Claim form. They must then refer the client to a medical practitioner for confirmation of diagnosis before we can determine cover.

This means the patient will see two providers before their claim is considered. ACC will pay for the consultation/visit to confirm the diagnosis, but won't be able to pay for the initial consultation/visit and any subsequent treatment until the diagnosis has been confirmed and the claim accepted. The types of provider to which this rule applies include acupuncturists, osteopaths and speech therapists.

For more information on lodging claims, see the online documents:

- Provider claim lodgement framework
- Lodge a claim electronically
- Lodging a claim with ACC or an Accredited Employer.

How ACC funds providers in training

ACC only pays for treatment given by qualified treatment providers who take full responsibility for the treatment provided to clients.

If you're a provider in training (e.g. an intern or a university or polytechnic student undertaking practical work for study) we can offer funding provided you're:

- already a qualified practitioner undertaking further study
- unqualified but have gained consent from the client and are supervised by a qualified practitioner who:
    - is personally present throughout the treatment delivery
    - takes responsibility for assuring its standard.

Note: An important exception is that sexual abuse counselling must always be provided by a fully qualified counsellor.

Three ways to provide services to ACC

There are three ways to provide services to ACC:

- service contracts

Every ACC contract for services includes details of the invoicing and payment arrangements that apply to those who sign it. Contract terms can differ from the Regulations – when this happens the contracted terms take precedence over the Regulations

- payments under agreed costs

  These comprise agreements between ACC and providers based on treatment costs. If an ACC case owner requests services at an agreed cost, you'll need to request a seven-digit purchase order number from ACC. This needs to be included on every invoice. For more information, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz
- Regulations. These comprise, for example, the:
  - Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003
  - Accident Compensation (Ancillary Services) Regulations 2002
  - Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002
  - any later amendments.

Payments under the Regulations

The Regulations cover a large number of treatment providers, including:

- acupuncturists
- audiologists
- chiropractors
- counsellors
- dentists
- hyperbaric oxygen treatment providers
- medical practitioners
- nurses and nurse practitioners
- occupational therapists
- osteopaths
- physiotherapists
- podiatrists
- radiologists
- registered specialists
- speech therapists.

ACC contributes to treatment costs at the rates/amounts specified in the Regulations. The Regulations cover basic treatment provider costs, while the Schedule of the Regulations specifies amounts for treatments and procedures.

These include rates and amounts:

- per consultation/visit, as long as you examined, assessed and/or treated the client in person, for an injury or condition covered by ACC (for details see Consultations/Visits)
- per treatment/procedure given to a client during a consultation/visit as long as the Schedule includes an amount for that treatment/procedure for your type of provider.

Providers' payment options

If you're a 'specified treatment provider' (or 'allied provider') working under the Regulations you have the choice of being paid on a per-treatment basis or on an hourly rate. Hourly rates are specified in the Regulations. For details see Specified treatment providers.

Treatment/Procedure guide for medical practitioners and nurses

For guidance on items in the Regulations for medical practitioners and nurses, see Guide to invoicing for medical practitioners and nurses.

Privacy

We take privacy seriously

ACC deals with the personal and health information of a large number of people. We often request that you provide us with information and sometimes you'll need access to this information to carry out services for ACC. It's important that we each do our part and work together to protect this information.

What to expect

If you have access to personal or health information we would like you to:

- work with us in a transparent way
- notify us of potential risks
- notify us of breaches and near-misses
- resolve issues as they arise
- maintain a privacy register that includes breaches, near-misses and remedial action plans.

What do we mean by 'breach' and 'near-miss'?

A *breach* is when personal information is disclosed to an external party when it shouldn't be, whether by error, mistake or without legal authority.

A *near-miss* is when you can identify something that would have led to a privacy breach but didn't because the information wasn't disclosed.

Not only does maintaining a privacy register help us to meet the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994, it also enables us to work with an enhanced level of transparency on breaches and near-misses. To achieve a high level of transparency we expect all providers to have effective preventive measures in place to avoid breaches and near-misses.

If you have a privacy breach, contact your local Supplier Manager, who will work with you, or call the Provider Contact Centre on **0800 222 070**, who will direct you to your local Supplier Manager.

Obligations

Every organisation has obligations under the Privacy Act 1993. When dealing with personal information you need to ensure that you comply with the 12 information privacy principles that cover the collection, handling and use of personal information, set out in the

Act. The Act also requires every organisation to have a Privacy Officer to oversee its compliance with the Act and investigate any complaints when they arise.

A privacy pack has been developed to help you manage the privacy of your clients' personal information. It's available from our website and was developed with information from the Office of the Privacy Commissioner.

Further information can be obtained by contacting the Office of the Privacy Commissioner either at its website or through its helpline on 09 302 8655 (or **0800 803 909**). You can also refer to the privacy management section on our website.

Health, safety and security

Keeping people safe and healthy at work

ACC fully supports the Government's 2020 goal of a 25% reduction in serious harm and fatalities in New Zealand workplaces. We want to be a responsible leader by demonstrating our Safe Kiwis and Good Partner strategic directions with everyone with whom we interact, including the health providers who deliver services on our behalf to our clients.

The health and safety risks in each health service category will vary greatly, from low to very high. We expect our providers to have appropriate health, safety and security procedures and policies in place to keep staff and subcontractors' staff safe and healthy.

ACC's website provides guidance for businesses on managing hazards, training and supervision and health and safety, including workplace safety programmes. If you require more information, go to our website. WorkSafe New Zealand also has resources available on its website.

To meet our responsibilities for health and safety, we need you to tell us about health and safety events, including close calls and personal threats that arise while you're providing services to us or our clients. We'll work with you to protect others from harm by eliminating or minimising the risks wherever possible.

What you need to do

If you provide services to ACC via a service contract or as payments under agreed costs then you need to report incidents to us using the Health and Safety Incident Reporting Procedure on our website. We need to know about any of the following that occur while you're delivering services on our behalf:

- notifiable events
- close calls/near-misses
- non-notifiable injuries
- personal or organisational threats.

This requirement does not apply if you provide services to ACC via Regulations.

Obligations

The Health and Safety at Work Act 2015 applies to nearly all businesses in New Zealand.

To learn more about the new Act and your obligations, and to subscribe to receive email alerts, please visit the WorkSafe website. You can also contact WorkSafe at **0800 030 040** or email info@worksafe.co.nz.

Definitions

Notifiable event	Under the Health and Safety at Work Act, a notifiable event is: • the death of a person • a notifiable injury or illness, or • a notifiable incident that arises from work. Refer to the legislation.
Notifiable incident	An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health and safety arising from an immediate or imminent exposure to one of the incidents listed in the legislation – for example: • the fall or release from a height of any plant, substance or thing • an implosion, explosion or fire • an electric shock. Refer to the legislation for a full list of notifiable incidents.
Notifiable injury or illness	• an injury or illness listed in the legislation that requires the person to have immediate treatment (other than first aid), or • an injury or illness that requires admission to hospital for immediate treatment, or • an injury or illness that requires medical treatment within 48 hours, or • any serious infection where the carrying out of work is a significant contributing factor as listed in the legislation, or • any other injury or illness declared to be notifiable by regulations. Refer to the legislation.
Close call/near-miss	Any incident that could potentially have resulted in a notifiable event.
Personal threat	Any written or verbal threat made to a staff member either in person or remotely, for example by telephone or email.
Organisational threat	Any written or verbal threat made to your organisation, for example a bomb threat or damage to the organisation's property.

3. Supporting quality

Resources for providers and clients

Resources to help you

ACC produces a range of resources to inform, encourage and support the use of best clinical practice. These are available on our website. Although some of the information may be dated, the page is under constant review and we encourage you to check it regularly.

Resources include:

Case studies

Treatment injury case studies are produced by ACC's Treatment Injury Centre to provide health professionals with:

- an overview of the factors leading to treatment injury
- expert commentary on how similar injuries may be avoided in the future.

Feedback reports

ACC produces annual *National Service Reports* that contain high-level data that can be compared to individual practice data and used for professional discussion. The content is developed using the Results Based Accountability framework, which measures how much we've done, how well we've done it, and whether anyone is better off.

ACC reviews

ACC reviews summarise the latest best-practice injury management and rehabilitation from a clinical perspective, drawing on recent available evidence and clinical guidelines. The reviews are developed by clinical subject matter experts in conjunction with ACC staff and relevant peer review groups.

Resources for clients

You can help your patients to understand their injuries by giving them information from the *Caring for your…* leaflet series. This series gives clients tips on how to look after their injuries.

These leaflets are available to order from our website through the Publications section.

Research

Research involvement

ACC invests in ongoing research as part of our commitment to ensuring the most appropriate treatment and rehabilitation for clients. This is often done in collaboration with partners in the broader clinical and health sectors.

Our Research team conducts research in-house and manages ACC-funded research that is contracted to external agencies. We also work in partnership with other areas of the

organisation where our research expertise is required for initiatives including consensus guidelines, evidence-based health care (EBH), programme evaluation, customer insights and innovations in treatment and rehabilitation.

Research advice

The Research team is committed to the principles of EBH. This enables a multifaceted approach to inform decision-making and guide health purchasing and supports best practice among treatment providers. The team's objectives include:

- developing impartial, evidence-informed purchasing recommendations to assist ACC in making appropriate purchasing decisions
- promoting best practice in injury management and rehabilitation
- evaluating new ACC services and primary health care initiatives
- consulting and collaborating with health care providers
- seeking feedback from providers and other partners through surveys and market research to analyse new and emerging issues that might affect ACC in the future.

Research partnerships

For purchasing recommendations the team uses internationally standardised EBH methods to summarise and evaluate existing clinical research on effectiveness and safety.

In partnership with subject matter experts and a purchasing advisory group, the team provides recommendations on whether the treatments, products or services in question should be purchased by ACC. Recommendations are formed through the analysis of research articles from peer-reviewed journals. These recommendations are then put forward for ratification by the ACC Clinical Governance Committee before becoming policy.

EBH reports written by the Research team can be found on our website. The Considered Judgement Forms (which facilitate the purchasing advisory group discussions) can also be found there.

Clinical records

ACC's emphasis on clinical records

Each of your clinical records should show the history you obtained, the examination you undertook, how you formulated your diagnosis, and how you planned the client's treatment. Reviewing your records will help ACC and others to see how you reached your conclusions.

It can be easy to forget details of a client's presentation or what you said and did in the consultation/visit. Good clinical note-taking can help you to review your practice and avoid uncertainties.

In the unlikely event of a complaint from or an adverse event for a client, good records help to demonstrate your standard of care and document your decisions and advice. It's therefore vital that you keep full and accurate clinical records, for your own and the clients' protection and support.

All professional bodies endorse the responsibility of professionals to regard record-keeping as a key area of competence, and most have processes to support and encourage this. Each profession also has its own standards for record-keeping, so check what your professional body suggests.

All services that you provide and for which you invoice us must be supported by clinical records that meet your profession's standards and ACC's recommendations. See What we recommend for all clinical records.

Requesting your clinical records

People wanting to lodge claims for injuries can have complex or confusing presentations. ACC has a legislated right to view your clinical records at any time. Your clinical records provide us with the necessary clinical evidence to determine whether your patients' injuries meet the legislative requirements for different types of cover and that your treatment was necessary and appropriate.

If a patient's injury is covered, they may be given treatment and other support as their 'entitlement'. Normally, primary care consultations/visits receive automatic financial contributions under the Regulations, but for special services such as surgery, pain management, weekly compensation and home help we're obliged to check that the requested support is directly related to the clients' injuries. Your records can be crucial in helping us to determine entitlements and overall rehabilitation plans.

We'll require copies of relevant clinical records when you submit an ACC32 Request for Prior Approval of Treatment form.

Your clinical records might also be requested:

- by other agencies for other reasons, such as an adverse patient outcome or patient complaint
- for certain invoiced services to ensure these are clinically justified
- by other treatment providers (you'll need patient consent for this)
- by your patients
- if your practice undergoes one of our periodic audits.

What we recommend for all clinical records

Your clinical records for each patient need to:

- provide client identifiers such as name, date of birth and ethnicity
- provide your name, a legible signature (if on paper) and the date and time of each consultation/visit
- be written at the time of the consultation/visit or shortly afterwards and have any later records dated and countersigned
- be written in English on a permanent electronic record or, if on paper, be legible and in pen, not pencil
- record any tests or communication that influenced your diagnosis or treatment
- record any prescribed medications the patient is taking
- provide clinical reasons to justify any consultation/visit or ongoing treatment
- provide a provisional diagnosis and supporting rationale if there is a differential diagnosis
- identify a treatment plan and rehabilitation expectations, as discussed with the patient

- record any referrals made
- show consistency between your appointment record and invoice dates
- be stored securely for a minimum of 10 years after the final consultation/visit
- be transported (physically or electronically) only when essential, taking all steps necessary to protect that information. See Privacy
- withstand scrutiny of the treatment provided in the event of peer review, audit (medical or financial) or medico-legal challenge.

What to avoid in your clinical records

Make sure you don't:

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

Our recommendations for the initial consultation/visit

To help us make appropriate decisions as swiftly as possible, we ask that in the initial consultation/visit you record details of the:

- accident, how it occurred and any mechanisms of injury
- injury symptoms and clinical significance
- reason for the presentation, or the main reason if the consultation/visit involves more than one condition
- history and examination findings, including important negatives
- relevant past history, including medications
- initial working diagnosis
- pain and effect on sleep, work and other activities of daily life
- employment history – current employment, the physical, perceptual and mental demands of work as it relates to the patient's functional limitations, and the willingness of the employer to make workplace accommodations
- initial advice you've given the patient, e.g. about work fitness or injury-related restrictions
- treatment undertaken and tests and investigations required
- management and follow-up plan.

Our recommendations for follow-up consultations/visits

Your records for any follow-up consultations/visits should demonstrate that your treatment meets the legislative requirements of being necessary and appropriate. We ask that you detail:

- the patient's progress
- your evaluation of the effectiveness of previous treatment
- new aspects of history and examination, and the results of any new tests or investigations
- any restated or revised diagnosis
- any subsequent advice given to the patient
- any treatment provided
- the reason for any change to an earlier treatment plan
- work capacity and return-to-work barriers

- any reports or communication relating to the injury.

Peer reviews

To ensure that we have the best possible information, we may sometimes approach peers in your clinical area for independent advice. Peer reviewers may be clinical advisors employed by ACC or external advisors nominated by your professional body.

Monitoring providers and fraud control

ACC requires assurance that providers are supplying services that match ACC's requirements, and that the invoices you submit are valid and correct.

The legal basis for any monitoring is set out in:

- any service contracts agreed between providers and ACC, and/or
- the Regulations, which cover invoicing and payments under the AC Act.

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

The assistance we offer includes:

- working with providers in an educative and supportive way
- monitoring the activities of providers whose invoicing patterns cause concern, in accordance with ACC's performance and monitoring framework
- helping to develop, negotiate and implement improvement plans for providers
- managing and resolving provider issues that affect client outcomes.

We've developed a suite of provider indicator reports. These reports have been developed to enable ACC to monitor provider service variations regularly within and across provider types, monitor provider billing behaviour, manage the risks involved in provider services, and identify and prioritise areas/groups where quality improvement/education is required.

How ACC investigates and controls fraud, wastage and abuse

In respect of fraud ACC understands that:

"Any person who commits an act or omission that is dishonest and without claim of right and for the purpose of obtaining a pecuniary advantage (money) or other valuable consideration (e.g. an entitlement) for oneself or any other person, commits fraud".

ACC has a dedicated team focused on minimising fraud, wastage and abuse to preserve the value and sustainability of the Scheme and keep it fair for those who need it most.

This is implemented through ACC's three lines of defence approach. The first line is the primary identification and management of risks through Supplier Manager monitoring. The second line is Integrity Services' data-led detection insights. The third line is independent reviews.

Integrity Services

Our Integrity Services team utilises a range of methodologies to achieve its planned objectives, including a prevention-first philosophy to minimise fraud occurring in the first place and, when it's discovered, intervening early to prevent further loss.

The remedies we consider when we detect fraud include:

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

Integrity Services provides national support and advice to the ACC business while also engaging through appropriate channels with professional bodies and peer agencies across the sector. This ensures that optimal strategies are adopted to manage fraud risk.

Situations requiring Integrity Services intervention include:

- claiming for treatments and services not provided
- intentional over-servicing for financial gain
- falsifying billing schedules and treatment invoices.

Contacting Integrity Services

If you have concerns that you believe may require ACC Integrity Services' attention, please contact the team on **0508 222 37283** or by email at fraud@acc.co.nz. You can also report fraud via our website.

4. Provider registration

Registering to become an ACC provider

Why become a registered ACC provider?

Registration with ACC enables you to:

- lodge claims for cover on your patients' behalf
- provide treatment for ACC clients within your scope of practice
- invoice us for the services you provide to our clients
- order stationery such as ACC claim forms
- receive important communications.

Who can register?

Any treatment providers seeking payment for services to ACC clients need to register with ACC. Registration is open to all those identified under the AC Act as treatment providers. This table shows the vocations that qualify, noting the groups that are identified under the Act as 'registered health professionals' and under the Regulations as 'specified treatment providers'.

Vocational classification	Treatment provider	Specified treatment provider	Registered health professional
Acupuncturist	✓	✓	
Audiologist	✓		
Chiropractor	✓	✓	✓
Clinical dental technician			✓
Counsellor	✓		
Dental technician			✓
Dentist	✓		✓
Medical laboratory technologist	✓		✓
Medical practitioner	✓		✓
Medical radiation technologist			✓
Midwife			✓
Nurse	✓		✓
Nurse practitioner	✓		✓

Occupational therapist	✓	✓	✓
Optometrist	✓		✓
Osteopath	✓	✓	
Pharmacist			✓
Physiotherapist	✓	✓	✓
Podiatrist	✓	✓	✓
Speech therapist	✓	✓	

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

ACC's registration requirements

The qualification, registration and certification requirements that treatment providers must meet differ slightly between groups. For details of the different invoicing arrangements, see Invoicing and payments.

Registered health professionals

Providers categorised as 'registered health professionals' are asked to demonstrate qualifications in a way that directly reflects the registration and professional standards required of them by the HPCA Act.

Registered health professionals can include those holding interim practising certificates, but only when they're acting in accordance with any conditions of their certification, as stated in the HPCA Act.

Nurses and nurse practitioners

Under the AC Act nurses and nurse practitioners are those who are registered as such in terms of the HPCA Act and hold current annual practising certificates. These categories don't therefore include enrolled nurses or nurse assistants.

Specified treatment providers

'Specified treatment providers' are designated in the Regulations. Their registration process is similar to that followed by registered health professionals.

Specified treatment providers have special arrangements for invoicing and payment that include the option of hourly rates or fixed rates per treatment. This reflects the way they provide treatment. For details, see Specified treatment providers.

Counsellors

Counsellors work with ACC in a slightly different way. To reflect these differences, counsellors have a separate registration process. See Counsellor registration.

Registering to provide contracted services

While some services can be provided under the Regulations, others can only be provided under contract. If you're interested in registering as an ACC health provider and want to take up a contract, your key initial contact will be the Provider Service Delivery team. This team negotiates and manages ACC contracting opportunities.

ACC's contracted services govern client assessment, planning and treatment/rehabilitation. We contract directly with treatment and rehabilitation providers to connect our clients with a wide range of services. Those services are summarised on our website.

For more information about applying for a contract you can:

- contact the Health Procurement and Contracting team on **0800 400 503** or by emailing health.procurement@acc.co.nz
- visit our website.

Individual registration

How to register as an individual treatment provider

If the organisation (vendor) for which you work has a contract with ACC you may not be required to go through a registration process for yourself. For example, clinics or practices holding Accident and Medical contracts or Rural General Practice Services contracts register in a different way.

If you do need to register as an individual, you'll need to supply:

- a completed ACC024 Application for ACC Health Provider Registration form
- a copy of your current annual practising certificate
- your bank account details, either on a pre-printed bank deposit slip or via bank verification.

For more information and registration forms, visit our website.

Alternatively, you can call the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz and we can fax, post or email the relevant application form to you.

Once you've completed the form and attached all additional information required, please send it to:

ACC Provider Registration
PO Box 30823
Lower Hutt 5040

Alternatively, you can fax your form to **04 560 5213** or email scanned images of the signed form to registrations@acc.co.nz.

