ACC
PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

28 July 2017

Mr David Lawson
fyi-request-6200-231d9c47@requests.fyi.org.nz

Dear Mr Lawson

Official Information Act Request

I refer to your email, of 13 July 2017, requesting the following information under the Official Information Act 1982 (the Act):

> *"It would be appreciated if you could provide the following official information with respect to the Auckland District Health Board (ADHB) and the Waitemata District Health Board (WDHB);*
>
> *1. Is ACC Prior Consent required for the ADHB and the WDHB under the subcontracts for services that relate specifically to;*
>
> > *(a) subcontracts, for the neurosurgical assessment, treatment and rehabilitation of an ACC claimant's injuries that involve accidental trauma.*
> >
> > *(b) subcontracts for the neurological assessment, treatment and rehabilitation of an ACC claimant's injuries that involve accidental trauma.*
> >
> > *(c) if the answer is yes to both (a) and (b) above, has this always been the case. If not when did ACC begin to request that DHB's, inclusive of ADHB and the WDHB, were required to seek Prior Consent for confirmation that ACC will fund the neurosurgical or neurological assessment, treatment and rehabilitation of an ACC claimant's injuries that involve accidental trauma.*
> >
> > *(d) If prior approval is required for neurosurgical and or neurological services provided by ADHB and WDHB, or any other DHB, please supply me with a copy of the ACC / DHB policy that governs the time frame and process that the DHB is required to undertake, and the time limits that the ACC is contracted to to respond to the DHB."*

Our response

Questions 1a) and b)

ACC has two contracts, that the ADHB and the WDHB both hold, which include the services referred to in your request. These are the Elective Surgery contract and the Clinical Services contract. I enclose copies of the service schedules that relate to these contracts, for your information. These include the provisions regarding prior consent. Please refer to Part B clause 7 of the Elective Surgery contract and Part B clause 8 of the Clinical Services contract.

Question 1c)
Elective Surgery contract
ACC prior approval is required for all neurosurgical elective procedures under this contract. This service is for eligible clients who have a covered personal injury which requires surgical treatment. Prior approval has always been required since the service was introduced in 2002.

Please note, this service does not include emergency acute treatment or surgery undertaken by DHBs. This is bulk funded under the Public Health Acute Services.

Question 1d)
Prior approval policy
ACC does not have a policy outlining the timeframes and process for submitting a request for a neurosurgical procedure. However, the DHBs are required to complete the requested procedure within the '*Priority Category*' timeframe described in the client's 'Assessment Report and Treatment Plan' (ARTP). This is outlined in Part B clause 8 of the Elective Surgery contract. A template of the ARTP is enclosed for your information.

With regard to ACC responding to a request, there is no contractual obligation for issuing an elective surgery decision. ACC is expected to make decisions in a timely manner and make every attempt to comply with the '*priority category*' timeframe wherever practicable.

Accordingly, in line with section 18(e) of the Act, ACC is unable to provide the policy document as it does not exist.

Queries or concerns
If you have any questions about the information provided, you can contact us at GovernmentServices@acc.co.nz.

You also have the right to make a complaint to the Office of the Ombudsman if not satisfied with ACC's decision. You can call them on 0800 802 602 between 9am and 5pm on weekdays, or write to *The Office of the Ombudsman, PO Box 10152, Wellington 6143.*

Yours sincerely

OIA Services
Government Engagement and Support

Encl: *Service Schedule for Elective Surgery Services*
Service Schedule for Clinical Services – includes in-room procedures
Service Schedule for Clinical Services – excludes in-room procedures
ARTP template

SERVICE SCHEDULE FOR ELECTIVE SURGERY SERVICES

CONTRACT NO: TRSXXXC

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING ELECTIVE SURGERY SERVICES

The Term for the provision of Elective Surgery Services is the period from 1 July 2008 ("Start Date") until the close of 30 June 2019 ("End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

2. CONTRACT AMOUNT (Part B, clause 11.1.1)

2.1 Contract Amount (exclusive of GST) for the period 1 May 2017 to 30 June 2018: [insert Contract Amount].

2.2 Table of Amounts by Specified Area

Specified Area	Maximum Amount (GST exclusive)

3. NAMED PROVIDERS

3.1 Named Providers (Part B, clause 6.1.1).

Last Name	First Name	Specialty or Category of Professional Registration	New Zealand Medical Council Number or Dental Council of New Zealand Number	ACC Provider Number

3.2 Named Red List Providers (Part B, clause 6.1.1) [where applicable].

Last Name	First Name	Specialty or Category of Professional Registration	New Zealand Medical Council Number or Dental Council of New Zealand Number	ACC Provider Number