The Health Practitioner Index

The Health Practitioner Index (HPI) is a Ministry of Health initiative that ACC supports. The HPI is an identification system that replaces the:

- ACC provider number with an HPI person number
- ACC vendor number with an HPI organisation number
- ACC facility number with an HPI facility number.

ACC will register you with your HPI-Common Person Number (HPI-CPN). If this isn't possible, you'll be allocated your own ACC provider number. We may contact you directly to change from an ACC number to an HPI number. Individual providers may already be using HPI-CPN, issued by their regulatory authorities.

Receiving your registration number

We'll let you know in writing that we've accepted your application for registration, and confirm your provider number within five working days of receiving the application.

ACC uses provider numbers to identify who's provided treatment, track payments and monitor treatment provider performance. Your provider number is therefore specific to you and mustn't be shared with other health professionals. Please use it whenever you can in communications and transactions with us.

If you're employed at more than one practice, you may need a separate provider number for each practice. This is due to restrictions with the electronic schedule and the invoice payment systems used by some practices. Please contact the ACC Provider Registration team on **04 560 5211** to find the best solution.

Keeping your details up to date

It's important that we hold up-to-date contact details for you, and we ask that you contact us if you've changed your name, postal or email address, or phone or fax number. You can update your details with us by phoning the Provider Contact Centre on **0800 222 070** or emailing registrations@acc.co.nz (please make sure you include your provider number in the email).

We'll update your records, send you confirmation of the change, and give your new details directly to our printing and distribution partners, so they have the correct details in their databases when you order stationery.

All bank account changes require either a pre-printed bank deposit slip or bank verification. We can also accept faxed or emailed copies if they're received via a previously verified email address or fax number.

To check the details we currently have recorded for you, please get in touch with the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Counsellor registration

Who can be an ACC counsellor?

ACC accepts applications from suitably qualified and experienced counsellors, including social workers, psychotherapists, psychologists and psychiatrists.

Benefits of being an ACC counsellor

Counsellors registered with ACC can lodge ACC45 Injury Claim forms on behalf of clients, which can make it faster and easier for the clients to receive our services.

We'll pay for your counselling services at published rates in accordance with the Regulations. The rates differ slightly according to whether treatment is given by a counsellor or a psychiatrist (a medical practitioner).

See also Payment for counsellors.

Counselling services purchased by ACC

ACC purchases counselling services for clients with:

- sensitive claims
- mental injuries from physical injuries or work-related events.

ACC also has a Sensitive Claims Unit that specialises in helping people to rehabilitate and recover from mental and physical trauma caused by criminal acts such as sexual violation, indecent assault and unlawful sexual connection. Counselling services are key to the recovery of these clients.

We also help people to recover from mental injuries that are the direct result of covered physical injuries or traumatic work-related events.

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

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

Required qualifications, skills and experience

To be registered as an ACC-approved counsellor, psychologist, psychotherapist or psychiatrist, you need specific qualifications, skills and experience.

The requirements include:

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

You'll need to include other supporting documents:

- a completed application form
- two case studies
- consent for a police check
- a copy of your current annual practising certificate.

If you belong to another profession you'll need to provide additional items, including certified copies of your academic qualifications. You'll also need to arrange for your supervisor to provide details about you and about their own membership of an appropriate professional body.

You can get more information on the required qualifications by:

- phoning the ACC Provider Registration team on **04 560 5211**
- emailing registrations@acc.co.nz.

Applying for registration

To find out how to apply to become an ACC-approved counsellor, we recommend that you visit our website.

How we assess your application

All applications are reviewed by an external evaluation panel made up of nominated representatives from various New Zealand counselling bodies.

The panel will assess your qualifications and experience against the ACC criteria and make its recommendation to us. We'll make the final decision.

The application process includes a Police check to find out if New Zealand Police holds any information about you. This includes details of criminal convictions, except those covered by section 7 of the Criminal Records (Clean Slate) Act 2004.

Letting you know

We aim to advise you of our decision within six weeks of receiving your completed application.

5. Lodging claims

Lodging a claim with ACC or an Accredited Employer

Forms used to lodge claims

There are five main forms used to lodge claims, and most can be lodged electronically:

ACC45 Injury Claim form

The ACC45 Injury Claim form is the primary form used to lodge claims for cover, and should be used wherever possible. This is because it has a unique number for security reasons, which we also use to monitor claims, and provides sufficient prompts within the form to ensure that all the necessary information is provided. See Completing the ACC45 Injury Claim form for more information. If your patient requires further time off work, you'll also need to complete an ACC18 Medical Certificate form.

ACC2152 Treatment Injury Claim form

Use this form in addition to the ACC45 Injury Claim form when lodging a treatment injury claim. For more information, see Treatment injury.

ACC18 Medical Certificate form

Use the ACC18 Medical Certificate if you're a medical practitioner or a nurse practitioner and you need to describe a person's ability to work. This is the only certificate we accept for compensating clients for time off work. For more information see Medical certificates (ACC18s). An ACC18 Medical Certificate form can also be used to request ACC to change or add a new diagnosis to an existing claim.

ACC42 Dental Injury Claim form

The ACC42 Dental Injury Claim form is a specialised form of the ACC45 Injury Claim form that dentists use to provide more specific details about clients' dental injuries.

ACC32 Request for Prior Approval of Treatment form

The ACC32 Request for Prior Approval of Treatment form can be used for several purposes (refer to ACC32) – such as when your patient's injury is covered and you:

- anticipate that you'll need prior approval from ACC for additional treatment funding
- want to add or change a diagnosis (see also What information does ACC need?)
- want additional splinting costs.

Ordering new forms

The easiest way to access and submit order forms is electronically; however, if you don't have access to a computer, printed forms can be requested. To order new forms, reply-paid envelopes and other ACC supplies, phone the Stationery Order Line on **0800 802 444**.

The claim lodgement process

When you lodge a claim using the ACC45 Injury Claim form you're asking us to cover a patient's personal injury.

Please complete the form with your patient and send it to ACC either as a paper form or electronically. The fastest way to lodge a claim is electronically. For more information on electronic lodgement, visit our website or see Working electronically with ACC.

Each ACC45 Injury Claim form has a unique, secure reference number that identifies the patient's claim once it's been lodged. The form is used for many injuries and conditions and enables you to provide important information that can help start the treatment, rehabilitation and/or entitlements process.

Only treatment providers defined by legislation can lodge claims on behalf of patients. See Who can register? for a list of accepted providers, and visit our website for more information. If you're an acupuncturist you may lodge a claim but you'll need the patient to have the diagnosis confirmed by another provider. Claims won't be considered for treatment or entitlements until a confirmed diagnosis has been received and cover approved.

Only medical practitioners and nurse practitioners can certify incapacity for work. For more information see Medical certificates (ACC18).

Lodging a claim with an Accredited Employer is slightly different. For more information see Lodging Accredited Employer claims.

The processes for lodging specific claims can differ. Visit our website for details on how to lodge:

- claims for mental injury caused by sexual abuse
- claims for treatment injury
- claims for work-related gradual processes, diseases and infections
- late lodgement claims.

If you're not sure how to lodge a claim with ACC we encourage you to check out the information on our website, or give us a call. This will make sure everything goes smoothly for you and your patient. If you have a question about lodging a claim or a claim already submitted, please get in touch with the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Completing the ACC45 Injury Claim form

There is information about how to complete, sign and lodge a claim on our website. See also Where to send the claim forms.

Things to note when completing the form and before you submit it:

If you want to check whether a claim has already been submitted

If you need help in finding out about a claim already submitted, call the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz with the patient and injury details. You can also check on a claim's status through the eLodgement system.

If your patient has claimed for their injury before

Quote the ACC45 number for their original claim. The number will be on the referral form or the first ACC45 Injury Claim form.

Check the client's personal details (Part A) and employer details (Part B) and, if necessary, update them.

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

If your patient is in paid employment

Employers' names and addresses must be included for all claims where your patients are in paid employment, regardless of whether their injuries are work related.

If you think your patient needs help beyond ACC's contribution to treatment costs

For example, if you think your patient needs further treatment, personal support or weekly compensation, there are several places on the ACC45 Injury Claim form where you can specify their additional needs.

You can also give them your professional assessment of these needs and encourage them to contact the Client Helpline on **0800 101 996** as soon as possible. In most cases they can apply for entitlements over the phone. However, entitlements aren't granted until cover has been accepted, so it's still essential that you lodge the ACC45 Injury Claim form promptly.

If your patient presents with a sexual abuse injury

It's important that you also ask them whether they want mail from ACC and providers to be sent to a different address from the one in your records.

Before submitting the form

Add NHI (National Health Index) numbers if you know them.

Be sure to go over the Patient Declaration and Consent section on the back of the ACC45 Injury Claim form with the patient to ensure they understand what they're signing.

Using Read Codes

Read Codes are a hierarchical coding system for injury types, with each level giving a more specific diagnosis. Each Read Code has five characters. If a Read Code only has four numbers it will end in a dot, which becomes its fifth character.

Primary care providers are required to record Read Codes for all diagnosed injuries for ACC claims. Hospitals and secondary care providers can use 'International Classification of Diseases: 10' (ICD-10) codes instead, although they can and often do also provide Read Codes. Having the correct Read Code helps to ensure that we cover the correct injury and provide the client with the most appropriate support, treatment and rehabilitation.

Recording a Read Code

When completing an ACC form, e.g. the ACC45 Injury Claim form, the ACC18 Medical Certificate or the ACC32 Request for Prior Approval of Treatments please:

- record the Read Code that best corresponds to your diagnosis of your patient's injury
- record the lowest relevant level of Read Code
- use a separate Read Code for each injury for a client with multiple injuries in the order of severity/complexity
- ensure that each Read Code includes the dot, if necessary, for the most accurate injury diagnosis
- use Code Z (unspecified condition) if there's no Read Code to match your diagnosis, and provide a detailed written diagnosis. An ACC staff member will complete the Read Code field and may contact you if they need to clarify anything.

If you don't have access to the full Read Code directory via Read Code software, refer to the ACC6343 Read Code reference list which is sorted by type and location of injury. You can also access the Read Codes commonly used in physiotherapy, osteopathy and chiropractic.

For more information, see Using Read Codes.

Where to send the claim forms

If you're sending claim forms using eLodgement, do so regularly during the day. Most claim forms can be sent electronically.

Visit our website for more information on lodging a claim electronically and working online with ACC.

If you're sending claim forms by post or fax, visit our website for a list of offices that deal with specific and general claims.

Work-related injury claim forms and documentation for employees who work for Accredited Employers must be sent directly to the employers.

What happens next?

For details on how we process a lodged claim, visit our website.

When cover has been accepted we advise the client by letter. If you want to find out whether cover has been accepted, call the Provider Contact Centre on **0800 222 070** and quote the ACC45 claim number or email providerhelp@acc.co.nz. You can also check via the eLodgement system.

It's important that we have all the information we need to make a decision. If we don't have enough information the claim can be put on hold, or declined pending further information. We don't usually pay for claims with insufficient information to make a decision unless they are work-related gradual process claims or sensitive claims.

Invoicing

For information on invoicing ACC and Accredited Employers, see Invoicing ACC or Accredited Employers or visit our website.

Lodging Accredited Employer claims

About Accredited Employers

An Accredited Employer is a business that's signed a 'Partnership Programme' contract with ACC. This allows it to deal directly with staff workplace claims and health providers on behalf of ACC.

Accredited Employers pay lower ACC levies than other employers and are expected to provide the same cost contributions and quality of service as ACC. Some Accredited Employers also choose, at their discretion, to refund co-payments for their employees. They manage their own:

- workplace health and safety
- employee injuries, including rehabilitation
- employee workplace (but not non-workplace) injury claims.

Over a quarter of New Zealand's full-time employees work for Accredited Employers. If your patient isn't sure whether they work for an Accredited Employer, you can find out by calling the Provider Contact Centre on **0800 222 070**.

Third-party administrators

An Accredited Employer may contract a 'third-party administrator' (TPA) to deliver injury and claim management services to its injured employees. TPAs include Gallagher Bassett, Wellnz and WorkAon.

TPAs can only act as payment agents and day-to-day points of contact, while Accredited Employers remain responsible for managing their injured employees' claims and injuries.

How to lodge an Accredited Employer claim

Send all documentation for your Accredited Employer patients (i.e. the initial ACC45 Injury Claim forms, treatment and rehabilitation plans, and invoices) to the Accredited Employers or their nominated TPAs, rather than ACC.

Visit our website for more information on lodging a claim with an Accredited Employer and for the answers to frequently asked questions on Accredited Employers and the ACC Partnership Programme.

6. Treatment

Acute treatment

Definitions: acute treatment and acute admission

The AC Act describes **acute treatment** as:

- the first visit to a treatment provider to get treatment for an ACC-covered personal injury
- if, in the treatment provider's judgement, the need is urgent (given the likely clinical effects on the client of any delay in treatment):
    - any subsequent visit to that treatment provider for the covered injury
    - any referral by that treatment provider to any other treatment provider, for the covered injury.

The Act describes **acute admission** as an admission to a publicly funded or agreed facility within seven days of the decision being made to admit, unless otherwise specified in the Regulations. See Accident Services – A guide for DHB and ACC Staff (see also Glossary).

Deciding if acute treatment/admission is needed

You need to be appropriately qualified to decide whether an injury needs acute treatment; otherwise you need to refer the client to a treatment provider who's qualified. The referred visit to another treatment provider is also regarded as acute treatment. The applicable qualification is described in the Provider claim lodgement framework.

If you determine that the client's injury is outside the scope of a primary care provider and that acute specialist assessment/treatment and/or acute hospital admission is required, you must ensure that the treatment is provided by:

- a publicly funded provider, or
- a provider that isn't publicly funded, if:
    - ACC agrees beforehand (prior approval), or
    - for reasons of clinical safety, treatment by a publicly funded provider isn't practicable.

Funding Public Health Acute Services (PHAS)

PHAS are funded by a bulk payment from ACC to the Crown. The Crown then funds the Ministry of Health to purchase these services from DHBs on behalf of ACC. You can find more details in the publication *Accident Services – A guide for DHB and ACC staff*.

Referring for other acute services

Radiology

For X-ray referrals we recommend that you complete your practice radiology referral form and remember to enclose a copy of it with the ACC45 Injury Claim form. If your patient is likely to need acute treatment outside the scope of a primary care provider, in addition to radiology for their injury, refer them to the nearest public hospital.

High-tech imaging

Acute high-tech imaging, such as MRIs and CT scans for ACC clients, is provided as part of PHAS. If your patient needs high-tech imaging as part of their acute treatment, please refer them to the nearest DHB.

Non-acute MRIs are funded separately by ACC under contract. For more information on how to access this service, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Surgery and specialist treatment

Acute surgery and specialist treatment is provided under PHAS. If your patient needs these services, refer them to the nearest DHB.

Elective surgery and specialist treatment are paid for by ACC through both the Regulations and contracts. You can refer your patient to a specialist directly. The specialist will request funding for treatment from ACC as required.

Nursing services

Nursing services

Nursing services can be provided in two ways to ACC clients who have covered injuries:

- under the Regulations (see How ACC pays)
- through contracted nursing services (community-based service delivery within the clients' homes, a clinic or any other appropriate community location).

Contracted nursing services

These are services to patients whose nursing needs can't be met by their primary care teams. There could be many reasons for this, including:

- the patient has reduced mobility
- the patient has little or no natural support, making it unsafe or impractical for them to attend a medical centre
- the injury-related needs of a seriously injured patient
- the patient needs care outside normal practice hours
- the patient has complex injuries – for example ulcers, wounds with heavy exudate, a large bacterial burden, pressure wounds or skin grafts
- the patient needs specialised treatment – for example stoma care, compression therapy or negative-pressure wound therapy
- the patient has a history of leg ulcers, slow-healing wounds, immuno-compromise, heart disease or diabetes
- the patient is a student with a complex wound and can't be managed by their primary health care team or school nurse. The supplier can provide services at the school, home or clinic
- the patient has made a full or partial return to work and their individual rehabilitation plan states the treatment is to occur at the workplace. This requires prior approval from ACC.

Please note, however, that eligibility for entry to this service isn't influenced by patient preference or convenience.

Entry to this service is by referral only, including for any subsequent injuries. Referrals can be generated by:

- the primary health care team (e.g. GP, nurse practitioner or practice nurse)
- patient self-referral (if the patient lives in a remote or rural area at least 50 kilometres or 30 minutes' drive from the nearest medical centre that has a doctor in regular attendance).

To satisfy the nursing supplier that there is a covered injury requiring the input of nursing services, your referral should include:

- the patient's personal details
- injury diagnosis
- treatments to date
- nursing needs
- rationale for requiring services outside what can be provided by the primary health care team.

Requesting further treatment

Using the ACC32 Request for Prior Approval Treatment form

The ACC32 Request for Prior Approval of Treatment form can be used for different purposes by specified treatment providers – for example when your patient's injury is covered and you:

- anticipate that you'll need ACC prior approval for additional treatment funding or are requesting additional splinting costs
- want to add a diagnosis to a covered injury (see also What information does ACC need?)
- want to change a diagnosis (see also What information does ACC need?)
- want to recommend another treatment provider in addition to completing another referral.

Further treatment and costs

Prior approval for further treatment

Prior approval is required from ACC when:

- it has been more than 12 months since the client last received treatment from a specified treatment provider, or
- a client first presents for management of an injury more than one year after the date of that injury, or
- the treatment trigger number for the covered injury has been (or is about to be) reached and your client requires more treatment.

Each Read Code identifies the number of treatments (trigger numbers) you can provide before you need ACC prior approval to fund further treatment. Trigger points are a guide to expected recovery timeframes only, and all decisions are based on individual clinical need.

ACC will consider each request on a case-by-case basis and will advise whether ongoing treatment has been approved or declined. It's important to include all available clinical information at the time of seeking prior approval. No payments will be made until prior approval has been granted.

When completing an ACC32 Request for Prior Approval of Treatment form it's important to specify the date of the injury, details of the covered injury and the treatment given to date. If this information isn't available from the client, call the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

What treatment profile trigger applies if you're registered with ACC for more than one treatment modality?

If you choose to move between different treatment modalities in the management of your patient, the treatment profile trigger relating to the primary modality applies, regardless of the type or combination of modalities used.

Example: A provider is registered with ACC as a physiotherapist and also as an acupuncturist. The client's injury is primarily treated with physiotherapy, but the provider determines that acupuncture is also required at the same presentation. Only the physiotherapy treatment profile trigger would apply.

A dual-registered provider can't refer to themselves for their second modality without first seeking prior approval by:

- completing an ACC32 Request for Prior Approval of Treatment form
- supplying clinical records that demonstrate the need for the change in treatment modality.

The treatment profile trigger numbers for multiple modalities can't be added up or used one after the other for ongoing treatments. The services should be invoiced under the provider's primary vocational scope.

What to include in the ACC32 form

The information we need in the ACC32 Request for Prior Approval of Treatment form will depend on what type of provider you are. It is important to send ACC your request well before your last treatment so that continuity of treatment can be assured.

Physiotherapists

If you're a physiotherapist or hand therapist you'll need to include both an 'outcome measure' report and the client's clinical notes with each ACC32 application.

Other specified treatment provider groups

Other specified treatment providers only need to submit clinical records with ACC32 applications. The clinical records should be dated, legible and in English (see What we recommend for all clinical records).

If the information you submit is incomplete, we'll return the form straight away and ask for the missing information.

If the treatment required is post-operative and within 12 months of the date of ACC-funded surgery, please note this on the ACC32 Request for Prior Approval of Treatment form along with the date of surgery. Alternatively, you can call the Provider Contact Centre on **0800 222 070** and obtain approval.

Outcome measures for physiotherapy

Outcome measures are a tool for measuring the effects of physiotherapy interventions over time. They give all parties a better understanding of the outcomes achieved from purchasing physiotherapy services for clients. They also enable physiotherapists to reflect on their clinical practice and quality of service.

Physiotherapists are required to use evidence-based outcome measures. We recommend either:

- the Patient Specific Functional Scale (PSFS) outcome measure, or
- the Numeric Pain Rating Scale (NPRS).

However, an alternative standardised, evidence-based outcome measure can be used if it's more appropriate to a client's condition.

For guidance on using evidence-based outcome measures see the ACC Guide to Outcome Measure Reporting. This document focuses on the PSFS and NPRS because of their widespread acceptance among physiotherapists and other clinicians.

Please record a validated outcome measure for every ACC client:

- at the initial consultation/visit
- after six treatments
- on discharge.

When patients are referred by other types of provider

Approval for treatment is discipline specific. Using the ACC32 Request for Prior Approval of Treatment form to refer a client to a different provider type isn't the same as using it to request ACC prior approval for further treatment.

If a provider of another discipline recommends referral to your discipline on an ACC32 form that they have submitted to ACC, or uses an ACC32 form to refer a client directly to you, you'll still need to determine if your treatment requires prior approval and submit an ACC32 form yourself. Please attach the other provider's referral letter or ACC32 form when you submit your ACC32 request.

If a client has been referred to you by another provider of the same discipline as yourself, you'll need to confirm how many treatments the client has received, and complete another ACC32 form if the treatment profile triggers have been reached.

Our decision process

Once you've completed the ACC32 Request for Prior Approval of Treatment form and included all relevant information, please send it to your nearest service centre. We aim to

issue a decision or advise you of any delay within five working days of receiving the documents.

The requests are assessed by clinical advisors as necessary and we'll write to both you and the client with our decision. If we decline the request we'll also try to contact the client to talk them through our decision.

What to do if you disagree with our decision

If we decline your request for funding additional treatment, you can seek clarification from an ACC clinical advisor. The client can also formally dispute the decision, as all decisions are issued with review rights, meaning the client can have the decision independently reviewed. A request for review needs to be submitted within three months of the date of our decision, although this can be extended if a situation beyond their control prevents the client applying within that timeframe.

Criteria for approving requests

If we approve your request for treatment we'll fund up to six treatments in addition to the treatment profile trigger, as long as you invoice ACC in the order that the services are delivered.

If it's a request for a serious injury client we can approve more than six treatments if it's clinically justified. Please ensure that you include all supporting information.

Criteria for declining requests

We're unable to approve an ACC32 treatment request if:

- there's no causal link

  There needs to be a clear link between the client's ongoing condition and the covered injury in order to receive funding. This link must be supported by medical evidence, as a condition may be similar to, but not caused by, an injury.
- it's not injury related

  If the request is for a condition not related to the injury, we're not able to cover it.
- it's not considered necessary or appropriate

  If clinical records show that there hasn't been any significant improvement as a result of treatment, further requests for treatment can't be justified.
- the injury site doesn't match the covered injury

  We can only approve requests for covered injuries. If you're unsure about whether your patient's injury is covered, please contact the Provider Contact Centre on **0800 222 070**.
- the surgery wasn't funded by ACC

  If we haven't funded the surgery we're unable to fund post-operative rehabilitation treatment.
- it's a gradual process injury

  Unless it's a covered work-related gradual process condition we're unable to fund treatment.
- it's for treatment plus cover, or cover only

Cover and entitlement are two different decisions. If you submit an ACC32 Request for Prior Approval of Treatment form to add an injury, we need supporting clinical information. We may or may not approve cover while determining treatment. See Adding or changing a diagnosis and What information does ACC need?

- it's a new claim

  If, as a result of a patient assessment, you believe that their current condition doesn't relate to the initial accident, you should inform the patient and not submit an ACC32 Request for Prior Approval of Treatment form.

  If during your assessment you find there has been a clear new event causing personal injury, your patient may want to submit a new ACC45 Injury Claim form.

Adding or changing a diagnosis

Adding a diagnosis to a covered injury

If, when you're treating your patient, you discover an additional injury(s) related to the injury we've covered, you'll need to request an 'additional diagnosis' before we can provide assistance for that injury.

Example: A patient falls and sustains a shoulder injury. A claim has been lodged and accepted for the shoulder injury. However, you find out that the patient also sustained a knee injury in the fall and you want to treat the knee injury under this claim.

Changing a diagnosis

We'll consider a request to change a diagnosis if:

- there's been an administrative error, e.g. a claim was lodged for the incorrect body site
- there's been a change from an ICD-10 code to a Read Code
- the initial diagnosis of the injury was incorrect.

Example: A claim was lodged with the lumber sprain Read Code S572. However, there's now a confirmed diagnosis that the client has a lumbar disc prolapse with the radiculopathy Read Code N12C2.

How to add or change a diagnosis

To request that ACC add an injury or change a diagnosis, please submit an ACC18 Medical Certificate form or ACC32 Request for Prior Approval of Treatment form. When making your request it's very important that you provide sufficient information for a timely decision to be made. If we don't have enough information the claim will be put on hold or declined pending further information. We don't usually pay for claims with insufficient information to make a decision unless they're work-related gradual process claims or sensitive claims.

What information does ACC need?

When requesting to add or change a diagnosis you'll need to provide your clinical justification and any supporting documentation.

Where possible, please include the following information to support the additional injury or the change in diagnosis:

- the date of the original event
- the original injury diagnosis
- a description of how the new or additional injury has been caused by the original event
- the body site of the new injury
- the Read Code for the new/additional diagnosis
- medical evidence, e.g. clinical notes, reports, correspondence and X-ray, MRI or other scan results.

What happens next?

An ACC case owner will review the information you provide and consider your request. They may also seek further internal clinical advice, for example from an ACC branch medical advisor.

If we need to clarify anything with you, an ACC case owner will get in touch with you prior to a decision being made. They'll contact you and the client when a decision has been made.

Work-related gradual process, disease or infection

Cover under legislation

ACC covers a range of gradually arising process injuries, diseases and infections if they involve a personal injury as defined in section 26 of the AC Act, and there is a causal link between the injury and the person's employment.

Eligibility criteria

To be eligible for this cover, clients must meet either of two criteria.

1. The client's work environment shows that:

    - there is a particular property or characteristic in a work task or the work environment that can be identified as having caused the condition
    - the property or characteristic isn't materially present outside the person's work activities or environment
    - those performing the work task or employed in that work environment are at significantly greater risk of developing the condition than those who don't.

    The more common musculoskeletal injuries that can develop over an extended period of time through work are epicondylitis (lateral or medial), tenosynovitis (e.g. de Quervain's), prepatellar bursitis and rotator cuff syndrome. Claims for these need to satisfy the three-part test above, which reflects section 30 of the AC Act.

    If your patient has noise-induced hearing loss

    Patients with noise-induced hearing loss may be covered if they've been exposed to hazardous noise levels while working in New Zealand and meet the above criteria. In

addition, the amount of occupational noise-induced hearing loss (i.e. 'net of age' corrections and an allowance for other otological conditions) must be at least 6%.

2. The injury is on the list of occupational diseases, with their causative agents, in Schedule 2 of the AC Act. Common Schedule 2 diseases include occupational asthma, allergic contact dermatitis, mesothelioma, leptospirosis and lead poisoning. This list enables an injured person to be granted ACC cover more quickly and easily than the above criteria.

   A person will be covered for a listed disease if evidence shows that they have the disease and were exposed to contributing factors while working in New Zealand. If it's unclear that the disease is linked to employment, ACC must establish that the Schedule 2 disease isn't work related.

Lodging a gradual process injury claim

Work-related gradual process injury claims can only be lodged by medical practitioners and nurse practitioners. Any other provider who believes a person has a gradual process disease or injury should refer them to a GP to complete an ACC45 Injury Claim form as quickly as possible. Any treatments given for the injury (e.g. by a physiotherapist) before the patient has seen a GP or medical specialist won't qualify for payment.

When we receive the ACC45 Injury Claim form we send three questionnaires to the patient. The patient must fill in their questionnaire and ensure that their employer and GP fill in theirs. All the questionnaires must be returned to ACC so that a cover decision can be made. As the patient will only be able to receive their entitlement (e.g. weekly compensation for incapacity) once we've accepted their claim, it's important that you fill in your questionnaire promptly.

For more information on gradual process claims, see Work-related gradual process, disease or infection.

We may ask for a copy of your clinical notes

As we require evidence of actual damage, including a specific diagnosis of the gradual process injury, disease or infection, we may ask for a copy of your clinical notes and require test results. Providing details of the patient's clinical history and your examination findings at the time you lodge the claim will speed up the cover decision process for them.

If the cause is work task or workplace related

If you're documenting aspects of work task or workplace cause (to help establish plausible consequence, an absence of non-work factors and epidemiological evidence), please give details of where the causative agent is present. This means accurately identifying the specific property or characteristic in the task or workplace that has caused, or contributed to, the person's condition. We may also request a workplace assessment to clarify these factors.

You might also need to get information on the person's non-work activities.

Treatment injury

How ACC defines treatment injury

Treatment injury is a personal injury suffered by a person seeking or receiving treatment from a registered health professional and caused by treatment and not a necessary part or ordinary consequence of the treatment (section 32 of the AC Act).

Before July 2005 medical misadventure legislation covered treatment injuries. Claims lodged before this date continue to be managed under the previous legislation.

What treatment injury covers

If a patient is injured as a result of treatment, they may be able to make a claim and get help through ACC. However, we don't cover all treatment outcomes that don't turn out as expected, so we encourage you and your patient to contact us before lodging a claim to discuss whether a treatment injury has occurred.

Treatment needs to be provided by a covered registered professional

The covered registered health professionals are:

- chiropractors
- clinical dental technicians
- dental technicians
- dentists
- medical laboratory technologists
- medical practitioners – doctors, surgeons, anaesthetists, etc
- medical radiation technologists
- midwives
- nurse practitioners
- nurses
- occupational therapists
- optometrists
- pharmacists
- physiotherapists
- podiatrists.

Several other provider groups qualify as ACC treatment providers but their treatment can't be the subject of treatment injury claims.

However, patients who receive injuries from these treatment providers may still be covered under the wider ACC personal injury claim provisions. There treatment providers are:

- acupuncturists
- audiologists
- counsellors
- osteopaths
- speech therapists.

Lodging a treatment injury claim

Treatment injury claims are lodged using the ACC45 Injury Claim form, or ACC42 Dental Injury Claim form, along with a completed ACC2152 Treatment Injury Claim form. The ACC2152 form provides additional information that may be sufficient for ACC to determine cover.

The ACC2152 form is available on our website. Payment for the consultation/visit when an ACC45/42 form is submitted is made separately.

For more information on treatment injuries and how to lodge claims, visit our website or phone the Treatment Injury Centre on **0800 735 566**.

Who can complete the ACC45 and ACC2152 forms?

The best person to complete the forms is the registered health professional involved in the treatment that caused the injury.

The forms can also be completed if you're a treatment provider who wasn't involved in the treatment injury (e.g. if you're helping a patient) as long as you have enough information.

If you don't have enough information you should only complete the ACC45 Injury Claim form and:

- tick the 'Treatment Injury Box'
- provide the place of treatment
- provide the name(s) of the person(s) involved in the treatment that caused injury
- provide any relevant clinical information.

We'll contact the health professional who provided the treatment for more information.

If you're helping a patient to complete a claim form, you don't need to ascertain the cause of the injury being treated. We understand that you may not have access to this information (e.g. for older injuries, or when records are incomplete).

Who can't complete the form?

Some health professionals can't lodge a treatment injury claim even if they were involved in the treatment that caused the injury. These include:

- clinical dental technicians
- dental technicians
- medical radiation therapists
- midwives
- pharmacists.

What to say to your patients

If possible, you should let your patient know that we'll assess the claim and we may ask for more information about the injury and the events that led to it, including from other treatment providers involved. This means it could take a few weeks or more to reach a decision on their claim.

Legislation gives us up to nine months to make a decision after a treatment injury claim has been lodged. However, we aim to determine cover as quickly as possible.

Eligibility criteria for clients

A patient may qualify for cover if they're injured as a result of treatment by a registered health professional and the treatment, not the patient's health condition or some other factor, is the cause of the injury.

The treatment from which the injury may stem includes the treatment itself, either given or directed by the health professional, or a lack of treatment that should have been provided.

Under special conditions we'll consider a claim from someone who was part of an approved clinical trial and suffered complications. We're unable to accept claims resulting from trials that are mainly for the benefit of the maker or distributor of the item being tested.

Assessing treatment injury claims

ACC's Treatment Injury Centre assesses all treatment injury claims. It also assesses claims for any potential risk of harm to the public.

The Centre starts the claim assessment process as soon as the ACC45 Injury Claim form, the ACC2152 Treatment Injury Claim form and/or supporting medical records are received. If only an ACC45 Injury Claim form is received, we'll need to obtain the ACC2152 form and other records before we can process the claim.

Each claim is allocated to one of the Centre's clinical advisors with clinical experience in nursing, midwifery, pharmacy, physiotherapy and medicine. Their role is to make decisions on whether to accept claims by assessing the individual facts of the claims and applying the legislative criteria.

Once a cover decision has been made, the Centre informs the client and advises them to let their health professional know about it (it doesn't contact the health professional directly). For an accepted claim, we either pay the relevant invoices (if no further help is needed) or transfer the claim to be managed by the client's local branch (if the client still needs help).

Assessing the potential public harm

The Treatment Injury Centre analyses treatment injury data to assess the potential risk of harm to the public.

The results are shared through monthly treatment injury case studies, which can be found on our website under Clinical best practice, and at presentations to clinical meetings, conferences and seminars. Notifications are also made monthly to authorities such as the Director-General of Health, Medsafe and, in some circumstances, registration councils and boards.

Mental injuries, sensitive claims and counselling

Definition of mental injury

A mental injury is defined as a "clinically significant behavioural, cognitive, or psychological dysfunction". ACC covers the effects of a mental injury from an event rather than the event itself.

Client eligibility

ACC funds counselling under the Regulations for:

- mental injuries arising from physical injuries or workplace events
- sensitive claims, i.e. mental injuries arising from certain criminal acts listed in Schedule 3 of the AC Act.

When a person's mental injury has been caused by sexual abuse, they can lodge their claim through a medical practitioner, an ACC-registered counsellor or a provider who delivers services via the Integrated Services for Sensitive Claims (ISSC) contract. Immediate help can be accessed through ISSC by self-referral. The Find Support website provides information about providers who deliver ISSC services and their locations.

Sensitive claims counsellors can choose to work under:

- an ISSC contract with a supplier, and/or
- the Regulations.

What are the differences between the Regulations and the ISSC contract?

The Regulations and the ISSC contract refer to ways that ACC can purchase sensitive claims counselling services. The differences between the Regulations and the ISSC contract are particularly important for providers treating clients with sensitive claims.

The table below explains some of the key differences between the two purchasing methods.

	The Regulations	ISSC contract
Consolidation of services	The Regulations were introduced in 1999 and replaced in 2003. Along with the Accident Insurance ("Counsellor") Regulations 1999, they determine who can deliver services and how much ACC can pay for them.	This contract was introduced on 24 November 2014. It ties together all the services that were in different sensitive claims contracts, and for the first time includes counselling services and social work.
Client payments and co-payments	May require co-payments from clients.	A client co-payment can't be charged by a provider (ACC funds sessions to the amount specified in the contract).

	The Regulations	ISSC contract
ACC provider payments	Providers are paid by the hour and only for face-to-face time with clients. There are no separate payments for clients who don't attend their appointments or for administration, referrals or contacting other agencies on clients' behalf.	Providers are paid at a new rate. The rate incorporates things such as administration and time spent on client referrals. There is some partial compensation for client sessions where clients don't attend and for providers to travel to see clients.
Clients accessing support for the first time	For a counsellor accepted to deliver counselling services under the Regulations, ACC provides a one-off lodgement fee for the first session when they submit an ACC45 Injury Claim form on behalf of a new client. This client will then be referred to the ISSC contract. If a client with an accepted claim returns for further counselling the counsellor will be able to offer treatment services.	For a counsellor accepted to deliver counselling services under the ISSC contract there is the ability to offer pre-cover, treatment and additional support services that are fully funded for clients.

Mental injury caused by physical injury and work-related mental injury

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

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

After receiving the treating medical practitioner's report, we may make a referral for an assessment from a psychiatrist or a clinical psychologist. The assessment is designed to help us understand more about the injury's clinical significance and the causal link to the event. We may also seek appropriate treatment recommendations.

Exception

The only exception to this process is when a treating practitioner advises that there is no clinically significant mental condition.

In this case we may decline the claim without a psychiatric report as long as we have confirmation from an ACC medical advisor that it's appropriate to do so. The decision will depend on the facts of each situation. For example, when the advice is from a GP, a claim will likely only be declined if they have had recent and regular contact with the client.

Treatment options

The recommended treatment options outlined in the psychiatric report can include referral to a counsellor, psychotherapist, psychiatrist or psychologist for treatment or counselling. We can contribute to the funding of treatment if the provider is registered with us to provide counselling services under the Regulations or the ISSC contract. We're unable to fund services for non-registered providers.

For a full list of ACC-registered counsellors, call the Provider Contact Centre on **0800 222 070**.

For a full list of ISSC suppliers, go to Find Support website.

To find out more about registering as an ACC counsellor, see Counsellor registration or contact the Provider Registration team on **04 560 5211** or by emailing registrations@acc.co.nz.

To find out more about how to become a contracted ISSC-named provider, please email health.procurement@acc.co.nz.

Sensitive claim injuries

A sensitive claim is a mental and/or physical injury caused by a sexual abuse crime such as sexual violation, indecent assault and unlawful sexual connection.

Because these claims are confidential and personal in nature, we have a special Sensitive Claims Unit to help people with these injuries. The claims can often be complicated. ACC staff may need to gather more information than what's collected on an ACC45 Injury Claim form or the Engagement form completed when a person accesses ISSC. As a result it can take longer to determine cover for these claims, so the legislation makes allowances for this.

Sexual abuse crimes considered by ACC are listed in Schedule 3 of the AC Act. ACC staff may refer to the 'event' as a 'Schedule 3 event'.

If you have any questions about a claim like this or wish to direct a patient to ACC for confidential advice, phone the Sensitive Claims Unit on **0800 735 566** option 1.

Crisis care and early intervention

If your patient is distressed and there are serious concerns for their safety, contact the Crisis Assessment and Treatment Team (CATT) at your regional DHB. Each DHB has its own team and details are available on all DHB websites.

The CATTs provide 24-hour, seven-day assessment and short-term treatment services for people experiencing serious mental health crises who have urgent safety issues.

ACC also funds early medical and forensic assessments and follow-up treatment through the Sexual Abuse Assessment and Treatment Service (SAATS). This service is delivered by Doctors for Sexual Abuse Care (DSAC) doctors and nurses under local DHBs. DSAC doctors and nurses are specifically trained in managing sexual assault cases. You can refer patients to SAATS by contacting the local DHB or Police.

Lodging a sensitive claim

Medical practitioners and ACC-registered counsellors can lodge sensitive claims on an ACC45 Injury Claim form. ISSC-named providers can lodge sensitive claims by completing an Engagement form.

GPs and counsellors can get help with lodging sensitive claims from two ACC guides:

- ACC1149 *GPs' Guide to Completing the ACC45 Injury Claim Form For a Sensitive Claim*
- ACC1363 *Counsellors' Guide to Completing the ACC45 Injury Claim Form For a Sensitive Claim*.

You'll find them in the 'Forms & fact sheets' sidebar in the 'Lodge a claim' section of our website.

When describing a criminal act

Important: When lodging a sensitive claim, describe the criminal act and/or the relevant section listed in Schedule 3 of the AC Act. The cover decision process is likely to be delayed if you use simplified wording such as 'sexual abuse', fail to describe the criminal act or give unclear details of a mental injury diagnosis.

When providing a preliminary mental injury diagnosis:

- if you're unsure about identifying a preliminary mental injury diagnosis, or are not qualified to provide one, please use clinically relevant terms to the best of your ability
- if in doubt, over-describe the symptoms, as this is likely to provide the most useful information to help us determine cover. Use a DSM-IV diagnosis, an ICD code, a Read Code or any other relevant diagnostic classification tool
- at the various stages of seeing the patient, you should always check whether their contact details need updating.

Ensuring client safety and privacy

Given the nature of these claims, ask your patient for a safe address, which may be different from the one you have on record.

This is particularly important for clients aged between 13 and 16; we prefer a caregiver/guardian and/or family/whānau to be involved if possible.

Who can sign the ACC45 Injury Claim form?

Only the patient or their legal representative can sign the ACC45 Injury Claim form.

If your patient is under 16, their parent or guardian must sign for them.

If any other person signs, or there's no signature, we won't be able to register the claim and will return the form to you.

Before sending us the form

To avoid any delays it's really important to double-check that all mandatory sections have been completed (e.g. whether the patient is working).