4. SPECIFIED AREA AND SERVICE LOCATION (Part B, clause 4)

Facility Name	Location	Certification/Accreditation Type

5. SERVICE ITEMS AND PRICES (Part B, clause 18)

Table 1 – Core Service Items and Prices

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
AFT22		Ankle Arthrodesis	$7,534.87
AFT23		Subtalar Arthrodesis	$7,534.87
AFT24		Triple Arthrodesis	$9,041.85
AFT25		Talonavicular Arthrodesis	$5,974.40
AFT26		Calcaneocuboid Arthrodesis	$5,974.40
AFT27		TMT or Arthrodesis Single	$5,974.40
AFT28		TMT or Arthrodesis Multiple	$6,571.85
AFT29		MTP Arthrodesis	$4,476.92
AFT30		PIP/DIP Arthrodesis	$3,458.84
AFT31		Distal Tibial Osteotomy with or without internal fixation	$8,286.22
AFT32		Distal Fibular Osteotomy with internal fixation	$8,286.22
AFT33		Calcaneal Osteotomy	$4,079.74
AFT34		Midtarsal Osteotomy	$4,211.58
AFT35		1st Metatarsal Osteotomy Unilateral	$4,211.58
AFT36		Lesser Metatarsal Osteotomy	$4,079.74
AFT37		Phalangeal Osteotomy	$4,211.58
AFT38		Tenotomy of foot	$2,282.92
AFT39		Amputation Toe – MTP/IP joint	$2,540.99
AFT41		Joint release for claw toe	$2,282.92
AFT42		Tendo Achilles Repair Primary	$4,310.94
AFT43		Tendo Achilles Debridement	$4,310.94
AFT44		Tendo Achilles Lengthening or Gastrocnemius Slide	$5,744.69
AFT45		Tendo Achilles Reconstruction (FHL graft, v/y- lengthening)	$5,744.69
AFT46		Tendon Transfer including Tibialis Anterior	$4,667.37
AFT47		Tendon Transfer Involving FDL, FHL or Peroneal Tendons <level 2	$4,890.37
AFT48		Tendon Transfer Involving FDL, FHL or Peroneal Tendons >level 2	$6,357.48
AFT49		Tendon Transfer Toes	$4,890.37
AFT50		Ankle Arthroscopic Surgery - Simple	$4,009.37
AFT51		Ankle Arthroscopy Proceed to Open Surgery - Simple	$5,258.78
AFT52		Ankle Open Surgery - Simple	$3,964.15
AFT60		Ankle Arthroscopic Surgery Complex	$4,906.67
AFT61		Ankle Arthroscopy Proceed to Open Surgery - Complex	$5,567.90
AFT62		Ankle Open Surgery - Complex	$4,757.00
AFT63		Repair Flexor Tendon Ankle/Foot	$4,890.37
AFT64		Repair Extensor Tendon Ankle/ Foot	$4,667.37
AFT65		Ankle Ligament Reconstruction without graft	$5,543.90
AFT66		Ankle Ligament Reconstruction with graft	$6,098.29
AFT67		Subtalar Ligament Repair or ankle ligament reconstruction - redo graft	$6,652.68
AFT68		Plantar Fascia Release	$2,501.29

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
AFT69		Decompression Fasciotomy Foot	$3,621.22
AFT70		Tarsal Tunnel Release	$2,501.29
AFT71		Botox for release of spasm/contractures. Not to be used as an equivalent (includes 1 x 100ml vial)	$2,635.11
AFT72	Red	Ankle replacement	$12,437.28
AFT73		ORIF Tarsal fracture	$5,277.17
AFT74		ORIF Uni-malleollar fracture	$4,845.90
AFT75		ORIF Bi-malleolar fracture	$4,985.79
AFT76		ORIF metatarsal fracture	$4,751.82
AFT77		ORIF phalanx fracture	$3,573.27
DNS01		lntra-oral Dental Implant x 1- stage 1 (includes bone graft)	$4,197.57
DNS02		Intra-oral Dental Implant x 2 - stage 1 (includes bone graft)	$5,773.56
DNS03		Bone Graft - Alveolar Osseous	$4,326.49
DNS04		Surgical Extraction of Teeth	$2,880.88
DNS06		Removal of Metalware – Wire, Screw or Plate	$3,139.48
ELF01		Excision Un-united Olecranon Process	$3,683.85
ELF02		Excision Radial Head	$3,378.11
ELF03		Arthroplasty - Radial Head	$4,752.29
ELF06		Epicondylitis Release	$3,042.41
ELF07		Ulnar Nerve Transposition - Elbow	$3,999.00
ELF08		Posterior Interosseus Nerve Release for Radial Tunnel Syndrome	$4,016.03
ELF09		ORIF Fracture Radius or Ulna	$4,932.62
ELF10	Red	Total Elbow Replacement	$13,196.79
ELF11		Reconstr./Corrective Osteotomy Radius	$5,171.20
ELF21		Removal of plate and screws – Radius, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,372.13
ELF22		Removal of plate and screws – Ulna, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,372.13
ELF23		Removal of Flexible Intramedullary Nail - Radius/Ulna (includes Titanium Elastic Nail (TEN) includes excision/revision of initial scar including hypertrophic or keloid scarring)	$3,025.36
ELF24		Removal of Tension Band Wiring Elbow , includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,025.36
ELF25		Distal Biceps tendon repair	$5,336.44
ELF50		Elbow Arthroscopic Surgery - Simple	$4,811.23
ELF51		Elbow Arthroscopy Proceed to Open Surgery - Simple	$5,573.68

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
ELF52		Elbow Open Surgery - Simple	$4,279.09
ELF60		Elbow Arthroscopic Surgery - Complex	$5,888.03
ELF61		Elbow Arthroscopy Proceed to Open Surgery - Complex	$5,882.80
ELF62		Elbow Open Surgery - Complex	$5,134.90
GNS01		Inguinal Hernia Repair (unilateral)	$4,285.74
GNS02		Incisional Hernia Repair	$6,017.39
GNS03		Laparosc. Ing. Hernia Repair - Prim./Recurr. (unilateral)	$5,400.90
GNS04		Umbilical Hernia Repair	$4,219.77
GNS05		Femoral Hernia Repair (unilateral)	$3,982.26
GNS06		Ventral Hernia Repair	$4,456.44
GOP01		Bone Graft - any area, minor or small *from a site other than the initial surgical site	$4,747.37
GOP02		Bone Graft - any area, major *from a site other than the initial surgical site	$5,189.72
GOP03		Excision Exostosis - superficial	$3,475.86
GOP04		Excision Exostosis - deep	$4,159.02
GOP05		Excision Bursa (not to be used for excision ganglion)	$3,503.26
GOP07		Diagnostic Arthroscopy any joint (excluding wrist and hip)	$3,236.53
GOP20		Removal of plate and screws not elsewhere specified, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,372.13
GOP21		Removal of screws not elsewhere specified x 1-3, includes removal of diastasis screws, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,025.36
GOP22		Removal wires/pins not elsewhere specified 1-3, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,025.36
GOP23		Removal wires/pins not elsewhere specified >3, includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,327.88
GOP24		Removal screws not elsewhere specified >3, includes removal of diastasis screws , includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,630.43
HIT01		Total Hip Replacement (not to be used for hip resurfacing)	$11,936.21
HIT02		Hemi-arthroplasty (Partial Hip Replacement)	$9,766.18
HIT03		Revision Hip Replacement	$14,158.38
HIT05		ORIF Fracture Femur	$11,633.16
HIT06		Osteotomy - Distal Femur with Fixation	$7,551.73
HIT07		Adductor/Hamstring Tendon Release,	$2,552.27