Dealing with challenging behaviour

Dealing with an aggressive patient

Patient violence against providers is uncommon in New Zealand. However, some providers may find themselves on the receiving end of verbal abuse and, on rare occasions, physical assault. Dealing with an aggressive or violent patient can be a huge challenge for you and your practice colleagues.

In most cases patients are keen to get back to everyday life or work. Others, owing to injury or debilitation, take out their frustrations on treatment providers and may blame the broader accident compensation and rehabilitation system.

There may or may not be a direct connection between a patient's behaviour and their presenting condition. Abusive or threatening behaviour can also stem from compensation issues such as entitlement, eligibility for treatment or investigation, the legitimisation of a claim, and issues of cooperation in rehabilitation.

How we can help

It's important that you let us know about any violent and/or aggressive patient who's also our client. We can help you to assess the situation and determine whether other known factors are contributing to the hostility.

If mental injury is a factor

If a patient has developed a mental illness post-injury, and this appears to contribute significantly to their aggression or violence, we can help by providing a psychiatric evaluation and therapy or a psychologist referral. In this case our staff can be crucial in working with you to rehabilitate the patient and help with your patient relationship.

If pain is a factor

If chronic pain resulting from an injury is central to a patient's frustration and escalating hostility, we can offer pain management options. This type of support could help you with returning your patient to everyday life and work. For more information see Managing pain.

We also train our client service staff to deal with difficult and hostile clients, so they can support you in getting information from these patients. ACC staff usually hold interviews in rooms that offer some protection and security for participants.

Preventing or handling attacks

Sudden, violent attacks are rare; most incidents are preceded by mounting tension and frustration or escalating threats. To help you recognise the warning signs and take appropriate action, practical guides are available through many professional bodies, including the New Zealand Medical Association and the Royal New Zealand College of General Practitioners. Working and communicating with a patient, their family/whānau, associated staff and other providers can go a long way to reducing or eliminating the patient's hostility.

For example, there are steps that you can take before a patient arrives, when they make appointments, when they're on your premises, while the consultation/visit is underway, and if they become violent.

Here are some essential points to remember and develop in assessing the risks of and managing these situations:

Anticipate	Make sure you and your colleagues are always aware that you could encounter an aggressive or violent patient, and have mechanisms in place to deal with them.
Detect	Detecting high-risk patients early and implementing harm-reduction measures can stop threatening behaviour escalating into full-blown violence.
Analyse	Try to identify the factors that promote or encourage aggressive or violent tendencies in a patient. A careful analysis of patient, practice and provider features may identify the cause of the problem and enable management strategies that benefit you and your patients.
Team	Take a team approach to planning and managing aggressive and violent patients.
Support	Get appropriate support if a patient becomes aggressive or threatens violence, e.g. from the Police, ACC, the New Zealand Medical Association, the Medical Council of New Zealand or other provider bodies.
Prevent and act	Effective prevention and appropriate action are crucial when dealing with violent and aggressive patients.
Practise and be prepared	Develop and practise strategies to make sure you and your staff know how to respond and keep yourselves safe.
Contact us	Call the Provider Contact Centre on **0800 222 070** as soon as possible to let us know what's happened. Make sure you speak directly to one of our staff.

Pharmaceuticals

ACC's definition

Pharmaceuticals are described in the AC Act as:

- prescription medicines, restricted medicines or pharmacy-only medicines, as listed in Parts 1, 2 and 3 of Schedule 1 of the Medicines Regulations 1984
- controlled drugs as defined in the Misuse of Drugs Act 1975.

Helping with costs

ACC may be able to contribute to prescription costs for clients who are prescribed medication to help them recover and rehabilitate after injury.

To be eligible for assistance your patients will need to complete the ACC249 Request for Reimbursement of Pharmaceutical Costs form.

This comes with an information sheet explaining what reimbursement we offer, and what we need to be able to reimburse costs, e.g. the receipts and invoices that need to be sent with the form.

How we decide to reimburse

ACC will consider helping with the cost of pharmaceuticals if a claim has been accepted and the item prescribed:

- is reasonably required to help the client's treatment or rehabilitation based on their injury and clinical information
- is prescribed within the scope of practice of the prescribing provider
- is classified as a prescription medicine, restricted medicine, pharmacy-only medicine or controlled drug
- follows best-practice prescribing protocols
- follows best-practice rehabilitation pathways.

We'll also consider the availability of similar pharmaceuticals and generic alternatives listed in the Pharmaceutical Schedule.

If there isn't enough information to support a reimbursement request, we may ask for more information.

What we're unable to reimburse

We're not able to reimburse any administration charges added by the prescriber or dispensing pharmacy, or the cost of substances not considered pharmaceuticals, such as herbal remedies and complementary medications

How we contribute to costs

We pay for clients' pharmaceuticals in several ways.

By contract

If the contract includes providing pharmaceuticals, we'll pay the contracted price. Clients shouldn't be charged pharmaceutical costs if the contract price covers pharmaceuticals.

By reimbursement

We reimburse clients or pharmacies:

- for co-payments on community pharmaceuticals
- as a contribution towards part-charges for partly subsidised community pharmaceuticals
- as a contribution towards pharmaceuticals that aren't on the Pharmaceutical Schedule or that don't meet its subsidy criteria, as long as we've pre-approved them.

Via Public Health Acute Services (PHAS)

The bulk amount that we pay to the Crown via the PHAS agreement covers pharmaceuticals that are:

- required by clients during acute hospital admissions or emergency department visits
- given as part of the treatment associated with clients' outpatient follow-ups for up to six weeks from discharge or treatment
- used during treatment given by medical practitioners less than seven days after referrals by other medical practitioners
- listed on the Pharmaceutical Schedule, meet its subsidy criteria and are used in the community.

Pharmacies, clients and other providers don't need to invoice ACC for these pharmaceutical costs as they're already paid for under the PHAS agreement.

When you're prescribing medicines

When prescribing medicines please record:

- the ACC45 Injury Claim form number against each item
- a Ministry of Health identifier for all medical illness scripts to distinguish between accident and medical cases.

When to seek prior approval

Prior approval is needed for all non-subsidised pharmaceuticals

If a patient needs non-subsidised pharmaceuticals not already covered by the PHAS time period or under another ACC contract, we may be able to reimburse the costs partially.

You'll need to seek funding approval from us before prescribing the pharmaceuticals. If you prescribe them without our prior approval, we ask that you let the patient know that we may not be able to contribute to the cost.

Requesting funding for non-subsidised pharmaceuticals

To apply for prior approval, complete an ACC1171 Request for pharmaceutical funding form with your patient.

We'll need to know how the non-subsidised medication will help treat the injury and why other subsidised medication is unsuitable. This type of approval is for a limited time only.

Things to note when prescribing

When prescribing please ensure that you:

- prescribe subsidised pharmaceuticals that meet the Pharmaceutical Schedule criteria for community pharmaceutical use
- always apply for PHARMAC special authority when this is available
- code prescriptions as A4 – all our clients are eligible people in New Zealand, including non-residents whose injuries are covered by ACC.
  Note: You'll need to change the code on the script if it's computer generated and you've categorised the client as non-resident in your practice management system

(PMS)

- prescribe generic names rather than brand names, e.g. diclofenac tablets, not Voltaren tablets. If this means your client needs a new generic brand, you may need to support their changeover. Information is available from the PHARMAC website
- support patient adherence – use the tool at the National Institute for Health and Care Excellence website
- prescribe small quantities when trialling new medicines
- report adverse reactions to the Centre for Adverse Reactions Monitoring, PO Box 913, Dunedin 9054.

7. Rehabilitation

Work and rehabilitation

ACC's definition of rehabilitation

Rehabilitation is the term we use to cover the overall process of helping clients to return to work or, if they weren't working at the time of their injuries, to independence in their daily lives as much as possible.

Rehabilitation can involve combinations of:

- treatment for the effects of an injury
- specialised inpatient rehabilitation
- support to maintain employment
- support to obtain employment
- education support
- support to regain independence
- support in everyday living activities.

It's a dynamic process in which we involve treatment providers and help make connections to other providers. It recognises that one clinician or organisation can seldom meet a client's total needs in isolation.

Our rehabilitation framework

Our clients' circumstances vary greatly according to injury, health, work and other factors. We've created a range of pathways to make it easier to tailor the best support for each person and help them to achieve the results that will be of the most benefit to them.

Together, the pathways fit into an overall rehabilitation framework. The table below summarises the core concepts as developed in conjunction with stakeholders and staff:

Intent	Rehabilitation framework principles
An inclusive relationship of support	Rehabilitation is based on listening to, and understanding, the person in the context of their personal circumstances and community.
A service approach based on client need	ACC works with the person and their family, employer and provider to plan and deliver the agreed rehabilitation tailored to the individual.
ACC acts as a partner and facilitates the expertise of others	We mobilise existing support and provide any additional support and services needed to help people return to productive lives.

Rehabilitation and you

Your involvement in helping our clients to rehabilitate

As a treatment provider you may be involved with our clients at various stages of their rehabilitation.

You may initiate rehabilitation yourself by treating an injury or make a referral to elective surgery or other specialists.

The clients might also need social and vocational rehabilitation services. Through your understanding of their needs you can help us to identify where support in their environment could help them.

Managing pain

At all stages of rehabilitation you should consider whether there are any pain-related disability factors that could inhibit the client's progress. We have a number of pain management services to which you can refer patients, or you can let us know your concerns so we can help you to choose the best option.

For more information, see our website and ACC4467 Pain management quick reference guide to our services.

Vocational rehabilitation

Vocational rehabilitation aims to help clients to maintain or obtain employment. The range of tools and programmes spans:

- helping clients to rehabilitate at work, e.g. via the SAW service
- helping clients to rehabilitate who have to consider different work
- re-training clients when necessary to help them to find different work.

When clients have some capacity to work and are at low risk of re-injury, we can work with employers to arrange alternative work duties or hours.

Clients might need ongoing help to return to work, including: return-to-work monitoring; a graduated return-to-work programme; work trials; agreed recovery initiatives such as lifestyle changes, help with workplace access or adaptation; and other equipment to enable their independence.

ACC, or sometimes another contracted provider, may ask you to verify that a client is medically fit for a vocational rehabilitation programme.

If a client's return to work isn't progressing as expected, discuss it with us. There may be other options such as pain management services.

Assessing a client's work capacity – overview

As part of a client's rehabilitation we'll ask an appropriately skilled treatment provider to assess their capacity to work. We might also ask them to assess any medical grounds on which we can compensate the client while they're unable to work.

The Stay at Work service

The Stay at Work (SAW) service aims to help ACC clients to recover from injury in the workplace.

SAW service providers visit clients and employers at their workplaces and review the work tasks and environment. Their aim is to establish a clear picture of the tasks the clients can and can't do safely, and whether there are barriers preventing their recovery at work.

A good early intervention is the SAW level 1 service, in which SAW service providers help clients and employers to develop suitable return-to-work plans, including possible short-term modifications to the employees' work tasks.

SAW level 2-4 services are longer term, cover more complex needs and require progress reports from providers. Levels 3 and 4 are multidisciplinary programmes that include both functional and vocational rehabilitation components and monitoring of clients' returns to work.

SAW service providers

SAW service providers have a range of backgrounds. They're registered or certified members of their chosen fields, have ergonomic and health and safety expertise and are skilled in working with injured people in the workplace.

Assessing a client's disability duration – resources

Tools to help you assess the duration of incapacity include:

- treatment profiles for some primary care professions
- the ACC14191 *Return to Work Guide* first published in May 2006.

These help to summarise the current best practice for common injuries and provide a starting point for managing a client's rehabilitation at work or their return to work with 'time off work' certification.

They should be used when possible. If you'd like paper copies, please phone the Stationery Order Line on **0800 802 444** option 0.

Factors that influence disability duration

The duration of a disability can be affected by factors such as dominant versus non-dominant arm, work requirements (use of wrist, forearm), conservative versus surgical treatment, and compliance with the rehabilitation programme.

There is a minimum recovery time that most people will need to return to work at the same performance levels as before their injuries. Clients may be fit to return to work in shorter timeframes, particularly if there are suitable selected or modified duties or other support.

Likewise there is the time identified when most people are likely to be able to return to work, subject to good health care and no significant complications and/or co-morbid medical conditions.

There is a time at which additional reviews and evaluations should occur to determine when (and if) clients may be able to return to work and whether there are specific factors, including psychosocial, that need to be addressed.

Definitions for degree of work

For details on work types see our website. The work types are listed at the bottom of that page.

Work type	Definition
Sedentary	Exerting up to 4.5 kilograms (kg) of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull or otherwise move objects, including the human body. Involves sitting most of the time, but may involve walking or standing for brief periods.
Light	Exerting up to 9kg of force occasionally and/or up to 4.5kg of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements exceed those for sedentary work. Usually requires walking or standing to a significant degree. However, if the use of any arm and/or leg controls requires exertion of forces greater than those for sedentary work, and the worker sits most of the time, the job is rated light work.
Medium	Exerting up to 22.5kg of force occasionally and/or up to 9kg of force frequently and/or up to 4.5kg of force constantly to move objects.
Heavy	Exerting up to 45kg of force occasionally and/or up to 22.5kg of force frequently and/or up to 9kg of force constantly to move objects.
Very heavy	Exerting over 45kg of force occasionally and/or over 22.5kg of force frequently and/or over 9kg of force constantly to move objects.

Frequency scale for degree of work example

This table gives an example of how often the degree of work can apply to a client when their work type work capacity and disability duration are being assessed.

Frequency	% of an 8-hour day	Example
Occasional	0-33	One lift every 30 minutes
Frequent	34-66	One lift every two minutes
Constant	67-100	One lift every 15 seconds

Medical certificates (ACC18s)

Why medical certificates are important

Medical certificates (ACC18s) are important because they verify that clients are entitled to ongoing ACC weekly compensation while they're off work recovering.

Following your clinical assessment you can use an ACC18 Medical Certificate form to:

- alert us early that a client might need extra rehabilitation support so we can look at the options
- recommend home help, personal care, a second opinion or an assessment for the client
- change a diagnosis or add a diagnosis to a covered injury
- make changes or corrections to the original ACC45 Injury Claim form.

We encourage you to use the spaces provided on the form, as well as other communication methods, to give us your views on a client's needs. If you're unsure about specifics, please still pass on any general concerns to our case owners.

Confidential discussions

If you'd like to talk to us about matters that you're not comfortable writing in a client's ACC18 Medical Certificate form, please tick the option 'I would like to discuss this with the client's case owner'.

In complex cases it can be in the client's interests for you to meet our staff, rehabilitation experts, the client, their family and others in a case conference facilitated by ACC.

How medical certificates work

When clients need time off work to recover from their injuries, the medical certificates validate this and specify tasks or exposures the clients should avoid while recovering. They also allow us to provide workers with compensation for lost income while they're off work. Please emphasise to clients that the sooner they send us their ACC18 Medical Certificate forms, the sooner we can process their applications for compensation.

Only a medical practitioner (e.g. GP, specialist or emergency department doctor) or nurse practitioner can complete an ACC18 Medical Certificate form. The practitioner records the client's incapacity details on the required form:

- the ACC45 Injury Claim form if this is the client's first visit. This can be used to certify incapacity for up to 14 days
- the ACC18 Medical Certificate form if an ACC45 Injury Claim form has already been lodged. The ACC18 form provides a detailed description of how the client's injury affects their capacity for work and their prospects for rehabilitation.

The ACC18 Medical Certificate form must show:

- that the client's examination was done in person, not by phone or based on third-party reports
- your clinical assessment following the examination – this should be in line with the relevant treatment profile, including your diagnosis, comments and recommendations

to meet the overarching needs of care.

How to fill in an ACC18 Medical Certificate form

Give a confirmed diagnosis

After you've examined the client, enter a Read Code and/or a diagnosis (preferably both) on the form. You can also use the ACC18 Medical Certificate form to add or change a diagnosis. If you do, you'll need to record a new Read Code along with the supporting clinical evidence.

Get work information

Find out:

- the type of work the client does and the tasks involved
- key facts about their work history (tasks, skills)
- what their work environment is like
- any problems or injuries they had before the accident
- any concerns or fears they have about returning to work
- what tasks they can still do.

An ACC18 Medical Certificate form can help you to gather this information. It provides you with an early opportunity to advise us about possible risk factors in the client's work that could affect their rehabilitation.

Indicate a client's capacity for work

If a client can't do the job they had before their accident they may still have other work options, so it's important to indicate whether they have a capacity for work.

Marking that they have some capacity (i.e. are fit for selected part-time or alternative work) enables us to negotiate with all parties for the client to return to other available duties within the medical limitations imposed by the injury. This doesn't mean that we'll stop their weekly compensation payments. When negotiating a partial return to work we'll need to ensure that payment levels are appropriate and in line with the client's entitlement.

If the client doesn't think there are light duties available, contact us so that we can discuss this with their employer and look at alternatives.

Determine fitness for work

To be fully unfit for work the client must be unable to:

- travel to and from work
- be at the workplace
- do specified tasks at the workplace.

If you identify only one or two of these points we can look at ways to help the client overcome these barriers. It's important that we know their functional limitations, e.g. if they can't lift more than 10 kilograms, lift above shoulder height or stretch etc.

Important: We recommend that you and the client each keep a signed copy for your records.

Specify the time off work

Time off work is usually certified from when the client first presents with an injury until the next scheduled consultation/visit, usually two weeks or less.

If they have a severe or chronic condition you may need to certify a longer period, usually a maximum of 13 weeks. However, in some cases – such as if the client has a serious injury – they may need medical certificates at intervals of more than 13 weeks, e.g. at six- or 12-monthly intervals. The case owner will let you know if the client meets the criteria.

A client can have a medical certificate for more than 13 weeks (up to a maximum of 12 months) if:

- their functional restrictions have stabilised and are likely to remain unchanged
- these restrictions mean they can't perform any work
- their eligibility for long-term entitlements isn't in doubt.

Highlight next steps towards a return to work

Estimate when you expect the client to be fit for normal work. This helps us to negotiate with their employer and develop appropriate rehabilitation and return-to-work programmes.

The client's return to work should always focus first on their pre-injury employment role, tasks and hours. If the client can't do their usual tasks or hours, options include part-time work, vocational rehabilitation services and temporary alternative duties.

See the certification page on our website for more information.

Submitting the ACC18 Medical Certificate form online

1. You can send us the form through a BPAC (Best Practice Advocacy Centre) module in your PMS
2. If you don't have a PMS, you can access the eACC18 via the stand-alone form hosted by BPAC
3. To set up either, please contact BPAC directly on **0800 633 236**; they will be able to arrange access for you.

When you use the eACC18 online, the form is received immediately after you press 'Submit'.

Three documents are produced for you:

1. ACC/Patient copy
2. Employer copy
3. Patient declaration.

To print a copy for the client and their employer, go to the stored documents and print as you would any document.

ACC doesn't require you to keep paper copies with written signatures; however, there is a mandatory tick-box in the Declarations tab that has to be checked before you can submit the eACC18.

The patient declaration is available in 14 languages from the 'Multi-lingual' link at the top of the eACC18.

If you'd like any more information on the eACC18, please contact our eBusiness Support team on **0800 222 994** option 1 or email ebusinessinfo@acc.co.nz.

Using the paper ACC18 Medical Certificate form

Give the paper form to the client to either post or deliver to us. Emphasise to them that the sooner they get the form to us, the sooner we can process their application and begin any compensation payments. You can also give them a copy to keep.

When using a paper copy the client must sign the consent section, declaring that the information they have given is true and correct and authorising us to collect all relevant information. We recommend that, for audit purposes, you keep a signed copy of this form in paper or image format.

Sustained return to work

Helping your patients to return to work

The benefits of early return to work are recognised by health professionals and employers. Modern practice supports safe and sustainable work that quickly integrates people back into their workplaces and their normal lives.

Informed work fitness certification is vital to opening the doors to the range of vocational rehabilitation services that ACC can deliver to your patients.

Returning to work after an injury has to be sustainable if it's to be successful. To establish your patient's work capacity there are a few things you can do:

1. Get in touch with their employer to:

    - understand the specific demands of their job
    - identify any barriers to returning to work
    - troubleshoot the barriers

2. Let us know if barriers are identified
3. Let the case owner looking after your patient know if you're unable to make contact with the employer.

There's a lot of good information on supporting and coordinating an effective return to work in the ACC2360 *Return to Work Guide*, which was developed by both ACC and treatment providers. It includes best-practice information and practical help for managing rehabilitation and supporting your decisions.

Understanding the demands of your patient's job

The first step in assessing your patient's ability to return to work involves identifying their work tasks. These might include things like sitting, standing, climbing a ladder, lifting heavy loads or working on a keyboard most of the day.

'Work type detail sheets' are available to help you. They specify tasks for various work categories and can be found on our website (scroll to the bottom of the page).

Check if the patient can complete any of their employer's minimum requirements. Observing directly is the most accurate way to do this.

How to identify return-to-work barriers

A number of barriers can affect a patient's fitness to return to full, partial or graduated work activities. A vocational/occupational provider may need to be involved. They will consult you and any rehabilitation providers involved in your patient's care on the following:

Disability and physical impairment

Residual impairments can stop a client returning to work fully. It's important to diagnose these and seek the help of providers with appropriate expertise to manage the rehabilitation.

Injury factors

Injury factors include safety, biomechanical, cognitive, perceptual and functional limitations. Pain itself isn't a contraindication to activity and work. If you identify specific safety concerns they may apply to only part of the job. Identifying the part(s) of the job that the client can still do is an important starting point for returning them to work part time or using a graduated approach.

Individual factors

Individual factors include the client's beliefs about their injury and symptoms, e.g. their fear of pain from movement. A client may believe that pain intensity signals significant damage to the body and that all activity and work must be avoided until the problem is completely fixed. This means they often respond to the anticipation of pain, which engenders a 'fear-and-avoidance cycle'.

In these cases you should consider prescribing appropriate pharmaceuticals as part of your response and ensure they're being used correctly.

Workplace factors

Workplace factors include job satisfaction, work organisation issues and relationships with managers and co-workers. An employer's willingness and/or ability to offer temporary modifications to work tasks are critical.

For an example of how to complete a return-to-work plan with your patient, see Appendix 3 of the ACC2360 *Return to Work Guide*.

Advising us of barriers preventing return to work

If your patient has ongoing restrictions or specific limitations, please let us know so we can get in touch with their employer to arrange duties and a phased return to work as appropriate.

A phased programme may involve:

- selected or alternative duties, meaning the tasks they can still do become the temporary focus of their work
- a graduated return to work, where they undertake full or selected duties for part of the day and steadily increase these over a few weeks. With this option it's important to keep to the usual work starting time
- a programme that provides an individual return-to-work plan containing physical and vocational rehabilitation targets
- part-time work, which is considered a temporary last resort and only used in exceptional circumstances, such as when the patient is suffering significant fatigue or serious medication side-effects. See Lifestyle substitution.

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

Dealing with return-to-work barriers

Fear of pain from movement

If there are no specific safety concerns your patient's activity levels should be based on time rather than pain. They should be given clear guidelines on steadily increasing their activity level to avoid the risk of 'disuse or inactivity syndrome' developing from a long-term withdrawal from activity. Reassurance, motivation and encouragement can often help to counter this problem.

Lifestyle substitution

A graduated return to work may not advance beyond, for example, a four-hour day, but it enables your patient to experience the benefits of work while avoiding the lifestyle pressures associated with working longer hours.

To change this pattern, ask them to work a full day followed by a short day, then steadily move towards every day being a full day.

Workplace barriers

An ergonomic review of the organisation and processes of the workplace might be needed. These might not have caused the injury but could be barriers to a full and

sustainable return to work. Health professionals who specialise in the work environment will usually conduct these reviews. You can contact your patient's case owner to discuss a workplace assessment.

Please watch carefully for other return-to-work barriers. Anecdotal evidence indicates that highly motivated people (such as the self-employed) return to work more quickly than other groups of workers. However, some of these may need close monitoring to ensure they modify their workloads temporarily and don't end up prolonging their recovery.

Support is important within the first few days, as this is when most return-to-work problems occur. Many concerns can be resolved by contacting your patient's ACC case owner and/or their employer (manager or supervisor). If this fails, you might consider a referral to a health professional specialising in the work environment.

Referral and rehabilitation services

Other health professionals involved

A number of health professionals specialise in the work environment, including:

- occupational health nurses
- occupational physicians
- occupational physiotherapists
- occupational therapists
- vocational rehabilitation providers.

Your patient's problems will indicate which provider is the most appropriate. Please contact their case owner to discuss any referral, as you might need prior ACC approval.

Vocational rehabilitation services

Some of the most common assessment, service and/or rehabilitation programmes available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table indicate the contract types.

Service	Purpose	Provider criteria
Initial Occupational Assessment	Assesses clients' education, training and work experience and identifies suitable work types.	Occupational assessor
Initial Medical Assessment	Follows an initial occupational assessment and helps to determine clients' vocational rehabilitation needs. It assesses the clients' medical and injury-related conditions and any non-injury-related barriers to ensure they can sustain rehabilitation medically and with safety.	Medical assessor
SAW 1 and 2	Evaluate and review workplaces, then implement supervised increases	Rehabilitation

	in hours with the clients via documented plans, including troubleshooting.	professional
SAW 3 and 4	Evaluate clients' workplaces and involve key work contacts in identifying changes needed to make the environments safe, or for the clients to return to work. They are multidisciplinary services where functional rehabilitation is provided alongside monitoring of the clients' return to work.	Rehabilitation professional
Vocational Medical Review	Allows certifying practitioners and claim managers to request expert medical views of clients' fitness for work. The service helps clients to return to work quickly and safely following injury. The vocational medical review provider consults all parties to ensure agreement on fitness for work.	Medical practitioner with vocational training
Work Readiness Programme	Helps clients to become work ready, even if they're not expected to return to their pre-injury jobs or can't maintain their current jobs due to injury-related factors after all practicable rehabilitation has been completed.	Vocational practitioner

Social rehabilitation services

Some of the most common assessment, service and/or social rehabilitation programmes available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table indicate the contract types.

Service	Purpose	Provider criteria
Equipment	Provides equipment, aids and appliances based on clients' assessed needs to support their rehabilitation.	Contracted provider
Home and Community Support Services	Provides high-quality, flexible support services in clients' homes and communities to support rehabilitation and help them return to 'everyday life'. Services include home help,	Contracted provider or personal carer

	attendant care and child care.	
Housing modifications	Provide project management and advice for housing modifications approved by ACC, such as the removal of structural barriers or addition of fixed features that are based on clients' assessed injury-related needs.	Contracted consultant
Inpatient non-acute rehabilitation	A service for clients who, as a result of personal injury, require fast-stream inpatient rehabilitation in a rehabilitation unit.	DHBs and some trust hospitals
Social rehabilitation assessment	Recommends to ACC the most appropriate and cost-effective combination of social rehabilitation services to enable clients to achieve the expected outcomes in the most rapid and durable manner.	Contracted provider

Specialised rehabilitation services

Some of the most common assessment, service and/or specialised rehabilitation programmes available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table indicate the contract types.

Service	Purpose	Provider criteria
Concussion service	An interdisciplinary traumatic brain injury (TBI) service. The service aims to prevent long-term consequences, such as post-concussion syndrome (PCS) by identifying clients at risk of PCS and giving them effective interventions and education.	Multidisciplinary providers
Spinal cord injury rehabilitation service and spinal reassessment service	The spinal cord injury rehabilitation service provides non-acute, inpatient rehabilitation services for clients who've sustained spinal cord injuries to assist them to return to acute participation in their homes, work, leisure and community in a planned and timely manner. Regular and routine reassessments are performed under the spinal reassessment service. This supports clients to maintain their health and	Multidisciplinary providers

	wellbeing and prevent secondary complications.	
Visual impairment services	Provide clients who are visually impaired as a result of their injuries with the support they need to regain the skills they need in everyday life.	Multidisciplinary providers
Education support	Aims to meet the short- and long-term injury-related learning support needs of children and young people attending early childhood education centres and primary and secondary institutions, and the long-term injury-related learning support needs of students in tertiary education.	Education support worker
TBI residential rehabilitation services	Support clients who've sustained moderate-to-severe TBI to return to active and meaningful participation in their communities and, if appropriate, support clients to return to work in a planned, timely, supported and sustainable manner.	Multidisciplinary providers
Child and adolescent rehabilitation services	Specialist inpatient, community rehabilitation and follow-up services for children and young people aged 0-16. They aim to enable these children to achieve and maintain their optimal level of functioning and participate in developmentally appropriate activities, prevent further injury and provide advice on appropriate rehabilitation planning.	Multidisciplinary providers
Training for independence	Trains and coaches clients as they adapt to the impacts of their injuries and helps maximise their participation in home and community activities.	Multidisciplinary providers
Residential support services	Provide slow-stream rehabilitation or 'home for life' environments for clients who've suffered serious injuries.	Contracted or designated provider

Pain management services

Some of the most common pain management services available to ACC clients are described in the table below. In almost all cases these are provided by contracted providers. The provider criteria in the table indicate the contract types.

Service	Purpose	Provider criteria
Pain Management Psychological Service	Uses psychological assessments and interventions to help clients cope with and adapt to their injuries.	Clinical psychologist/psychiatrist
Functional Reactivation Programme	An individualised exercise programme that incorporates education in pain management and the practical applications of self-management principles.	Registered physiotherapist and/or occupational therapist
Comprehensive Pain Assessment	A comprehensive, fully integrated and independent clinical assessment. The emphasis is on determining functional goals for clients' rehabilitation. The comprehensive pain assessment consists of three separate clinical assessments (medical, functional and psychological) followed by a team discussion. The team produces a combined 'formulation' with recommendations.	Multidisciplinary providers
Activity Focus Programme	For clients who have persistent pain-related disabilities with significant functional problems due to injury. The purpose of this programme is to help clients adopt a self-management approach to independent functioning both at work and at home, despite pain.	Multidisciplinary providers
Multi-disciplinary Persistent Pain Programme	A three-week residential programme that primarily focuses on helping to modify clients' responses to pain, rather than removing the pain stimulus.	Multidisciplinary providers
Interventional Pain Management	Provides specialised assessments and treatment for ACC clients. Pain is a complex phenomenon and best treated using an integrated approach. Interventional Pain Management procedures should be undertaken within the wider context of clients' rehabilitation (i.e. it's not appropriate for a client to be receiving the procedures in isolation, with no concurrent rehabilitation).	Contracted specialised medical practitioners

8. Invoicing and payments

Our legislation and policies

Payment criteria

ACC pays providers for the costs of treating patients with personal injuries that are covered by the Scheme.

Legislation and policies specify that the treatment provided must be for the purpose of restoring clients' health to the maximum extent practicable. That means treatment needs to be:

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

In deciding whether the points above apply to a client's treatment, the legislation also says that ACC must take into account the:

- nature and severity of the injury
- generally accepted treatment for the injury in New Zealand
- other treatment options available in New Zealand for such an injury
- New Zealand cost of both the generally accepted treatment and the other options, compared with the likely benefit to the client of the treatment.

Your provider responsibilities are significant. In making payments for your services we may need to query and verify aspects of your treatment or approach. This is to ensure that the treatment meets the criteria, including 'necessary', 'appropriate' and 'of the quality required', and that you're supporting the treatment given with auditable clinical records. For more information on monitoring, see Monitoring providers and fraud control.

Invoicing

You can invoice ACC:

- under the Regulations
- through a contract arrangement (see your particular contract for details of the invoicing process)
- by agreement with ACC against a purchase order.

If you're providing services under an ACC contract, you need to follow the invoicing or payment arrangements in the contract, as these will supersede the Regulations.

For more information, visit our website, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

See also Electronic invoicing: eSchedule.

Invoicing under the Regulations – key points

ACC and Accredited Employers pay, or contribute to, costs at the rates and/or amounts specified in the Regulations. Contributions go towards basic consultation/visit costs and additional costs for specific treatment and procedure types. For details of the contributions see the Schedule of the Regulations.

The Regulations allow invoicing for:

- a consultation/visit relating to an injury or condition covered by ACC. The price of the consultation/visit includes any procedures not specified in the Regulations
- a treatment or procedure carried out during the consultation/visit if it has an amount specified in the Schedule. The amount we pay includes the cost of the most effective treatment materials for the client's injury. Procedures that don't have specified prices in the Schedule are included in the price for the consultation/visit and can't be invoiced separately.

You can only invoice us for payments if your client is eligible for the service you provide. Our policy is to recover any money paid through incorrect invoicing.

For more details about inclusions and exclusions for invoicing treatments and procedures, see Consultation/Visit and procedure costs and codes.

Invoicing ACC and Accredited Employers

ACC

We pay you once we've accepted a claim and received your invoice for services, usually on an ACC40 schedule (for medical practitioners) or ACC47 schedule (for other treatment providers), or electronically through your PMS.

Accredited Employers

If your patient works for an Accredited Employer you'll need to send your invoices directly to the Accredited Employer. If you have any queries about invoice payments, prior approval or injury management when treating an employee of an Accredited Employer, please discuss these with the employer's contact person or their nominated TPA. For more information see Lodging Accredited Employer claims.

Consultations/Visits

Definition of a consultation/visit

For ACC to pay for a consultation/visit, it must be a necessary and appropriate face-to-face assessment, treatment or service relating to a covered injury.

This includes providing injury-related advice, completing prescriptions, making referrals, issuing any certificate to ACC and all relevant documentation that may result from the consultation/visit. It doesn't include insubstantial medical services for which clients wouldn't normally pay, e.g. phone consultations and informal encounters.

For billing purposes a consultation/visit includes:

- removing sutures

- removing a non-embedded foreign body from an eye, mouth, auditory canal or other site (excluding rectum or vagina) without incision
- dressing minor single burns or abrasions
- re-dressing wounds that don't need significant dressings
- checking a plaster cast
- removing casts or splinting
- removing packing of the nose, an abscess or haematoma
- cleaning of, and minor dressings for (e.g. small gauze and non-stick dressings), small burns or abrasions
- cleaning of, and minor dressings for (e.g. plaster strips), small, open wounds
- managing minor sprains that don't need significant splinting.

For more details about inclusions and exclusions for invoicing consultations/visits, see Consultation/Visit and procedure costs and codes.

When appointments are missed

You can invoice us for missed appointments or cancellations only if:

- we made the appointment and agreed to pay a non-attendance fee
- your contract with us covers payments for non-attendance by clients.

Paying for more than one consultation/visit per day

Generally, we only pay for one consultation/visit per day per client, for all provider types. However, we consider each case individually and if clinically justified we may pay for a second consultation/visit.

Criteria for more than one payment

Paying for two consultations/visits in one day may be clinically justified if:

- you need to reassess the client for a second time later in the day e.g. if you need to change a dressing or check a client whose condition may deteriorate or be likely to deteriorate
- the client initiates the second consultation/visit because of concerns about their condition
- the client is treated for one injury then leaves the consultation/visit and has a second, separate accident that day.

We're unable to pay for more than one consultation/visit in a day when:

- a client is referred for X-ray and returns for a consultation/visit afterwards to discuss the outcome
- more than one covered injury is managed at the same presentation.

If you have any queries, please call the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

To help us make quick decisions on invoices for additional same-day consultations/visits, you must explain why they were necessary. If you use manual invoices or a bulk-billing schedule, note your reasons on the invoice. If you invoice electronically, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Medical practitioners' treatment costs

Our contribution to medical practitioners' costs

We contribute to two aspects of a medical practitioner's treatment costs:

- **a consultation rate for a covered injury**. The rate we pay depends on the client's age and is specified in the Regulations. We pay a higher rate for clients under 13 years old than for other clients. The higher rate is to compensate medical practitioners for providing free visits to under 13s.

- **specific treatments or procedures a client receives during a consultation/visit**. ACC only contributes to the cost of treatments or procedures listed under the heading 'Medical practitioners', nurses' and nurse practitioners' costs'. We pay the amounts stated in the Schedule of the Regulations.

How to invoice when different injuries need different treatments

If a client has more than one injury and needs procedures for more than one injury at the same consultation/visit, the rates we pay are scaled.

We contribute:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

Example 1: An adult client needs three treatments or procedures for more than one injury.

Example 1	Regulated amount	Invoice shows
Treatment/Procedure A	$34.83	@ 50% = $17.42
Treatment/Procedure B	$75.44 (highest-cost procedure overall)	@ 100% = $75.44
Treatment/Procedure C	$40.35	@ 50% = $20.18
Consultation/Visit	$29.90	$29.90
Invoice total		$142.94
Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the Regulations or Schedule.		

How to invoice when the same injury needs different treatments

If a client receives a basic treatment or procedure and a more comprehensive treatment or procedure during the same consultation/visit, we pay only the rate for the more comprehensive procedure.

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

Nurses' treatment costs

'Nurse' defined for invoicing

For ACC's purposes a 'nurse' means a registered nurse (including a nurse practitioner) but not an enrolled nurse or nurse assistant.

Our contribution to nurses' costs

We contribute to two aspects of a nurse's treatment costs:

- **a consultation rate for a covered injury**. The rate we pay depends on whether you're a registered nurse or a nurse practitioner. We pay a higher rate for clients under 13 years old than for other clients. The higher rate is to compensate medical practitioners for providing free visits to under 13s.

- **specific treatments or procedures a client receives during a consultation/visit**. The treatment or procedure must be listed under the heading 'Medical practitioners', nurses' and nurse practitioners' costs'. We pay the amounts stated in the Schedule of the Regulations.

These payments apply to nurses, or providers of nursing services, who don't have contracts with ACC. Nurses and nurse practitioners wanting to claim under the Regulations need to be registered with us as individual treatment providers.

How to invoice when different injuries need different treatments

If a client has more than one injury and needs two or more treatments or procedures at the same consultation/visit, the rates we pay are scaled – see Example 1.

We contribute:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

How to invoice when the same injury needs different treatments

If a client receives a basic treatment or procedure and a more comprehensive treatment or procedure during the same consultation/visit, we pay only the rate for the most expensive procedure.

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

Joint medical practitioner and nurse treatment costs

Our contribution to joint treatment costs

If both a nurse and a medical practitioner treat a client during the same consultation/visit, and if both make relevant clinical notes, we contribute to both aspects of the treatment costs:

- **a joint consultation rate for a covered injury**. The rate we pay depends on the client's age and is specified in the Regulations. We pay a higher rate for clients under 13 years old than for other clients. The higher rate is to compensate medical practitioners and nurses for providing free visits to under 13s.

- **specific treatments or procedures a client receives during a consultation/visit**. The treatment or procedure must be listed under the heading 'Medical practitioners', nurses' and nurse practitioners' costs'. We pay the amounts stated in the Schedule of the Regulations.

Only use the medical practitioner's provider number when you invoice for a joint consultation/visit.

When we contribute to the costs of a joint consultation/visit we don't pay:

- more than once for the same treatment
- the individual consultation/visit costs specified for a registered nurse, nurse practitioner or medical practitioner.

Invoicing for joint work on multiple treatments and procedures

If a client has more than one injury and needs two or more treatments or procedures from a nurse and a medical practitioner working together at the same consultation/visit, the rates we pay are scaled.

We pay:

- the full amount stated in the Schedule for the most expensive treatment or procedure the client receives
- 50% of the amount stated in the Schedule for any other treatment or procedure the client receives.

Example 2: An adult client needs three treatments or procedures for more than one injury. At a joint consultation/visit a nurse and a medical practitioner work together on each treatment or procedure.

Example 2	Regulated amount	Invoice shows
Treatment/Procedure A	$34.83	@ 50% = $17.42
Treatment/Procedure B	$75.44 (highest-cost procedure)	@ 100% = $75.44
Treatment/Procedure C	$40.35	@ 50% = $20.18

Joint consultation/visit	$32.90	$32.90
Invoice total		$145.94
Note: This example is based on indicative rates and isn't intended to reflect any amounts in the Regulations or Schedule.		

Invoicing for joint work when the same injury needs different treatments

If at a joint consultation a client receives a basic treatment or procedure and a more comprehensive treatment or procedure during the same consultation/visit, we pay only the rate for the more comprehensive service.

If you need help clarifying whether the criteria for dual treatments apply, contact the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz. We also recommend using the list of treatments and procedures from the Schedule of the Regulations to find the most appropriate category.

Working separately on multiple treatments or procedures

When a nurse and a medical practitioner work separately to provide more than one treatment or procedure for a client for more than one injury during a joint consultation/visit, we contribute according to the following table:

The nurse	The medical practitioner
The full amount specified in the Schedule for the most expensive treatment/procedure the client is given by the nurse. 50% of the amount stated in the Schedule for every other treatment/procedure given by the nurse.	The full amount stated in the Schedule for the most expensive treatment/ procedure the client is given by the practitioner. 50% of the amount stated in the Schedule for every other treatment/ procedure given by the practitioner.