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		Percutaneous	
HIT08		Lateral Cutaneous Nerve of Thigh Release	$2,409.64
HIT09		Decompression Fasciotomy - Thigh/Knee	$5,137.84
HIT17		Primary Removal Compression Hip screw and plate, includes excision/revision of initial scar including hypertrophic or keloid scarring	$5,112.67
HIT18		Primary Removal of Cannulated Hip screws (not to be used in combination with Hip Arthroplasty), includes excision/revision of initial scar including hypertrophic or keloid scarring	$4,235.51
HIT19		Intraoperative Removal of Cannulated Hip screws (for use in combination with Hip Arthroplasty), includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,025.36
HIT20		Primary Removal of plate and screws Femur, includes excision/revision of initial scar including hypertrophic or keloid scarring	$5,538.72
HIT21		Removal Intramedullary Femoral Rod (includes removal of all locking screws at time of procedure), includes excision/revision of initial scar including hypertrophic or keloid scarring	$5,964.76
HIT22		Removal Intramedullary Femoral Rod Locking Screws x 1-3 (not to be used in combination with Removal of Intramedullary Femoral Rod), includes excision/revision of initial scar including hypertrophic or keloid scarring	$3,630.43
HIT50	Red	Hip Arthroscopy simple	ESU
HIT51	Red	Hip Arthroscopy proceed to open surgery- simple	ESU
HIT52	Red	Hip open surgery - simple	ESU
HIT60	Red	Hip Arthroscopy Complex 1	ESU
HIT61	Red	Hip Arthroscopy proceed to open surgery -complex	ESU
HIT62	Red	Hip open surgery - complex	ESU
HIT70	Red	Hip Arthroscopic Surgery – Complex 2	ESU
HIT71	Red	Hip Arthroscopy Proceed to Open Surgery – Complex 2	ESU
HIT72	Red	Hip Open Surgery – Complex 2	ESU
KNE01		MUA - Knee Joint +/- injection **IF USED IN COMBINATION WITH OTHER CODES GOOD REASONING MUST BE SUPPLIED**	$2,330.34
KNE03		Reconstruction Collateral Ligament	$5,477.98

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
KNE07		Patellectomy	$4,899.27
KNE09		**Primary** Total Knee Replacement	$12,653.47
KNE10		**Partial** Knee Replacement (hemiarthroplasty – e.g. Oxford)	$11,367.90
KNE11		**Revision Total** Knee Replacement	$12,825.37
KNE12		Arthrodesis Knee	$8,082.17
KNE13		ORIF # Tibia or Fibula (includes tibial plateau fracture)	$6,450.84
KNE14		Amputation - Below Knee	$8,535.76
KNE15		Revision of Below Knee Amputation (**not to be used as an equivalent code)**	$4,471.71
KNE16		Osteotomy - Proximal Tibia with Fixation (not to be used in combination with KNE124, KNE125, KNE126, KNE127) **Not to be used for** Tibial Tubercle Transfer	$8,286.22
KNE17		Lateral Popliteal Nerve Decompression	$2,923.92
KNE18		Fasciotomy Calf	$3,621.21
KNE20		**Removal of plate and screws Tibia**, includes removal of diastasis screws) **Includes**: any excision/revision of initial scar including hypertrophic or keloid scarring	$3,372.13
KNE21		**Removal of Intramedullary Tibial Rod** (includes removal of all locking screws at time of procedure). **Includes:** any excision/revision of initial scar including hypertrophic or keloid scarring	$5,470.70
KNE22		**Removal of Locking Screws from Intramedullary Tibial Rod** (includes removal of any number of locking screws at time of procedure) **Not to be used in combination with** KNE21 - Removal of Intramedullary Tibial Rod **Includes:** any excision/revision of initial scar including hypertrophic or keloid scarring.	$3,327.88
KNE23		Removal of Tension Wiring Patella. **Includes** : any excision/revision of initial scar including hypertrophic or keloid scarring	$3,025.36
KNE26		ORIF intra-articular osteochondral fracture of the knee	Via non-core process
KNE27		Posterolateral corner reconstruction	Via non-core process
KNE50		Knee Arthroscopic Surgery - Simple	$4,009.37
KNE51		Knee Arthroscopy Proceed to Open Surgery - Simple	$8,688.57
KNE52		Knee Open surgery - Simple	$5,452.03
KNE60		Knee Arthroscopic Surgery - Complex 1	$4,906.67
KNE61		Knee Arthroscopy - Proceed to Open Surgery - Complex 1	$9,461.39
KNE62		Knee Open Surgery - Complex 1	$6,542.43

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
KNE70		Knee Arthroscopic Surgery – Complex 2 **Includes:** more than one procedure listed under KNE50 AND one or more of the procedures listed under KNE60 OR More than one procedure listed under KNE60	$5,972.03
KNE71		Knee Arthroscopic Surgery – Complex 2 **Includes:** more than one procedure listed under KNE51 AND one or more of the procedures listed under KNE61 OR More than one procedure listed under KNE61	$10,358.70
KNE72		Knee Arthroscopic Surgery – Complex 2 **Includes:** more than one procedure listed under KNE52 AND one or more of the procedures listed under KNE62 OR More than one procedure listed under KNE62	$7,632.84
KNE81		**Primary Knee ACL reconstruction** (Anterior Cruciate Ligament) **Primary and Simple: Arthroscopic and/or Open.** Allograft is not to be used in this procedure except for when the reconstruction involves multiple ligament transfers and/or the patient has a medical condition that precludes the use of autograft tissue	$9,105.00
KNE83		**Revision Knee ACL Reconstruction** (Anterior Cruciate Ligament) **Simple:** arthroscopic and/or open	$10,315.14