Example 3: An adult client needs several treatments or procedures for more than one injury. At a joint consultation/visit a nurse and medical practitioner work separately on each treatment or procedure.

Example 3	Regulated amount	Invoice shows	Provider number
Treatment/Procedure by nurse A	$34.83	@ 100% = $34.83	Nurse
Treatment/Procedure by nurse A	$32.16	@ 50% = $16.08	Nurse
Treatment/Procedure by medical practitioner B	$113.09	@ 100% = $113.09	Medical practitioner

Treatment/Procedure by medical practitioner B	$68.59	@ 50% = $34.30	Medical practitioner
Joint consultation/visit	$32.90	$32.90	Medical practitioner
Invoice total		$231.20	
Note: This example is based on indicative rates and isn't intended to reflect any amounts specified in the latest Regulations or Schedule.			

Specified treatment providers

Defining specified treatment providers

Specified treatment providers are acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists and speech therapists, as listed in section 3 of the Regulations.

Rule for invoicing

Specified treatment providers can provide services to our clients either under contract or under the Regulations.

Invoicing under contract

Providers invoicing for services given under contract should follow the invoicing requirements specified in the contract.

Invoicing under the Regulations

All specified treatment providers invoicing under the Regulations must choose whether they want to be paid per hour or per treatment.

When you start invoicing, we take your approach as your chosen option. To change your invoicing option, please write with your reasons to ACC Provider Registration, PO Box 30823, Lower Hutt 5040 or email registrations@acc.co.nz

When you request a change to your invoicing option you won't be eligible to receive any back-payments for services. Your new invoicing option will be effective from the date of receipt of the change request.

The Regulations specify the rates for invoices per hour and per consultation/visit. For more information visit our website, contact the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Invoicing per hour

If you provide 'direct treatment' for less than one hour, we calculate the payment in increments of five minutes, e.g. if your treatment takes 44 minutes we pay for 45 minutes of the hourly rate (i.e. three-quarters of the hourly rate).

Direct treatment

You provide 'direct treatment' when you directly apply your expertise to a client's treatment. Direct treatment includes:

- assessing and/or reviewing the client's injury
- developing a treatment plan with the client (including taking a patient history and writing clinical notes during the consultation/visit)
- physically applying treatment(s)
- observing the client while treatment(s) is in place.

If you're only seeing one client at a time you can invoice ACC for the time you're not providing direct treatment, as long as you're immediately available for the client should they require assistance.

When attending to multiple clients you can't invoice concurrently. Instead, calculate the total time spent on direct treatment with each. You can't invoice for more than one hour's treatment in any hour.

If you treat a client for less than 60 minutes or multiple clients within 60 minutes, the rates in the part-hour payments table below apply.

You can't invoice ACC for more than 60 minutes in any given hour. The rules below for invoicing for multiple clients per hour apply.

Specified treatment provider part-hour payments		
Minutes	Hourly rate (GST exclusive	Hourly rate (GST inclusive)
5	$4.73	$5.44
10	$9.46	$10.88
15	$14.19	$16.32
20	$18.92	$21.76
25	$23.65	$27.20
30	$28.38	$32.64
35	$33.11	$38.07
40	$37.84	$43.51
45	$42.57	$48.95
50	$47.30	$54.39
55	$52.03	$59.83

Specified treatment provider part-hour payments		
60	$56.76	$65.27

These prices came into effect in the Regulations on 1 April 2014. In all cases your clinical records must support and document your direct treatment. If it's clinically justified you can claim for a block of direct treatments of more than an hour's duration, as long as you document it in your clinical records.

We'll follow up any invoicing patterns outside the expected norms for specific discipline. For more information on provider monitoring and other quality assurance functions, see Monitoring providers and fraud control and Supporting quality.

Invoicing at the hourly rate for more than one client

If you treat more than one client in an hour, we pay only up to 60 minutes in total.

Example 3a: You treat six clients in a group for an hour.

You **can** invoice us for six individual clients for 10 minutes each (i.e. invoice us for a total of one hour of your time).

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

Your records must always demonstrate that your clinical input is necessary and appropriate; see Clinical records.

You can invoice us in five-minute increments for accuracy – that is for 5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55 or 60 minutes of treatment.

Example 3b: You treat a client from 10:00am to 10:30am (30 minutes), and another from 10:15am to 11:00am (45 minutes).

We'll pay for the hour between 10:00am and 11:00am, but not for 75 minutes of treatment time. However, if your second client's 45-minute slot begins at 10:20am (so finishes at 11:05am) we'll pay for one hour and five minutes.

You can't invoice us for the overlap of the clients' treatment during the hour, but you can invoice us for the five minutes beyond the hour.

Limitations to invoicing per treatment

If treatment profiles and their trigger numbers apply to your treatment, you can't combine the number of treatments for different injuries (i.e. the sum of different Read Codes) to give an aggregated number of treatments. You can only provide treatments up to the highest individual trigger number before you need to provide an ACC32 Request for Prior Approval of Treatment form.

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

Example 4	Injury	Trigger number of treatment profiles
S50	Sprain shoulder	12
SE31	Contusion elbow	12
S5400	Sprain knee joint	14

The injury that allows the most treatments before you need to get ACC approval for additional treatment is the S5400 sprain knee joint. You can invoice us for up to 14 treatments in this example, but not the sum of the treatment trigger numbers for all the injuries, which would be 38 treatments.

Similarly, if you're dual ACC registered you can't combine the number of treatments under both provider types to give an aggregated number of treatments. You can only provide treatments up to the highest individual trigger number before you need to provide an ACC32 Request for Prior Approval of Treatment form.

Example 4a: A chiropractor can provide up to 18 treatments before prior approval is required, and an acupuncturist can provide up to 16 treatments. A dual-registered chiropractor/ acupuncturist can invoice us for up to 18 treatments (the larger number of the two) before prior approval is required. The treatment numbers can't be combined to 34 treatments before prior approval is sought.

If none of the injuries has a treatment profile with a treatment trigger, you can provide six treatments before requesting approval for additional treatments.

If you anticipate that you'll need ACC prior approval for additional treatment funding or are requesting funding for additional splinting costs, you need to complete an ACC32 Request for Prior Approval of Treatment form. For more information, see Requesting further treatment: referring clients via the ACC32 Request for Prior Approval of Treatment form.

Payment for counsellors

How to invoice

The Regulations specify counsellors' invoicing and payment arrangements. They require you to provide treatment face to face.

Exception

You can invoice for one session of counselling provided in another way (e.g. by phone) if the client urgently needs it for mental injury caused by certain criminal acts outlined in section 21 of the AC Act. See also Mental injuries, sensitive claims and counselling.

ACC will pay either the:

- hourly rate fixed in the Regulations for treatment provided by a counsellor who's a medical practitioner, or
- hourly rate fixed in the Regulations for treatment provided by a counsellor.

Actual rates may be adjusted from time to time. For the latest rates, contact the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

Different invoicing and payment arrangements may apply to counsellors who deliver treatments or services under contracts with ACC.

Invoicing for services under contract

If you're providing services under an ACC contract, you need to follow the invoicing and payment arrangements in the contract, not the Regulations.

Services and reports

Invoicing for imaging services

You'll find a list of imaging services and fixed rates for treatments and procedures in the Schedule of the Regulations. The Schedule covers a wide range of radiological procedures used in everyday practice, including mammography, ultrasound and special procedures such as myelogram and arthrogram.

High-tech imaging

The Schedule doesn't cover high-technology items such as MRI scans. You can only access them and have us pay for them if you're working under contract for these services.

Invoicing for supplying reports and records

If we ask you to provide a report you can invoice us for a report fee at the rate quoted in our request letter. You need to cite the purchase order number and the appropriate report code, e.g. 'STPR' for specified treatment providers and 'MEDR' for medical practitioners.

The standards we expect in your reports are the same as those of your professional organisation, i.e. they must be honest, impartial, unbiased, clear and relevant. They will serve your patients' interests best if they focus on verifiable clinical evidence wherever possible.

We sometimes ask for copies of existing clinical notes and typically pay the expenses for providing this information at identified rates. You can get the latest rates from your local Supplier Manager or by phoning the Provider Contact Centre on **0800 222 070** or emailing providerhelp@acc.co.nz.

Section 309(4) of the AC Act requires you to provide us with any information we request if the client has authorised us to make the request and you have notice of that authorisation. Clients give us this authority when they sign their ACC45 Injury Claim forms.

We use the information to make decisions about entitlements and to detect fraud. It's an offence to not supply the information to us without a reasonable excuse.

If a patient asks for their own medical records, you must supply them free of charge unless the patient has requested the same information within the previous 12 months, or the information includes video recordings, X-rays and CAT scans.

Invoicing correctly

Procedures for invoicing ACC

How you invoice ACC will depend on the conditions of your contract, the purchase order or the Regulations.

If you're contracted to ACC, follow the invoicing process in the contract.

If you're seeking payment for services that we've asked you to provide, make sure you have a seven-digit purchase order number from us and include it in your invoice to the requesting unit. It will be processed by our Accounts Payable team.

If you're invoicing under the Regulations, see our website.

A claim needs to be lodged prior to submitting an invoice. When invoicing, please be aware that:

- only one consultation/visit per day/per client can be invoiced to ACC
- where there are exceptional circumstances and a client returns for a second consultation/visit on the same day, full details of this (including the relevant clinical records) should be provided to ACC for consideration
- where multiple claims are being managed at the same consultation/visit, you can only invoice ACC for one consultation/visit against one claim – normally the most significant injury being treated
- if, as an individual provider, you choose to utilise elements of more than one treatment modality, e.g. chiropractic and acupuncture, at the same consultation/visit (or on the same day), you can only invoice ACC once under one provider number
- all invoices need to be complete and accurate
- at times ACC will request copies of clinical records. Failure to provide these could result in non-payment.

Ensure that the following information is correct for every line:

- ACC claim number or ACC45 number, or both
- READ code
- full client name (no abbreviations or incorrect spelling)
- date of injury
- date of service
- date of birth.

Completing and sending a bulk-billing schedule

ACC recommends that all providers invoice electronically as it is a faster process, but we still enable a manual process (see Electronic invoicing: eSchedule).

The bulk-billing process applies to all invoices from treatment providers. It enables you to send several invoices at once on either an ACC40 schedule (for medical practitioners) or an ACC47 schedule (for other treatment providers).

Every schedule must show your GST number.

Directions for bulk-billing are on our website.

Where to send your schedule

Please send your schedule to the Medical Fees unit for your area, see Key ACC contacts for treatment providers.

If you have any queries about the process, or about a specific payment, phone the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz.

9. Working electronically with ACC

Digital certificates

How to get a digital certificate

In order to access ACC online services, including eLodgement, eSchedule and Online Claims Queries, you need to apply for a digital certificate.

For more information:

- download the application forms for your digital certificate on our website – see Apply for a digital certificate
- visit HealthLink's website. HealthLink creates, distributes and supports digital certificates
- email the New Zealand Health and Disability Sector Registration Authority (NZHSRA), which approves and administers digital certificates, at registrar@nzhsra.co.nz or call **0800 117 590**.

Receiving and connecting your digital certificate

Complete and return the HealthSecure application forms, and NZHSRA will liaise with HealthLink to create and courier your digital certificate on a CD-ROM. If you don't have a CD-ROM drive, please contact our eBusiness Support team, who will be able to help you.

Digital certificates are valid for one year. NZHRSA will send you an email each year to confirm that you still require a digital certificate. When you reply to the email your new certificate will be issued automatically.

If you're eligible, ACC will cover the cost of your annual digital certificate.

When you receive your certificate you'll need to have a password for installation. This will usually be sent to you via text message from HealthLink. Alternatively, you can call HealthLink on **0800 288 887** and request your certificate password. HealthLink can also talk you through the installation if you need help.

The ACC eBusiness Support team will contact you to schedule a phone training session, which will take approximately 30 minutes. They'll also monitor your progress to ensure everything is running smoothly.

Already have a current digital certificate?

If you're already an ACC-registered vendor (and/or provider), complete Section 2 and Section 7 of the ACC1534 Change of vendor details form to request access to the ACC eBusiness Gateway.

Online claim lodgement: eLodgement

About eLodgement

Any provider who submits ACC45 Injury Claim forms can use eLodgement. You can learn about the benefits of using eLodgement on our website.

What you need to use eLodgement

To start using eLodgement you need:

- a computer or compatible mobile device. You can find information on the minimum computer specifications and browser settings on our website
- a digital certificate – a software application that creates your unique digital signature. Issued on CD-ROM and stored on your computer, your digital certificate authenticates the origin of data and secures data as it travels between you and ACC. Your digital certificate is free, renewed annually and issued by ACC. For more information see Digital certificates
- a compatible PMS. Your PMS will generate ACC45s completed with the data you normally use and prompt you for any additional data needed. To find out about PMSs:
    - see our online list of PMSs that support eLodgement
    - phone our Provider eBusiness Support team on **0800 222 994** option 1
    - email ebusinessinfo@acc.co.nz.

If you don't have a PMS you can still take advantage of the system by using our eLodgement website. Please get in touch with the eBusiness Support team, who will arrange access to the eLodgement website on your behalf.

You might also like to read our Security Policy for Electronic Business.

Electronic invoicing: eSchedule

Who can use eSchedule?

You can use eSchedule if you submit invoices to us for payment under business rules specified in a contract, purchase order or the Regulations.

You can use the service to send us your ACC40 schedule (for medical practitioners) or ACC47 schedule (for other treatment providers) electronically, either from your PMS or through our eBusiness Gateway.

The benefits of eSchedule

eSchedule offers you the benefits of:

- faster payments, normally within seven working days, as electronic invoices have priority
- 24-hour online tracking to check the progress of your schedules, payments and the registration of ACC45 Injury Claim forms
- online remittance advices
- time and paper savings through streamlined processes
- quality information between systems
- easy checking that a claim is for an Accredited Employer
- schedule payments being processed within five days if the information is complete and accurate
- partial payments for incomplete schedules, rather than having them held for payment in their entirety
- the ability to diagnose any invoicing and payment problems quickly and easily
- not having to submit printed schedules or copies of referral forms and approval letters.

Make sure you keep copies of referrals and approval letters, as we may need to see them to validate your invoices.

What you need to use eSchedule

If you're an existing vendor with ACC and have been sending your invoices to us by post, you'll need to complete an ACC1534 Change of vendor details form. You can indicate on this form that you're going to bill electronically. Providers not registered with us will need to complete the ACC24 Application for ACC Health Provider Registration form, which includes a section on electronic claiming. The team will advise you in writing when your request has been approved, usually within a week of your application being submitted.

How to send eSchedules

To send an eSchedule:

1. Check that your billing schedule is correct:
    - send separate schedules for individual contracts. For example, physiotherapy services can't appear on the same schedule as GP services
    - ensure that you use the correct service codes to avoid payment delays. If you're not sure what service code you should be using, contact the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz
    - check that your claim numbers are correct and in the required format. Use ACC45 numbers where possible, but be careful not to use zero in place of the letter 'O' or vice versa. Enter alpha and numeric data only (i.e. not symbols such as / and –)
    - if you're providing services on an hourly rate, list the service duration(s).
2. Before you send your first eSchedule, check that your ACC vendor ID is active and you have a valid digital certificate installed. If you use a PMS, check with your PMS vendor that your system is configured correctly to start sending eSchedules to ACC.
3. Don't send test schedules. The eBusiness Support team will be happy to help you remotely if you'd like some support and guidance with your first submissions.
4. The day after you send your first batch of schedules, phone the Provider Contact Centre on **0800 222 070** to check that they have arrived. If you use a PMS you may have received an acknowledgement, but there are occasions when acknowledged schedules are rejected. The eBusiness Support team will let you know if you need to fix your system or resubmit the schedules.

   If at any other time you want to check your payment schedules, you can use our eBusiness Gateway to run queries against the status of your invoice, or phone the Provider Contact Centre quoting your ACC vendor ID and each schedule number you're querying.
5. ACC pays the amount owing into the bank account you provided and sends you a payment advice letter confirming the amount.

Late invoicing

If you send us an invoice 12 months or more after providing a service, you'll need to give us extra information to show that we're still liable to pay for the service. For further advice contact the Provider Contact Centre on **0800 222 070**, or contact your local Supplier Manager.

Querying payment delays

Where we have enough information we usually decide on cover for a claim within 24 hours. However, some claims (e.g. gradual process claims) can take longer because we need additional information. In these cases delays in payment are unfortunately inevitable. Payments can also be delayed if we've asked a client to visit another treatment provider for a second opinion.

The bulk-billing payment advice and the Invoice Status Query on our eBusiness Gateway web page will show you which payments have been withheld and why. Call the Provider Contact Centre on **0800 222 070** or email providerhelp@acc.co.nz to discuss late payments, or if you think a claim has been accepted for payment but you haven't been paid.

Online eBusiness Gateway queries

Invoice queries, payment advice and claim status

Online queries can be used by:

- valid digital certificate holders with active ACC vendor IDs
- providers with active ACC provider numbers who've been granted access to the eBusiness Gateway.

With online queries you can:

- query the status of an ACC45 claim number to check:
  - whether the claim has been accepted or declined by ACC
  - the client's injury diagnosis
  - the date of the client's accident
  - whether the claim is being managed by an Accredited Employer
  - whether the injury has been resolved
- query the current payment status of any invoice/schedule you've sent us, including:
  - whether a schedule has been paid
  - how much was paid
  - the reason for a payment being put on hold or declined
- download an online copy of your payment advices.

Online claim queries

All you need to access query functions is a computer that meets the specifications with an internet connection and a Health Secure digital certificate.

If you're already using a digital certificate for other health sector transactions such as eLodgement or Special Authority, it's likely to be a Health Secure digital certificate which you can also use for running queries.

To check if you have the right digital certificate phone our Provider eBusiness Support team on **0800 222 994** option 1, or email ebusinessinfo@acc.co.nz.

If you need to apply for a HealthSecure digital certificate, complete and return both the HealthSecure Organisation Registration and HealthSecure User Registration forms.

Working online FAQs

Q: Why are claim numbers important?

A: The ACC system checks that claims belong to the people whose services are being claimed for.

If the ACC database and your database have different details for a client (such as name and date of birth), the discrepancy will be flagged so all involved can make sure they're sharing the correct details.

Q: If we eLodge, do we still need to send printed copies to ACC?

A: No, we only need the electronic copies. However, you must keep copies in paper or image format of signed documents that show your patients have authorised you to lodge claims on their behalf.

Q: Does the treatment provider who generates an ACC45 Injury Claim form during a consultation/visit have to send it to ACC straight away?

A: No. However, all ACC45 Injury Claim forms should be lodged on the day of the consultations/visits to ensure that the patients can receive their ACC entitlements as quickly as possible. If you have a network of practice computers, a practice administrator can pick up the ACC45 forms on their computer, check that the information is complete and submit them to ACC. This should be done at least once a day.

Q: Do all treatment providers need computers?

A: No, you can complete ACC45 forms by hand and give them to your administrative staff for input that day to minimise the time required on a computer.

Q: We already send online invoices to ACC – how will lodging the ACC45 Injury Claim form online affect our billing?

A: The eLodgement system allows you to lodge your ACC45 forms online without affecting your electronic invoicing. The process of invoicing ACC won't change.

However, you'll find that you can invoice us a lot faster when eLodging your ACC45 forms as we'll have details of your patients' claims in our system at the time you submit your invoices.

Q: Will the information I send online be secure?

A: Yes. The digital certificate protects the information you transmit by letting ACC know that it was you or your organisation that sent the data. Your computer system also encrypts (or 'scrambles') the data with your digital certificate to protect it as it travels from you to ACC.

Q: Does every treatment provider need a digital certificate?

A: No. It will depend on whether you're submitting invoices, medical certificates or medical reports or eLodging online.

Q: Is there any cost to me to start using ACC online services?

A: No. If you currently have a digital certificate for Ministry of Health access, we can explore using this for your ACC access. Otherwise, ACC will cover the cost of your new digital certificate and its annual renewal. You only incur the cost if you lose or damage your certificate and require a replacement before its annual renewal. Our eBusiness Support team is available Monday to Friday for free remote support if you have any technical issues.

Q: Can I use my mobile device to lodge my ACC45 forms and eSchedules?

A: Yes, if you have a compatible device. You'll need to install your digital certificate on your device – our eBusiness Support team will be happy to help you do this.

Q: My computer doesn't have a CD drive; how do I install my digital certificate?

A: If you can gain temporary access to a computer with a CD drive, you can transfer your digital certificate to a USB drive or email the files to yourself. If you need any assistance, contact the eBusiness Support team on **0800 222 994** option 1, or email ebusinessinfo@acc.co.nz.

10. Consultation/Visit and procedure costs and codes

Guide to invoicing for medical practitioners and nurses

This is a guide to invoicing under the Regulations.

The guide should be read in conjunction with the ACC1520 Medical practitioners', nurses' and nurse practitioners' costs 2014.

Section 8 of this handbook also carries detailed information about invoicing under the Regulations.

What a consultation/visit covers

You can invoice ACC for a consultation/visit. A consultation/visit includes:

- a face-to-face examination and/or assessment
- a necessary and appropriate service or treatment, performed by a provider, for an injury or condition covered by ACC
- any claim-related advice, prescription or referral, and the issue of certificates as appropriate following the consultation/visit
- managing conditions, including providing a small range of minor treatments/procedures, such as:
    - removing sutures
    - removing a non-embedded foreign body from eye, mouth, auditory canal or other site (excluding rectum or vagina) without incision
    - re-dressing wounds that don't require significant dressings
    - performing a plaster check
    - removing casts/splinting
    - removing packing of nose, or packed abscesses or haematomas
    - cleaning and minor dressings (e.g. small gauze or non-stick dressings) to small burns or abrasions
    - cleaning and minor dressings (e.g. plaster strips) to small, open wounds
    - managing minor sprains that don't involve significant splinting
    - completing clinical records.

What a consultation/visit doesn't cover

A consultation/visit doesn't include:

- telephone consultations (except for a one-off phone-counselling session if required)
- medical services where no substantial service is given by the provider and for which the patient wouldn't reasonably be expected to pay.

All invoices for procedures, regardless of the number claimed, must be clinically justifiable.

Understanding procedure codes

The procedure codes start with two letters:

- the first letter is M, which stands for ‘Management of’
- the second letter is phonetic and covers the procedure code topic (e.g. B for burns and D for dislocations).

The two letters are followed by a number that defines a sub-category within the code.

Summary of procedure codes

This table summarises the procedure codes, the injuries to which they refer and the recommended maximum treatments per injury.

Procedure code	Injury type	Recommended maximum treatments claimed per injury
MB#	Burns and abrasions	4
MD#	Dislocations	1
MF#	Fractures	1 (except MF7, MF9-MF12 = 3)
MM#	Miscellaneous	1
MW#	Open wounds	1
MT#	Soft tissue injuries	1 (except MT3 = 2 and MT5 = 3)

Burns and abrasions

General invoicing criteria

Practitioners can invoice for treating burns and abrasions under the following eligibility criteria.

Eligible – all MB codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- treating significant skin damage
- cleaning and debriding wound(s)
- managing significant wound dressings
- providing a significant amount of practitioner time
- providing post-injury advice and patient education.

Not eligible – all MB codes

Services that are not eligible for invoicing include:

- treating trivial and superficial burns or abrasions at a first or subsequent consultation/visit, and applying only a simple gauze or similar dressing. This is covered as part of a consultation/visit
- follow-up consultations/visits involving: dressing removal, or re-dressing where significant dressings are not used; wound inspection; and recommendations about infection control. These are covered as part of consultations/visits.

Invoicing criteria for each MB code

MB1 – Treatment of burns less than four square centimetres (m^2) (e.g. 2cm x 2cm)	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB2 – Treatment of burns greater than $4cm^2$ at a single site	
Included	See Eligible – all MB codes. Note: Claims in this category are usually few.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB3 – Treatment of significant abrasions less than $4cm^2$ at a single site	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB4 – Treatment of significant abrasions greater than $4cm^2$ at a single site	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
MB5 – Significant burns or abrasions (not including fractures) at multiple sites (greater than $4cm^2$), necessary wound cleaning, preparation and dressing	
Included	See Eligible – all MB codes.
Excluded	See Not eligible – all MB codes.

	Note: If there are multiple wounds but only one needs significant time or dressing, only one claim would be made for the significant wound under MB2 or MB4.
Procedures per injury	Recommend: maximum of four procedure claims per injury.
This section should be read in conjunction with the ACC2136 MB and MW Codes. For more information about ACC2136 see the link above and see General practitioner resources or Burns and scar management.	

Dislocations

General invoicing criteria

Where there is evidence of significant joint dysfunction (e.g. major effusion or haemarthrosis and/or ligament laxity), practitioners can invoice for treating confirmed dislocations of any of the five joints listed in the table below, under the following eligibility criteria.

Eligible – all MD codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- referral for, review of and action on an X-ray (if necessary)
- use of appropriate anaesthetic technique (including local, intravenous (IV) or regional anaesthesia, or mild central sedation)
- treating significant subluxation
- providing post-injury advice and patient education
- management using best-practice splinting techniques, which may include providing a plaster cast. See also ACC579 Treatment profiles 2001 and ACC2373 Practical Techniques in Injury Management. ACC2373 isn't available online but can be obtained through your local Supplier Manager.

Not eligible – all MD codes

Services that are not eligible for invoicing include:

- minor joint trauma, including minor sprains not involving confirmed dislocations or significant subluxation, and where there is no evidence of serious subsequent joint dysfunction. These are covered as part of consultations/visits or by a soft tissue injury procedure, whichever fits best
- possible dislocations to joints not covered under the following five codes (MD1-5). In that case a 'nearest equivalent' treatment or procedure will be considered. However, a soft tissue injury procedure may be appropriate
- treatment before referral to a specialist centre, including temporary splinting. This is covered under a soft tissue injury procedure
- follow-up assessments, including removal of splinting. These are covered as part of consultations/visits
- treatment of injury that doesn't require the use of best-practice splinting with

significant dressing cost. This is covered as part of a consultation/visit.

Invoicing criteria for each MD code

MD1 – Dislocation of finger or toe, with splint or strapping	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD2 – Dislocation of thumb, closed reduction and immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD3 – Dislocation of elbow with radiological confirmation, closed reduction and immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD4 – Dislocation of shoulder, closed reduction and collar and cuff immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.
MD5 – Dislocation of patella, closed reduction and cast immobilisation	
Included	See Eligible – all MD codes.
Excluded	See Not eligible – all MD codes.
Procedures per injury	Recommend: one procedure claim per injury.

Fractures

General invoicing criteria

Practitioners can invoice for treating diagnosed fractures under the following eligibility criteria. If there is no diagnosis of a fracture, a soft tissue injury code (MT) may be appropriate.

Each service code includes tasks that can and can't be invoiced for, on top of the general invoicing eligibility criteria below that cover all codes.

Eligible – all MF codes

Services that are eligible for invoicing include:

- assessment
- providing initial care and patient/caregiver education
- X-ray confirmation (or clinical certainty) of a fracture
- applying best-practice soft tissue splinting, or plaster cast immobilisation, for more than three weeks
- providing post-injury advice and patient education
- management that may include (where clinically appropriate):
    - the use of appropriate anaesthesia
    - fracture reduction.

Not eligible – all MF codes

Services that are not eligible for invoicing include:

- undisplaced simple fractures that don't need plaster cast immobilisation. These are covered as part of a simple soft tissue injury procedure
- plaster checks and removal. These are covered as part of consultations/visits
- treatment before referral to a specialist centre, including providing temporary splinting. This is covered as part of a soft tissue injury procedure.

For fractures that aren't covered under these specific procedure codes, and where best practice would suggest a plaster cast, a 'nearest equivalent' procedure will be considered. In other cases, a soft tissue injury procedure may be appropriate. See also ACC579 Treatment profiles 2001 and ACC2373 Practical Techniques in Injury Management (available through your local Supplier Manager).

Invoicing criteria for each MF code

MF1 – Fractured finger or toe (proximal, middle or distal phalanx), closed reduction and immobilisation	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of consultations/visits as they don't require the same degree of assessment or significant new splinting.

	See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF2 – Fractured finger or toe (proximal, middle or distal phalanx), requiring digital anaesthetic	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of consultations/visits as they don't require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF3 – Fractured metatarsal: closed reduction (not requiring cast), closed reduction, immobilisation by strapping	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of consultations/visits as they don't require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF4 – Fractured metacarpal(s) hand: with or without local anaesthetic, immobilisation by strapping	
Included	See Eligible – all MF codes.
Excluded	Follow-up treatments are usually covered as part of consultations/visits as they don't require the same degree of assessment or significant new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF5 – Fractured carpal bone, including scaphoid: treatment by cast immobilisation, not requiring reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also

	eligible under this code.
Excluded	If a new plaster cast isn't required, invoice for a soft tissue injury procedure if it involves significant best-practice soft tissue strapping or splinting. If it doesn't, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF6 – Fractured tarsal or metatarsal bones (excluding calcaneum or talus): treatment by cast immobilisation	
Included	See Eligible – all MF codes.
Excluded	If the injury needs significant best-practice soft tissue splinting (rather than a plaster cast), invoice for a soft tissue injury procedure. If it doesn't, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF7 – Fractured calcaneum or talus: treatment by cast immobilisation	
Included	See Eligible – all MF codes.
Excluded	If the injury needs significant best-practice soft tissue splinting (rather than a plaster cast), invoice for a soft tissue injury procedure. If it doesn't, invoice for a consultation/visit. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury if repeated plaster casts are needed.
MF8 – Fractured clavicle	
Included	See Eligible – all MF codes.
Excluded	These follow-up treatments are usually covered as part of consultations/visits as they don't need the same degree of assessment, or any new splinting. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF9 – Fractured distal radius and ulna: cast immobilisation not requiring reduction	

Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF10 – Fractured distal radius and ulna requiring closed reduction, involving regional or other form of anaesthesia	
Included	See Eligible – all MF codes. This must involve the use of appropriate anaesthetic (intra-fracture, arm block and/or IV sedation).
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. Follow-up visits involving reapplying a plaster cast are invoiced under MF9. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF11 – Fractured shaft radius and ulna: treatment by cast immobilisation	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF12 – Fractured distal humerus (supracondylar or condylar): by cast immobilisation	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also

	eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF13 – Fractured proximal or shaft humerus: immobilisation by collar and cuff or U-slab	
Included	See Eligible – all MF codes. Involves immobilisation by collar and cuff or U-slab.
Excluded	Follow-up visits involving fracture checks or removal of splinting are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.
MF14 – Fractured shaft tibia and/or fibula: treatment by cast immobilisation with reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: three procedure claims per injury.
MF15 – Fractured distal tibia and/or fibula: treatment by cast immobilisation with reduction	
Included	See Eligible – all MF codes. Follow-up treatments that involve reapplying a plaster cast are also eligible under this code.
Excluded	Follow-up visits involving plaster checks or removal of plaster are covered as part of consultations/visits. See also Not eligible – all MF codes.

Procedures per injury	Recommend: three procedure claims per injury.
MF16 – Fractured fibula (without tibial fracture): immobilisation with soft tissue splinting, strapping or cast	
Included	See Eligible – all MF codes. Covers either best-practice soft tissue splinting or strapping, or plaster cast if appropriate. Follow-up treatments that involve reapplying appropriate splinting, strapping or plaster cast are also eligible under this code.
Excluded	Follow-up visits involving fracture checks or removal of splinting are covered as part of consultations/visits. See also Not eligible – all MF codes.
Procedures per injury	Recommend: one procedure claim per injury.

Miscellaneous

Invoicing criteria for each MM code

MM1 – Abscess or haematoma: drainage with incision (with or without local anaesthetic agent)	
Included	The incision and drainage of abscess or haematoma must involve a significant opening of lesion, drainage, and packing of cavity.
Excluded	Simple needle aspiration without packing wound is covered as part of a consultation/visit. Wound check. Re-packing cavity. Removal of dressings.
Procedures per injury	Recommend: one procedure claim per injury.
MM2 – Insertion of IV line to administer medications, electrolytes or transfusions (if provided under local or national guideline approved by ACC)	
Included	Insertion of an IV cannula and administration of IV fluids or antibiotic infusion. This includes repeat infusions over a 24-hour period. Note: This must be provided under a local or national guideline

	approved by ACC.
Excluded	Administration of medication into an existing IV cannula is covered as part of a consultation/visit.
Procedures per injury	Recommend: one procedure claim per 24 hours. Normally no more than three IV insertions would be required.
MM3 – Nail: simple removal of	
Included	Removal of an adherent nail and significant dressing of the wound.
Excluded	Removal of non-adherent nail with wounds not requiring significant dressing.
Procedures per injury	Recommend: one procedure claim per injury.
MM4 – Nail: removal of or wedge resection, requiring the use of digital anaesthesia	
Included	Use of a digital anaesthesia, excision of wedge or whole nail, cauterisation of wound (if necessary) and the dressing of a nail bed with significant dressings.
Excluded	Simple nail removal. Wound checks are covered as part of consultations/visits.
Procedures per injury	Recommend: one procedure claim per injury.
MM5 – Removal of embedded or impacted foreign body from cornea or conjunctiva (with use of topical anaesthetic), or from auditory canal or nasal passages, or from skin or subcutaneous tissue with incision, or from rectum or vagina	
Included	Foreign body that is impacted or embedded and requires active removal.
Excluded	Simple flushing or syringing, or removal using forceps or similar instrument without use of anaesthetic or incision is covered as part of a consultation/visit. Fluorescein check of cornea/conjunctiva without removing embedded foreign body is covered as part of a consultation/visit.
Procedures per injury	Recommend: one procedure claim per injury.
MM6 – Pinch skin graft	
Included	Application of skin removed from separate site to cover open wound. Involves the dressing of donor and graft sites.

Excluded	Follow-up checks and re-dressing are covered as part of consultations/visits unless the injury requires significant dressing, in which case it can be invoiced for.
Procedures per injury	Recommend: one procedure claim per injury.
MM7 – Dental anaesthetic	
Included	Insertion of dental local anaesthetic using best-practice dental treatments and procedures.
Excluded	Application of topical, oral or IV anaesthetic.
Procedures per injury	Recommend: one procedure claim per injury.
MM8 – Epistaxis: arrest during episode by nasal cavity packing with or without cautery	
Included	Application of first-aid measures; packing of nasal cavity using ribbon gauze; best-practice ear, nose and throat treatments and procedures; and advice given to the client after treatment or procedure.
Excluded	Simple first-aid epistaxis measures or simple cautery of nostril are covered as part of consultations/visits. Removing the packing.
Procedures per injury	Recommend: one procedure claim per injury.

Open wounds

General invoicing criteria

Eligible – all MW codes

You can invoice for treating open wounds under the following eligibility criteria, if the wounds have significant full-thickness skin damage.

Each service code includes tasks that can and can't be invoiced for, on top of the general invoicing eligibility criteria below that cover all codes.

Services that are eligible for invoicing include:

- assessment
- providing initial care, advice and patient/caregiver education
- cleaning and debriding wound(s)
- closing wounds by active apposition of wound edges using appropriate wound-closure

materials, including wound-closure strips, surgical glue and equivalent adhesive and suture materials
- management by appropriate wound dressings
- providing post-injury advice and patient education.

Not eligible – all MW codes

Services that are not eligible for invoicing include:

- the treatment of trivial and superficial open wounds, at a first or subsequent consultation/visit, that need no more than a minor clean, and no more than a simple gauze, plaster strip or similar dressing. This is covered as part of a consultation/visit
- follow-up consultations/visits involving wound inspections, recommendations about infection control and dressing removal, or where re-dressings are not significant. These are covered as part of consultations/visits.

Invoicing criteria for each MW code

The general invoicing criteria cover all MW codes, but each code may have additional inclusions and exclusions. The details below show what can and can't be invoiced for under each code. MW codes are for procedures that occur within seven days of the initial injury.

MW1 – Closure of open wounds less than 2cm	
Included	Any necessary care and treatment, including cleaning, debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.
Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW2 – Closure of open wound(s) of skin and subcutaneous tissue or mucous membrane 2cm to 7cm long	
Included	Any necessary care and treatment including cleaning, debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.
Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW3 – Closure of open wound(s) of skin and subcutaneous tissue or mucous membrane greater than 7cm long	
Included	Any necessary care and treatment including cleaning, debriding, exploration, administration of anaesthetic, and dressing. See also Eligible – all MW codes.

Excluded	See Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.
MW4 – Amputation of digit: including use of anaesthetic, debridement of bone and soft tissue, closure of wound	
Included	Removal of the whole or part of a digit, requiring use of a local anaesthetic, active excision and debridement of wound, attempted stump closure using flap or equivalent technique, and appropriate dressing of wound. See also Eligible – all MW codes.
Excluded	Follow-up wound checks. Removal of dressings. See also Not eligible – all MW codes.
Procedures per injury	Recommend: one procedure claim per injury.

This section should be read in conjunction with the ACC2136 MB and MW Codes.

Soft tissue injuries

General invoicing criteria

You can invoice for sprains or soft tissue injuries that need compression or other best-practice splinting.

Each service code includes tasks that can and can't be invoiced on top of the general invoicing eligibility criteria below that cover all codes.

Eligible – all MT codes

Services that are eligible for invoicing include:

- assessment
- providing initial care, advice and patient education
- referral for and review of X-ray (if necessary)
- management by best-practice splinting (this may include providing a plaster cast)
- providing post-injury advice and patient education.

Not eligible – all MT codes

The service that isn't eligible for invoicing is:

- minor soft tissue trauma involving the use of initial care and advice (such as rest, ice, compression and elevation (RICE)), and not requiring the application of simple wound compression, which is covered as part of a consultation/visit.

Invoicing criteria for each MT code

The general invoicing criteria cover all MT codes, but each code may have additional inclusions and exclusions. The details below show what can and can't be invoiced for under each code.

MT1 – Significant soft tissue injuries: managing simple sprain of wrist/ankle/knee/elbow or other soft tissue injury requiring crepe bandage or similar immobilisation not requiring formal strapping	
Included	Splinting or compression dressings. Management of dislocations, subluxations and minor fractures that don't need plaster cast immobilisation. See also Eligible – all MT codes.
Excluded	See Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT2 – Soft tissue injury (other than splinting of dislocated or fractured digit), unless specified elsewhere	
Included	Limited best-practice application of plaster cast, padded splint or specific strapping to significant soft tissue injury (such as strained or ruptured Achilles tendon or serious ankle sprain) that needs more than three weeks' immobilisation. See also Eligible – all MT codes.
Excluded	Soft tissue injuries requiring less than three weeks' splinting or compression are invoiced under MT1. See also Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT3 – Aspiration of inflamed joint, tendon, bursa or other subcutaneous tissue or space (with or without injection)	
Included	Significant soft tissue inflammation requiring either aspiration or injection of steroid, or both. See also Eligible – all MT codes.
Excluded	See Not eligible – all MT codes.
Procedures per injury	Recommend: two procedure claims per injury.
MT4 – Extensor tendon, primary repair	
Included	Primary repair of significantly damaged extensor tendon, requiring

	use of local anaesthetic and surgical repair using best-practice techniques. Dressing of wound, splinting of limb or digit, and providing post-operative advice. See also Eligible – all MT codes.
Excluded	Follow-up checks, including removal of dressings, are covered as part of consultations/visits. See also Not eligible – all MT codes.
Procedures per injury	Recommend: one procedure claim per injury.
MT5 – Ruptured tendon Achilles: management by plaster immobilisation	
Included	Rupture of Achilles tendon requiring plaster cast immobilisation for more than three weeks. Repeat applications of plaster cast. See also Eligible – all MT codes.
Excluded	Soft tissue splinting of strained or ruptured Achilles tendon for more than three weeks is invoiced under MT2. Soft tissue splinting or other care to strained Achilles tendon is invoiced under MT1. Follow-up checks, removal of plaster cast without re-applying the cast are covered as part of the consultation/visit. See also Not eligible – all MT codes.
Procedures per injury	Recommend: three procedure claims per injury.

11. Glossary

Introduction

Definitions relating to the Regulations

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

Accordingly, most of the terms relate to the AC Act and associated ACC-specific regulations, such as the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Definitions specific to contracts are not covered

If definitions in this Glossary differ from terms and definitions in service specifications (for example, the understanding of consultations/visits for providers working under the ACC Rural General Practice Services contract), the contract versions apply.