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
KNE85A	Red	**Primary Knee PCL** reconstruction (Posterior Cruciate Ligament) – arthroscopic and/or open – **Simple** **Includes:** Harvesting, preparation of GRAFT and any combination of: Chondral debridement irrespective of Grade (including notchplasty, chondromalacia) and/or debridement of any soft tissue impingement (including Patella Tendon, ganglion, Hoffa's fat pad) and/or loose body removal and/or Meniscal debridement and/or lateral retinacular release	$12,755.34
KNE91		**Primary** Knee ACL Reconstruction **(Anterior Cruciate Ligament)** ***Complex*** Includes a KNE81 with Meniscal Repair &/or Outerbridge drilling. Allograft is not to be used in this procedure except for when the reconstruction involves multiple ligament transfers and/or the patient has a medical condition that precludes the use of autograft tissue	$10,925.99
KNE93		Revision Knee ACL Reconstruction (Anterior Cruciate Ligament) ***Complex*** Includes a KNE83 with Meniscal Repair &/or Outerbridge III-IV drilling or microfracture	$12,378.17
KNE95A	Red	**Primary Knee PCL** reconstruction (Posterior Cruciate Ligament) – arthroscopic and/or open – **Complex** Includes a KNE85 with Meniscal Repair &/or Outerbridge III-IV drilling or microfracture	$14,596.33
KNE99		**Revision of Knee Components** – including bearing exchange and/or patella resurfacing	Via non-core process
KNE124		Repair of Patella Tendon – primary. Not to be used in combination with KNE126 and/or KNE127 and/or KNE16	$4,952.61
KNE125		Patella Tendon Reconstruction (includes harvesting of graft) Not to be used in combination with KNE126 and/or KNE127 and/or KNE16.	$6,438.39
KNE128		Arthroscopic examination of the patellofemoral joint AND open or arthroscopic Patella realignment - **soft tissue repair/reconstruction** ***Simple*** Includes any procedure found in a	$7,828.18

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		KNE50, KNE51, KNE52 AND 1. Primary repair of medial retinacular soft tissues including tightening suturing 2. Vastus medialis obliquus (VMO) muscle advancement 3. Lateral Release 4. Treatment of articular cartilage	
KNE129		Arthroscopic examination of the patellofemoral joint AND open or arthroscopic Patella realignment - **soft tissue repair/reconstruction** ***Complex*** Includes any procedure found in a **KNE128** AND **Medial Patellofemoral Ligament Reconstruction** with Graft includes harvesting and preparation; tunnel drilling; graft.	$10,925.99
KNE130		Arthroscopic examination of the patellofemoral joint AND Patella Realignment – Reconstruction/distal realignment **bony procedure** Includes any procedure found in a **KNE128** AND Tibial tubercle realignment – includes tibial tubercle transfer medially and/or distally and internal fixation +/- excision lateral patellar osteophyte	$10,925.99
NRV01		Delayed Repair of Major Nerve	$6,223.70
NRV02		Delayed Repair of Digital Nerve	$3,853.75
NRV03		Excision of Neuroma	$3,507.74
NRV04	Red	Reconstruction Digital Nerve with Nerve Graft	$8,254.94
NRV05	Red	Reconstruction Single Major Nerve with Nerve Grafts	$9,798.16
NRV06	Red	Neurolysis	$3,671.47
NRV07		Suture of Nerve requiring extensive mobilisation	$6,039.35
NRV09		Excision of Neurofibroma Major Peripheral Nerve	$5,075.51
OPT01		Cataract Extraction & Insertion of IOL	$3,936.22
OPT02		Cataract Extraction - Insertion IOL with Anterior Vitrectomy	$5,470.68

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
OPT03		Cataract - Secondary Intraocular Lens with Anterior Vitrectomy	$4,721.90
OPT04		YAG Laser Capsulotomy	$1,265.41
OPT05		Repair of Blepharoptosis	$2,998.94
OPT06		Lid/Adnexa - lid surgery - minor	$2,359.22
OPT07		Lid/Adnexa - lid surgery - major	$3,296.56
OPT08		Dacryocystorhinostomy with intubation	$5,027.85
OPT09		Strabismus Surgery - one muscle	$2,425.07
OPT10		Strabismus Surgery - two muscles	$3,087.91
OPT11		Strabismus Surgery - more than two muscles	$3,750.73
OPT12		Corneal Transplant	$6,985.15
OPT13		Phototherapeutic Keratectomy (PTK)	$2,740.60
OPT14		Trabeculectomy with Antimetabolite Application	$5,166.05
OPT15		Enucleation/Evisceration with implant	$6,160.88
OTY01		Reduction of Fractured Nose	$1,859.83
OTY02		Cauterisation +/- Ablation Mucosa of Turbinates (not to be used in combination)	$3,125.40
OTY03		Septoplasty/SMR	$4,876.65
OTY04		Septorhinoplasty Intranasal	$6,422.32
OTY05		Septorhinoplasty - External Approach	$8,274.00
OTY06		Major Revision Septorhinoplasy	$7,732.33
OTY07		Nasal/Sinus Endoscopy +/- Polypectomy (FESS)	$5,505.36
OTY08		Tympanostomy/Myringotomy	$1,897.51
OTY09		Myringoplasty - simple +/- patch	$3,128.12
OTY10		Myringoplasty - Endaural/Transcanal/Postauricular	$5,306.81
OTY11		Tympanoplasty - Ossicular Reconstruction +/- prosthesis	$6,259.35
SHU01		MUA Shoulder Joint +/- injection **NOT TO BE USED IN COMBINATION WITH OTHER CODES** **NOT TO BE USED AS AN EQUIVALENT**	$2,139.91
SHU06		Excision Outer End of Clavicle (not to be used in combination with other codes)	$4,271.66
SHU07		ORIF Clavicle	$5,566.14
SHU08		Open Reduction of AC Dislocation	$6,199.66
SHU09		Proximal Biceps Tendon Tenotomy/Tenolysis/Release. (not to be used in combination with other codes)	$5,336.44
SHU13		Partial Shoulder Replacement	$9,519.18
SHU14		Total Shoulder Replacement	$11,897.68
SHU15		Arthrodesis Shoulder	$7,369.87
SHU16		ORIF Humeral Fracture	$6,252.29
SHU17A		Reverse Total Shoulder Replacement	$11,897.68
SHU20		Removal of plate and screws Humerus.	$4,260.54