Other definitions

You might also find the general Glossary of ACC terms helpful.

Definitions

Term	Meaning
ACC18 Medical Certificate form	This certificate is completed by a medical practitioner or nurse practitioner to describe how an injury has affected a patient's capacity for work when they can't continue in their normal employment for a time because of their injury; or to confirm that they're now able to return to their normal work. We publish guidelines on how to complete the form and resources that help medical and nurse practitioners to determine their recommendations for time off work. This certificate can also be used to add or change a diagnosis. ACC recommends that ACC18 Medical Certificate forms be submitted electronically.
ACC32 Request for Prior Approval of Treatment form	This form is completed by a specified treatment provider: • to add or change a diagnosis • when they believe a client needs additional treatment beyond the treatment profile trigger numbers • when a client needs to resume treatment after more than 12 months have passed • when a client presents for treatment for the first time for an injury more than 12 months old.

Term	Meaning
ACC45 Injury Claim form	This form is used to lodge a new injury and to determine ACC cover on a person's claim. It's completed by both the client, who provides a signed 'patient authority and consent', and the initial treatment provider.
ACC705 Referral for Support Services on Discharge	This form is used by a hospital to provide ACC with information about a client's needs when the hospital's clinical team has identified that the client will need home support services on discharge. An ACC staff member acknowledges receipt by returning the form with details of action taken.
ACC706 Early Notification of Complex Case	This form is used by a hospital to refer to ACC when the clinical team has identified that a patient has complex needs post-discharge and will require a range of support services. The form is sent to ACC as soon as possible so that ACC's client service staff can liaise with DHB staff to arrange for the required support before the client is discharged. ACC staff return the form to acknowledge receipt.
ACC1171 Request for Funding from ACC for Non-Subsidised Pharmaceuticals	This form is used to request pharmaceutical funding approval and should be completed by a provider and submitted to ACC before they prescribe a non-subsidised pharmaceutical for a client. ACC may contribute towards the costs of partly and non-subsidised pharmaceuticals. Approvals are for a limited time.
ACC2152 Treatment Injury Claim form	This form is used by a treatment provider (always together with a new ACC45 Injury Claim form) when lodging a claim for an injury caused by treatment from a registered health professional.
Accident Compensation Act 2001 (the AC Act)	This Act (and subsequent amendments) prescribes the ways in which ACC provides and pays for, or contributes to, the costs of comprehensive, no-fault cover and entitlements for all New Zealand citizens, residents and temporary visitors who sustain personal injuries in New Zealand.
Accredited Employer	This is an employer who's signed a contract with ACC to take responsibility for the management and costs of their employees' work-related injuries and work related gradual process, disease or infection claims for a specific period of time in exchange for a levy reduction.
Acute admission	This is an admission to a publicly funded hospital within seven days of a medical practitioner's decision to admit the person to hospital, unless otherwise specified in the Regulations. An acute admission may be from an emergency department, outpatient department or a GP/private specialist.

Term	Meaning
Acute treatment	In relation to a client, this means: (a) the first visit to a treatment provider for treatment for a personal injury for which the client has cover, and (b) if, in the treatment provider's reasonable clinical judgement, the need for the treatment is urgent (given the likely clinical effect on the client of any delay in treatment): (i) any subsequent visit to that treatment provider for the injury referred to in (a), and (ii) any referral by that treatment provider to any other appropriate treatment provider for the injury referred to in (a). *From the AC Act, Part 1, Section 7*
Advocacy service	This service provides independent advocacy that's free to patients and funded by the Health and Disability Commissioner. It can help and support people to know their rights and the actions they can take if they have concerns about any health or disability service, including ACC.
Ancillary services	These are services that are 'ancillary' to a client's rehabilitation (i.e. the client needs them to be able to access or receive their rehabilitation). They include emergency transport, non-emergency transport to and from treatment, accommodation in relation to treatment, and payment to enable a client to be escorted to and from treatment (e.g. if the client is a child). The AC Act also classifies pharmaceuticals and laboratory tests as ancillary services. Some ancillary services are funded through an agreement with the Ministry of Health (e.g. community pharmaceuticals and laboratory tests). The eligibility for many ancillary services is determined by ACC's client service staff, taking into consideration the context of the requests and the claims.
Annual practising certificate	This is a certificate issued annually to medical practitioners and other health practitioners under the HPCA Act, which allows them to practise their professions in New Zealand. The certificate is intended to ensure that health practitioners are competent and fit to practise.
Capacity for work	This describes a person's ability to perform work duties, based on their education, experience or training (or any combination of these) in relation to the consequences of their personal injury.

Term	Meaning
Client	An ACC client is a person who's sustained a personal injury and has had their claim for ACC cover approved under the AC Act or an earlier Act.
Client consent	This is required when an ACC claim is lodged on a client's behalf. It authorises the treatment provider to lodge the claim and ACC to collect and disclose certain information.
Clinical advisors	These are qualified health professionals ranging from medical practitioners to specialist practitioners, nurses, pharmacists, physiotherapists. Their role is to provide advice on claim cover and entitlement, and to determine cover for treatment injury claims.
Code of Rights	All people who use health and disability services have the protection of the 'Code of Health and Disability Services Consumers' Rights'. An independent commissioner promotes and protects these rights under legislation. More details can be found at the Health and Disability Commissioner website.
Consultation/Visit	As defined by the Regulations, this means an assessment in person (face to face), and a necessary and appropriate service performed, or treatment provided, by a provider for an injury or condition covered by ACC. It includes providing claim-related advice, completing a prescription or referral, and issuing any certificate to ACC as a result of the consultation/visit. A consultation/visit doesn't include: • medical services where no substantial service is given by the provider and for which the patient wouldn't reasonably be expected to pay • any telephone consultation • any informal encounter. A number of minor treatments/procedures are also included in a consultation/visit for billing purposes under the Regulations. For examples of these, see Consultation/Visit and procedure costs and codes. Providers using hourly rates or variable fees should invoice ACC in a way that shows the proportion of time spent directly treating the clients' ACC-covered injuries or conditions. (See also Direct treatment.)
Co-payment	This is a fee that a treatment provider can charge a client over and above ACC's contribution to the treatment, unless the provider has signed a contract with ACC that doesn't permit them to charge co-payments.

Term	Meaning
Criminal disentitlement	ACC is unable to provide entitlements other than treatment to a client who's injured in the course of committing an offence for which they're subsequently charged, and then imprisoned or sentenced to home detention for the offence.
Direct treatment	This means the amount of time a treatment provider directly applies their expertise to a client's treatment. It includes assessing and/or reviewing their injury, developing a treatment plan with them and/or applying direct hands-on treatment.
Discharge summary	This is a report prepared by a health care facility or service responsible for a person's care when it discharges them from inpatient, custodial or residential care. It includes a statement on their health status immediately before discharge, their prognosis, the nature, duration and objective of any continuing treatment, care or support needed, and the ACC claim number (the ACC45 number).
Doctors for Sexual Abuse Care (DSAC)	This is a professional organisation of doctors from many disciplines. Its prime focus is to educate and help medical practitioners to maintain international-best-practice medical and forensic standards when managing victims of sexual assault. For more information, see the DSAC website.
Emergency transport	This is transport needed to get urgent treatment for a client who has a personal injury. It must be dispatched by an Emergency Ambulance Communications Centre from a contracted provider within 24 hours of the client sustaining the personal injury or being found after sustaining the injury (whichever is later). 'Being found' relates to situations such as an injured person being located by a search and rescue service.

Term	Meaning
Entitlement	A fundamental requirement of the ACC statutes is that people who become clients with cover for personal injury can apply for 'entitlements'. The entitlements provided under the AC Act include: a) rehabilitation, comprising treatment, social rehabilitation and vocational rehabilitation b) first-week compensation c) weekly compensation d) lump sum compensation for permanent impairment, or independence allowance e) funeral grants, survivors' grants, weekly compensation for the spouse (or partner), children and other dependants of a deceased client, and child care payments. If a client meets all the relevant statutory criteria, ACC has a legal obligation to pay or contribute to the cost of entitlements. These are often delivered by providers working under the Regulations or ACC contracts.
Hāuora Māori – Cultural Competency	All contracts between ACC and providers include an organisational quality standard, a Hāuora Māori clause, which takes into account the practical application of the articles of the Treaty of Waitangi when providing services, and commits providers to complying with ACC's Guidelines on Māori Cultural Competencies for Providers.
Health Practitioners Competence Assurance Act 2003 (HPCA Act)	This Act supports the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession. This legislative framework allows for consistent procedures and terminology across the many professions regulated by the Act. The HPCA Act includes mechanisms to ensure that practitioners are competent and fit to practise their professions through their working lives.

Term	Meaning
Home and Community Support Services	This service provides flexible, high-quality flexible home and community support services for Clients in their Homes and community to support rehabilitation from their covered injury and to achieve, and sustain, their maximum level of participation in everyday life. There are three service types: 1. Initial Support Package: Allows DHBs to refer clients with low-complexity and/or short-term home support needs directly to suppliers. The service includes service set-up and up to 10 hours of support in a two-week period. 2. Return to Independence: For clients with a time limited need for support whilst they recover from their injuries. The service assists clients to achieve pre-injury levels of independence in their everyday lives. 3. Maximise Independence Service: For clients with long-term needs for support to live their everyday lives.
Impairment	This is a general term for any loss or abnormality of the following bodily structures or functions: • psychological (relating to the mental state) • physiological (relating to body function) • anatomical (relating to body structure).
Incapacity	This describes an injured person's inability to work owing to personal injury, or an injured person's absence from work for necessary treatment owing to personal injury. See the AC Act.
Independence allowance	This is an entitlement for a client who, as a result of an ACC-covered injury, has a permanent loss of bodily (physical and/or mental) functions. The independence allowance compensates for significant long-term impairment and is paid in addition to any other entitlements. ACC requires an ACC18 Medical Certificate form from a medical practitioner indicating that it's likely there is impairment, and that the condition is stable, before any assessment for this entitlement can be carried out.
Individual rehabilitation plan	This is a plan that ACC develops in consultation with a client and their family, employer and treatment provider. It outlines the rehabilitation support needed to meet the client's rehabilitation goals and timeframes.
Injury Prevention, Rehabilitation, and Compensation Act	This was the name of the AC Act before the passing of the Accident Compensation Amendment Act 2010. Some of the regulations that pertain to the AC Act are still referred to as the Injury Prevention, Rehabilitation, and Compensation Regulations.

Term	Meaning
Medical advisors	These are medical doctors, often with specialist qualifications, who are part of ACC's clinical advisor group. Their role is to provide medical advice and guidance to case owners and other ACC staff managing injury claims.
Medical Fees Processing (MFP)	This is ACC's computer software system for provider contracting, payments and service management. The software: • is used to process health providers' invoices using bulk-billing and electronic schedules • can allow automatic approvals and payments for goods and services that ACC purchases in relation to client rehabilitation and treatment • handles some areas of contract management.
Mental injury	ACC covers the treatment of mental injury that is shown to be "a clinically significant behavioural, cognitive, or psychological dysfunction" and is the result of a covered personal injury (see personal injury). A mental injury must be substantial enough to be observed, be diagnosable with a specific diagnosis and require treatment.
Missed appointments	You can only invoice ACC for missed appointments or cancellations if we made the appointment for the client and agreed to pay a non-attendance fee.
National Serious Injury Service: Client Support/Service Plan	This is a detailed support and rehabilitation plan developed with a client who has long-term or lifelong support needs due to a serious injury (i.e. spinal cord injury, moderate-to-severe traumatic brain injury, multiple amputations or severe burns). Each plan focuses on the client's goals and identifies the support they need to achieve an 'everyday life'. The outcomes aim to maximise the client's independence and community participation and, if possible, sustainable employment.
Natural use of teeth	This means the normal use of teeth for eating, such as chewing and biting, or using teeth to prise or tear food. Any injuries caused by the natural use of teeth are excluded from cover under the AC Act. We'll consider covering a claim for tooth damage that hasn't been caused by the natural use of teeth – such as a tooth damaged when a person bites a foreign object while eating (e.g. a piece of glass in a bread roll).

Term	Meaning
Ordinarily resident	In general, to be 'ordinarily resident' a client must: • hold the required citizenship, permit or visa of a New Zealand resident, or • be the spouse or dependant of an ordinarily resident person and generally accompany them, and have a permanent place of residence in New Zealand, and • if overseas, have intended to return to New Zealand within six months of leaving. Other detailed conditions may apply.
Pain management services	These are designed to support a client's broader rehabilitation goals and act as an enabler for the client to access further rehabilitation services that they can't currently because of ongoing or chronic pain conditions.
Personal injury	This means a: • physical injury • mental injury resulting from a physical injury • mental injury resulting from sexual assault or abuse • mental injury caused by a traumatic work-related event • person's death. Personal injury includes damage to: • dentures (other than wear and tear) • prostheses that replace a part of the human body (except for hearing aids, spectacles and contact lenses).
Pharmaceuticals	These are classified by the AC Act as prescription medicines, restricted medicines, pharmacy-only medicines and controlled drugs specified in legislation controlling such substances. ACC will only consider contributing to costs of pharmaceuticals within this definition.
Physical injury	The category of 'physical injury' requires an actual diagnosis of the injury and evidence that shows damage to the body. A diagnosis of pain is insufficient for establishing a physical injury.
Provider claim lodgement framework	This framework lists injuries by description and Read Code and specifies the provider groups that are able to lodge ACC45 Injury Claim forms for cover on each one. The framework is designed to support claim lodgement by providers who are appropriate for specific types of injury.

Term	Meaning
Public Health Acute Services (PHAS)	Acute services provided to ACC clients by DHBs are funded under PHAS. ACC pays for these services through a bulk payment that's given, via the Treasury, to the Ministry of Health. The publicly funded acute services provided by a DHB to treat clients for covered personal injuries are regulated by the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002. They include services provided: • as part of an acute admission • as part of an initial emergency department presentation, and any subsequent services given by the emergency department within seven days of that presentation • for an outpatient by a medical practitioner within six weeks of acute discharge or emergency department attendance • by a medical practitioner within seven days of the date on which a client is referred for those services by another medical practitioner • that are ancillary to any of the above services, such as travel and accommodation for a client, and an escort or support person, but excluding emergency transport • to aid treatment as above, such as consumables, diagnostic imaging and equipment. PHAS also covers the costs of pharmaceuticals that are prescribed as per the listings in all parts of the Pharmaceutical Schedule and for community laboratory/diagnostic tests.
Registered health professional	This is defined in the AC Act as: (a) a chiropractor, clinical dental technician, dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, nurse practitioner, occupational therapist, optometrist, pharmacist, physiotherapist, or podiatrist, and (b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when they're acting in accordance with any conditions of such interim certificate, and (c) includes a member of any occupational group included in the definition of 'registered health professional' by regulations made under section 322 of the Act.
Rehabilitation	This is a process of active change and support to help a person regain their health and independence and therefore their ability to participate in their usual activities as far as possible. It comprises treatment, social rehabilitation, specialised rehabilitation, pain management and vocational rehabilitation.

Term	Meaning
Rehabilitation outcomes	These are rehabilitation goals, objectives or results that may stem from a rehabilitation intervention, and are agreed by the client with ACC through an individual rehabilitation plan.
Review rights	A client has the right to have a decision made by ACC about their claim independently reviewed within a specified timeframe. ACC is required by its legislation to tell clients that they have the right to a review and what the review timeframe is. Clients must be told early enough to allow them the maximum amount of time to exercise the right.
Scope of practice	This means a health service that's part of a health profession. Scopes of practice for health professions covered by the HPCA Act are decided and published by the relevant registration authorities (e.g. the Medical Council of New Zealand). A practitioner must practise within any conditions imposed by their registering authority.
Self-inflicted injury	ACC has to decide if a self-inflicted injury or suicide was the result of a wilful act or a covered or coverable mental injury. If not, we may withhold entitlements other than treatment.
Sensitive claims	For clients who've been injured by specific sexual crimes, ACC covers mental injuries as well as any physical injuries. These are called 'sensitive claims' owing to the sensitive and confidential nature of the injuries. ACC's national Sensitive Claims Unit specialises in managing these claims.
Short-term Claim Centre	ACC has Short-term Claim Centres in Christchurch, Dunedin, Hamilton and Wellington. They typically manage claims involving mild injuries, or injuries from which clients would usually make a complete recovery within several weeks.
Significant dressings	These are specialised dressings, usually of moderate to high cost per application, or multi-layered dressings. This term doesn't cover simple gauze and tape, plaster strips or strips of adhesive tape, and non-stick dressings.
Social rehabilitation	This helps clients to regain their independence in daily living activities as much as possible. It includes home and community services, equipment for independence, training for independence, modification of vehicles or home, and education support. The provision of these services is based on the client's injury-related needs, identified through an appropriate assessment completed by a health professional.

Term	Meaning
Specialised rehabilitation	This aims to achieve the best possible rehabilitation and community participation outcomes for clients who have long-term or lifelong support needs owing to significant injuries (e.g. spinal cord injuries or TBI). Services include residential rehabilitation for clients who've sustained spinal cord injuries, TBI residential rehabilitation, child and adolescent rehabilitation, transition services, training for independence, community-based rehabilitation, education support and services for the blind.
Specified treatment providers	Also known as allied providers, these are specified in the Regulations as acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists and speech therapists.
Supervision for counselling	Clinical supervision plays a fundamental role in the successful progress of counselling. The Regulations require counsellors, as members of professional bodies, to have effective, regular and ongoing supervision that involves ACC.
Telephone counselling	ACC pays for counselling only when it's provided on a face-to-face basis. However, in a single exception under the Regulations, we can pay for one telephone counselling session for a client who has an accepted sensitive claim, if they need it urgently.
Treatment	Treatment includes physical rehabilitation, cognitive rehabilitation and an examination to provide a medical certificate and the provision of it.
Treatment injury	This is a personal injury that's occurred as a result of treatment provided by, or at the direction of, one or more registered health professionals. The injury must be directly caused by the treatment, and can't be a necessary part or ordinary consequence of the required treatment.
Treatment profile	These are a collection of injury profiles developed by a group of independent practitioners that give providers standardised expectations about treatment and incapacity. The information on each injury includes: • appropriate treatment • the probable duration of the incapacity • the probable duration of the treatment • the possible complications • an illustration of the relevant injury site (for fractures).
Treatment profile number	This is the number of treatments for a specific diagnosis without complications that's been referred for treatment at an appropriate stage in the healing process. Treatment profile numbers provide a consensus on acceptable treatment ranges.
Treatment profile trigger number	This indicates the number of treatments after which ACC would seek a review of a service that has been provided.

Term	Meaning
Treatment provider	The following are treatment providers under the AC Act and can lodge claims within their own scopes of practice. • acupuncturists • audiologists • chiropractors • counsellors • dentists • medical laboratory technologists • nurses and nurse practitioners • occupational therapists • optometrists • osteopaths • physiotherapists • podiatrists • medical practitioners (only medical practitioners and nurse practitioners can give clients medical certificates for time off work) • speech therapists. See also our Provider claim lodgement framework.
Visitors	Overseas visitors injured in New Zealand are covered by ACC, so we can help pay for suitable treatment here if we accept their claims. However, we can't reimburse visitors for loss of income or for treatment costs in their home countries.
Vocational independence	This means a client's capacity, as determined by the AC Act, to engage in work for which they're suited by reason of experience, education or training (or any combination thereof), and to do so for 30 hours or more a week.
Vocational rehabilitation	This helps a client to maintain or obtain employment, or regain or acquire vocational independence. The employment must be appropriate to the client's capacity to function, and to their training and experience. Assessors are also encouraged to take clients' previous earning levels into account.
Weekly compensation	This entitlement compensates a client for loss of earnings or loss of potential earning capacity. A spouse, partner or dependant of a deceased client may also be entitled to weekly compensation.

Term	Meaning
Work-related gradual process, disease or infection	There are three key criteria for establishing cover for a personal injury caused by work-related gradual process, disease or infection. • there is a particular property or characteristic in a work task or the work environment that can be identified as having caused the condition • the property or characteristic isn't materially present outside the person's work activities or environment • those performing the work task or employed in that work environment are at significantly greater risk of developing the condition than those who don't. Any condition must meet all the criteria of the AC Act, although some occupational diseases are listed in Schedule 2 of the AC Act and have a simplified cover process.