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		Includes: any excision/revision of initial scar including hypertrophic or keloid scarring	
SHU21		Removal Intramedullary Humeral Rod. **Includes**: Removal of all locking screws at time of procedure; excision/revision of initial scar	$5,470.70
SHU22		Removal Intramedullary Humeral Rod Locking Screws x 1-3 **Includes**: excision/revision of initial scar. (Not to be used in combination with Removal of Intramedullary Humeral Rod)	$3,327.88
SHU23		Removal of plate and screws Clavicle. **Includes:** any excision/revision of initial scar including hypertrophic or keloid scarring.	$3,771.66
SHU50		Shoulder Arthroscopic Surgery - Simple	$5,321.29
SHU51		Shoulder Arthroscopy Proceed to Open Surgery - Simple	$4,429.35
SHU52		Shoulder Open Surgery - Simple	$4,026.70
SHU60		Shoulder Arthroscopic Surgery - Complex 1	$5,630.43
SHU61		Shoulder Arthroscopy - Proceed to Open Surgery - Complex 1	$5,369.03
SHU62		Shoulder Open Surgery - Complex 1	$4,832.03
SHU70		Shoulder Arthroscopic Surgery - Complex 2	$6,510.42
SHU71		Shoulder Arthroscopy Proceed to Open Surgery - Complex 2	$6,972.78
SHU72		Shoulder Open Surgery - Complex - 2	$6,174.39
SHU80		Shoulder Arthroscopic Repair - 1 (if majority of procedure is arthroscopic then SHU80 applies) **Includes:** Any combination of procedures listed under SHU70 AND: Single Tendon rotator cuff repair or Biceps Tenodesis * * **Note**: Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$9,794.77
SHU81		Shoulder Arthroscopy and Proceed to Open Repair 1 **Includes:** Any combination of procedures listed under SHU71 AND: Single Tendon rotator cuff repair or Biceps Tenodesis *	$9,493.41

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		*** Note:** Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	
SHU82		Shoulder Open Repair 1 **Includes:** Any combination of procedures listed under SHU72 AND: Single Tendon rotator cuff repair or Biceps Tenodesis * *** Note:** Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$8,198.77
SHU85		Shoulder Instability Repair – Simple Arthroscopic and/or Open **Includes:** Any procedure listed in SHU70; SHU71; SHU72 and capsular shift AND: Repair of Recurrent Dislocation Shoulder Single labral region: Anterior including inferior or; Posterior including inferior OR Repair of SLAP lesion and/or labral tear Single labral region: Superior including posterosuperior and anterosuperior.	$9,794.77
SHU90		**Shoulder Arthroscopic Repair 2** (if majority of procedure is arthroscopic then SHU90 applies) **Rotator Cuff Repair two or more tendons** (one of which may include tenodesis of the Biceps tendon) **Includes:** Any combination of procedures listed under SHU70 AND: Rotator Cuff repair two or more tendons and may include Biceps Tenodesis * *** Note:** Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$12,089.81
SHU91		**Shoulder Arthroscopy and Proceed to Open Repair 2** **Rotator Cuff Repair two or more tendons** (one of which may include tenodesis of the Biceps tendon) **Includes:** Any combination of procedures listed under SHU71 AND: Rotator Cuff repair two or more	$9,802.51

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		tendons and may include Biceps Tenodesis * *** Note:** Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	
SHU92		**Shoulder Open Repair 2** **Rotator Cuff Repair two or more tendons** (one of which may include tenodesis of the Biceps tendon) **Includes:** Any combination of procedures listed under SHU72 AND: Rotator Cuff repair two or more tendons and may include Biceps Tenodesis * *** Note:** Tenodesis means the actual removal of the long head of biceps from its normal attachment and re-anchoring it along its length to the humerus including within the bicipital groove	$9,838.54
SHU95		**Shoulder Instability Repair – Complex 1 Includes:** Any combination of procedures listed under SHU85 and rotator cuff repair one or more tendons (one of which may include tenodesis of the biceps tendon) AND/OR: Repair of extensive labral tear – More than one region and/or Revision Repair of Recurrent Dislocation Shoulder and/or Labral repair and Remplissage of Hill Sachs defect *Remplissage is defined as a posterior capsulotenodesis into a Hill Sach's lesion	$12,089.81
SHU96A		Shoulder Instability Repair – Complex 2: **Latarjet Procedure** **Includes:** Osteotomy, transfer and fixation of the coracoid process and attachments and/or other bone graft to glenoid) **NOT TO BE USED IN COMBINATION WITH OTHER CODES.** **NOT TO BE USED AS AN EQUIVALENT**	$12,089.81
SKP01		Removal of foreign body	$3,000.92
SKP02		Debridement of skin and subcutaneous tissue	$3,689.26
SKP03		Debridement of skin-partial thickness	$3,445.20
SKP04		Revision of Scar of Face	$3,243.95
SKP05		Revision of Scars of Face (2-4 scars)	$4,052.34
SKP06		Revision of Scar Trunk/limbs	$3,612.96
SKP07		Revision of Scars Trunk/Limbs (2-4	$4,361.32

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		scars)	
SKP09		Split skin graft face and /or neck	$4,994.98
SKP10		Split skin graft trunk and/or limbs	$4,413.20
SKP11		Full thickness skin graft, <20cm	$4,282.77
SKP12	Red	Insertion of tissue expander	$6,294.12
SKP13	Red	Removal of tissue expander(s) and reconstruction	$6,872.40
SKP14		Minor finger surgery (stump revision/cyst)	$2,237.74
SKP15		Excision of Nail and Nail bed (Toe)	$2,458.51
SPN201		Posterior Fusion - C1/2 with instrumentation	$11,422.15
SPN202		Posterior Cervical Fusion - Simple – Single Level (excl C1/2 with instrumentation)	$10,030.43
SPN203		Posterior Cervical Fusion Complex – Single Level (excl C1/2 with instrumentation). **Includes:** Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy	$14,719.11
SPN204		Posterior Cervical Fusion - Simple – Two or more Levels (excl C1/2 with instrumentation) If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.	$15,396.90
SPN205		Posterior Cervical Fusion Complex – Two or more Levels (excl C1/2 with instrumentation) If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. **Includes:** Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy	$16,860.51
SPN206	Red	Posterior Cervical Decompression Laminoplasty	$13,313.85
SPN207	Red	Posterior Cervical Decompression - Simple **Includes:** Laminectomy, Foraminotomy	$10,706.94
SPN208	Red	Posterior Cervical Decompression - Complex **Includes:** foraminotomy/foraminectomy with laminectomy, bilateral formaminectomy or double level foraminectomy	$12,848.34
SPN210		Anterior Cervical Discectomy without Fusion	$7,800.13
SPN211		Anterior Cervical Discectomy with Fusion - Single level. **Includes**: Foramen Decompression, without instrumentation Discectomy and/or Decompression	$10,744.73
SPN212		Anterior Cervical Discectomy with Fusion - Two or more levels	$12,097.75

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes**: Foramen Decompression, without instrumentation. Discectomy and/or Decompression	
SPN213		Anterior Cervical Discectomy and Instrumented Fusion with Graft - Single level. **Includes:** Discectomy and/or Decompression	$11,981.41
SPN214		Anterior Cervical Discectomy and Instrumented Fusion with Graft – Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression	$16,860.00
SPN215		Cervical Disc Replacement (Arthroplasty) – Single Level. **Includes:** Discectomy and/or Decompression	$11,981.41
SPN216		Cervical Disc Replacement (Arthroplasty) - Two or more Levels If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. **Includes:** Discectomy and/or Decompression. Hybrid operation (a single level anterior cervical intervertebral fusion in combination with a single level disc replacement)	$16,860.00
SPN220	Red	Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Simple	$17,383.95
SPN221		Posterior Thoracic/Thoracolumbar Fusion with instrumentation – Complex. **Includes:** Discectomy and/or Decompression	$20,799.49
SPN222		Posterolateral Lumbar Fusion Without Instrumentation Simple – Single Level	$8,401.06
SPN223		Posterolateral Lumbar Fusion Without Instrumentation Complex - Single Level. **Includes:** Discectomy and/or Decompression (Including Laminectomy)	$11,899.30
SPN224		Posterolateral Lumbar Fusion Without instrumentation Simple – Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used.	$12,944.54
SPN225		Posterolateral –Lumbar Fusion, without instrumentation Complex – Two or	$16,967.09

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression	
SPN226		Posterolateral Lumbar Fusion with instrumentation Simple – Single level	$13,685.61
SPN227		Posterolateral Lumbar Fusion with instrumentation Complex - Single level. **Includes:** Discectomy and/or Decompression	$17,101.16
SPN228	Red	**Revision** Posterolateral Lumbar Fusion with Instrumentation – Single Level. **Includes:** removal of existing implants	$17,225.19
SPN229		**Revision** Posterolateral Lumbar Fusion With Instrumentation - Single Level. **Includes:** Removal of existing spinal implants and Discectomy and/or decompression	$21,142.83
SPN230		Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used.	$15,136.43
SPN231		Posterolateral Lumbar Fusion with instrumentation Complex – Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression	$19,158.99
SPN232	Red	**Revision** Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** removal of existing spinal implants	$21,531.52
SPN233		**Revision** Posterolateral Lumbar Fusion With Instrumentation Complex - Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes**: Removal of existing spinal implants and Discectomy and/or decompression	$27,512.23
SPN240	Red	Anterior Lumbar Fusion Simple – Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or. Direct lateral interbody fusion (DLIF).	$17,429.73

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		Includes: Discectomy and/or Decompression. **Not to be used for laproscopic/endoscopic techniques. These should be done non core.**	
SPN241		Anterior and Posterior Lumbar Fusion Complex - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). **Includes:** Discectomy and/or Decompression AND Posterior fusion with or without instrumentation (SPN222, SPN223. or SPN226, SPN227). **Not to be used in combination.** **Not to be used for laparoscopic/endoscopic techniques. These should be done non core.**	$22,903.98
SPN242		Revision Anterior Lumbar Fusion - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). **Includes:** Removal of instrumentation. **Not to be used for laparoscopic/endoscopic techniques. These should be done non core.**	$20,250.45
SPN243	Red	Anterior Lumbar Fusion Simple - Two or more levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression. **Not to be used for laparoscopic/endoscopic techniques. These should be done non core**	$17,868.90
SPN244		**Anterior and Posterior** Lumbar Fusion Complex - Two or More Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression AND Posterior fusion with or without instrumentation (SPN224, SPN225 or SPN230, SPN231).	$23,923.48

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		Not to be used in combination	
SPN245		**Revision Anterior Lumbar Fusion -** Two or more Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). **Includes:** Removal of instrumentation	$20,980.44
SPN246		Lumbar Disc Replacement (Arthroplasty) – Single Level. **Includes:** Discectomy and/or Decompression	$17,429.73
SPN247		Lumbar Disc Replacement (Arthroplasty) Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy and/or Decompression; Hybrid operation (a single level anterior lumbar intervertebral fusion in combination with a single level disc replacement.	$17,868.90
SPN250		Lumbar Discectomy Simple – Single level	$7,409.66
SPN251		Lumbar Discectomy Simple - Two or more Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used.	$10,373.51
SPN252		Lumbar Discectomy Complex – Single level. **Includes:** extensive foraminal and/or extraforaminal and/or far lateral disc protrusions/extrusions and central disc protrusions/extrusions requiring bilateral approach. **Note:** If the majority of the procedure is to address spinal stenosis, use the spinal stenosis decompression codes (SPN256-259).	$7,839.67
SPN253		Lumbar Discectomy Complex - Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Extensive foraminal and/or extraforaminal and/or far lateral disc protrusions/extrusions and/or central disc protrusions/extrusions requiring bilateral approach. **Note:** If the majority of the procedure is to address spinal stenosis, use the spinal stenosis decompression codes	$10,975.53

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		(SPN256-259).	
SPN254		Revision Lumbar Discectomy – Single level	$7,640.11
SPN255		Revision Lumbar Discectomy – Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used.	$10,696.15
SPN256		Spinal Stenosis Decompression - Single level. **Includes:** Discectomy. **Note:** If the majority of the procedure is to address the disc, use discectomy codes.	$10,148.29
SPN257		Spinal Stenosis Decompression - Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy. **Note:** If the majority of the procedure is to address the disc, use discectomy codes.	$12,484.50
SPN258	Red	Revision Spinal Stenosis Decompression - Single Level. **Includes:** Discectomy. **Note:** If the majority of the procedure is to address the disc, use discectomy codes	$10,451.66
SPN259	Red	Revision Spinal Stenosis Decompression - Two or more levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Discectomy. **Note:** If the majority of the procedure is to address the disc, use discectomy codes.	$14,951.80
SPN260	Red	Transforaminal Lumbar Interbody Fusion (TLIF) Simple - Single Level. **Includes:** Posterior lumbar interbody fusion (PLIF) - (Unilateral approach). Not to be used for laparoscopic/endoscopic techniques. These should be done non core.	$15,054.19
SPN261		Transforaminal Lumbar Interbody Fusion (TLIF) Complex - Single Level. **Includes:** Posterior lumbar interbody fusion (PLIF) - (Bilateral approach) or TLIF if any combination of the following is present: - Discectomy and/or Decompression for neurological symptoms. - Revision discectomy for neurological symptoms - Large central disc prolapse causing bilateral compression symptoms	$16,572.92

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
		- Ossified disc. **Not to be used for laparoscopic/endoscopic techniques. These should be done non core.**	
SPN262	Red	Transforaminal Lumbar Interbody Fusion (TLIF) Simple - Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Posterior lumbar interbody fusion (PLIF) - (Unilateral approach). **Not to be used for laparoscopic/endoscopic techniques. These should be done non core.**	$16,650.07
SPN263		Transforaminal Lumbar Interbody Fusion (TLIF) Complex - Two or More Levels. If the procedure involves more than two levels and the procedure is more complex, non core pricing can be used. **Includes:** Posterior lumbar interbody fusion (PLIF) - (Bilateral approach) or TLIF if any combination of the following is present: - Discectomy and/or Decompression - Revision discectomy - Large central disc prolapse causing bilateral compression symptoms - Ossified disc. **Not to be used for laparoscopic/endoscopic techniques. These should be done non core**	$21,121.23
SPN290		Coccygectomy	$8,633.88
SPN291		Removal of Spinal Instrumentation (Anterior or Posterior) Not to be used in combination (See Revision codes)	$7,332.85
SPN292	Red	Anterior Endoscopic Interbody Fusion – Single level	$13,962.40
SPN293		Interspinous spacer	$9,015.62
WAH01		ORIF - Phalangeal fracture	$3,723.88
WAH02		ORIF - Metacarpal fracture	$3,723.88
WAH03		Corrective Osteotomy of Phalanx	$5,615.04
WAH04		Corrective Osteotomy of Metacarpal	$3,929.33
WAH05		Arthrodesis IP joint	$3,996.78
WAH06		Arthrodesis CMC joint	$4,858.78
WAH07		Arthrosdesis MCP joint	$3,894.56
WAH08		Arthrolysis/ Synovectomy joint	$4,123.46
WAH09		CMC Joint Arthroplasty	$5,321.28
WAH10		Replacement - MCP/ IP joint	$5,200.12
WAH11		Repair Collateral Ligament Joint - Wrist	$4,491.87
WAH12		Reconstruction Collateral Ligament - joint	$4,546.55
WAH13		Simple Amputation Digit	$3,196.53

Core Procedure Code	Type of Procedure	Procedure Description	2017/18 Pricing (Excl GST)
WAH14		Ray Amputation Digit	$4,403.12
WAH15		Repair Flexor Tendon in Digit or Palm	$5,162.57
WAH16		Repair Flexor Tendon Wrist or Forearm	$3,424.75
WAH17		Extensor Tendon Repair - Hand/Finger	$3,687.79
WAH18	Red	Reconstruction Extensor Tendon	$3,991.59
WAH19	Red	Reconstruction Flexor Tendon	$6,258.20
WAH20	Red	Tenolysis Flexor Tendon	$3,166.89
WAH21		Tenolysis Extensor Tendon	$2,988.31
WAH22		Tenotomy Hand/Wrist	$2,787.50
WAH23	Red	Pulley Reconstruction	$5,254.75
WAH24		Tendon Transfer	$4,851.84
WAH25		Reconstruction for Radial Nerve Palsy	$7,492.12
WAH26	Red	Reconstruction for Ulnar Nerve Palsy (Claw hand)	$7,775.42
WAH27	Red	Reconstruction Median Nerve Palsy	$7,775.42
WAH28		Carpal Tunnel Release	$2,362.21
WAH29		ORIF Scaphoid Fracture	$4,582.16
WAH30	Red	Revascularisation Carpal Bone	$8,000.71
WAH31	Red	Reconstruction Carpal Bone	$5,189.72
WAH32		Repair Ligament Injury for Carpal Instability	$6,420.35
WAH33		Reconstruction for Carpal Instability	$5,617.26
WAH34		Open Triangular Fibro-Cartilage Repair	$5,997.10
WAH35		Reconstruction DRUJ for Instability	$4,495.46
WAH36		Sauve Kapandji procedure	$6,072.21
WAH37		Intercarpal Fusion/Partial Wrist Fusion	$6,012.93
WAH38		Arthrodesis - wrist with bone graft	$6,512.53
WAH39		Wrist - Proximal Row Carpectomy	$6,862.39
WAH41		Reconstr./Corrective Ulnar Osteotomy wInternal Fixation	$4,898.52
WAH42	Red	Diagnostic Arthroscopy Wrist	$4,092.36
WAH43	Red	Arthroscopic Debridement/Repair TFC/Repair Carpal Ligament Injury	$4,782.20
WAH44		Release of Scar/Fasciectomy - hand, major	$4,718.46
WAH45		Release of Scar/Fasciectomy - palm/finger, minor	$3,389.91
WAH46		Excision Pisiform	$3,911.60
WAH47		Excision Hook of Hamate	$3,481.55
WAH48		Repair Nail Bed	$2,478.53
WAH49		Reconstruction Nail Bed	$2,667.48

Table 2: Non-core Service Items and Prices

Non-core Procedure Code	Description	Unit of Measure	2017/18 Pricing (Excl GST))
ESRNC	Includes Theatre set up, Base Supplies and Recovery Fee	Flat Fee	$1,154.36
ESR01	Theatre time (up to 120 minutes)	Per minute ≤ 120 minutes	$41.98
ESR02	Theatre time (over 120 minutes)	Per minute > 120 minutes	$44.24
ESR03	Anaesthetist’s set up RVU	Per RVU	$62.07
ESR04	Anaesthetic other	Actual Costs	Actual Cost
ESR05	Ward stay	Per day	$650.51

Non-core Procedure Code	Description	Unit of Measure	2017/18 Pricing (Excl GST))
ESR06	High Dependency Unit (HDU)	Per day	$1,377.82
ESR07	Intensive Care Unit (ICU)	Per day	$4,739.79
ESR08	Plain x-rays	Per x-ray (max amount	$181.94
ESR09	2nd surgeon - consultant	Per minute	$23.63
ESR10	2nd surgeon - assistant	Per minute	$3.07
ESR11	Splints/Orthotics	Actual Costs	Actual Costs
ESR12	Unique Supplies (consumables, drugs – extra to base)	Actual Costs	Actual Costs
ESR13	Unusual/Unspecified costs	Actual Costs	Actual Costs
ESR14	Laparoscopic/Endoscopic supplies	Actual Costs	Actual Costs
ESR15	Image Intensifier	Per minute	$5.88
ESR16	Day stay only	Per day	$340.75
ESR17	Inpatient physiotherapy	Per visit	$45.62
ESR18	Follow up specialist visits	Per visit	$116.21

6. RELATIONSHIP MANAGEMENT (Part B, clause 17)

Table 3 - Relationship Management

Level	ACC	Supplier	Frequency
Client	ACC Client Service Staff	Individual staff or operational contact	
Branch	Branch Manager	Operational contact	
Region	Designated Engagement and Performance Manager		

7. ADDRESSES FOR NOTICES (Standard Terms and Conditions, clause 23)

NOTICES FOR ACC TO:

ACC Health Procurement (For deliveries)
Justice Centre
19 Aitken Street
Wellington 6011
ACC Health Procurement (For mail)
P O Box 242
Wellington 6140
Marked: "Attention: Procurement Specialist"
Phone: 0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

(insert street address including postcode) (For deliveries)
(insert postal address including postcode) (For mail)
Marked: "Attention: (contact person)
Phone:
Mobile:
Fax:
Email:

8. CHANGES TO STANDARD TERMS AND CONDITIONS

The Standard Terms and Conditions are changed as set out in Appendix 3.

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B. SERVICE SPECIFICATIONS FOR ELECTIVE SURGERY SERVICES

1. PURPOSE

1.1. ACC wishes to purchase Elective Surgery Services.

1.2. The purpose of the Service is to purchase timely, effective elective surgical procedures for eligible Clients who have a covered personal injury which requires surgical treatment to meet their rehabilitation outcomes.

2. SERVICE OBJECTIVES

2.1. This service specification covers the purchasing of elective surgical Treatment through inpatient and day patient procedures and Outpatient Post Discharge/Post Procedure Care, and includes diagnosis for all Clients. This service specification outlines the requirements that the Supplier and Provider must meet in the specialties included in (but not limited to) the list below:

2.1.1. General Surgery;
2.1.2. Maxillo-Facial;
2.1.3. Neurology and Neurosurgery;
2.1.4. Ophthalmology;
2.1.5. Orthopaedics;
2.1.6. Otorhinolaryngology (ENT); and
2.1.7. Plastic Surgery
2.1.8. Urology.

3. SERVICE COMMENCEMENT

3.1. Eligibility for Service

3.1.1. A Client is entitled to Services from the Supplier under this Contract if

3.1.1.1. They have suffered a personal injury as defined in the AC Act 2001; and

3.1.1.2. They have been accepted by ACC as having cover for that injury; and

3.1.1.3. The Supplier has received a completed Assessment Report and Treatment Plan (ARTP); and

3.1.1.4. ACC has approved funding for the Treatment; and

3.1.1.5. All the relevant provisions of this Contract are complied with.

3.1.2. ACC will not pay the Supplier for any Services where Treatment is carried out prior to the Supplier receiving ACC approval and any advice as to Priority Category in accordance with Clauses 7 and 8 of this Part B.

3.2. If a Client has not been admitted prior to the Date of Expiry or earlier Termination Date and the Supplier does not enter into a further agreement with ACC that provides for the Treatment of that Client, then the Supplier will immediately refer the Client to another contracted supplier.

3.3. Summary of Referral Process

In the event of a conflict or inconsistency between the summarised process in this Clause 3.3 and a specific provision in this Part B, the specific provision will prevail:

3.3.1. The Supplier receives an ARTP and ensures the ARTP meets the standards as detailed on ACC's Provider Website. The ARTP on the ACC Provider Website is the ACC approved version and is the only version of ARTP that will be accepted by ACC. If the ARTP does not meet these standards the Supplier will return the ARTP to the relevant Service Provider for the ARTP to be completed.

3.3.2. The Supplier will ensure they are able to meet the Clinical Priority timeframe requirement for each Client, including ensuring that they have sufficient capacity in Contract Amount and theatre. (See Part B Clause 8.4 for process to be followed if Supplier cannot ensure this);

3.3.3. The Supplier will follow the applicable funding approval process set out at Part B Clause 7.

3.3.4. ACC will process the application and advise the Client and the Supplier simultaneously in writing whether ACC approves or declines funding for the recommended Treatment. If approved, ACC will advise the Supplier of the Purchase Order Number and any change in the Priority Category for the Treatment.

3.4. Treatment and Post Discharge/Post Procedure Care

Subject to Part B Clause 11.1.1 (Contract Amount) and Clause 8 (Priority Category Timeframes) and prior approval (refer to Part B Clause 7 "Funding Approval Process"):

3.4.1. The Supplier will arrange for Treatment in accordance with any completed ARTP received during the Term of this Contract for any Client Resident in the Specified Area; and

3.4.2. The Supplier will arrange for Post Discharge/Post Procedure Care for any Client Resident in the Specified Area who has received Treatment by or through the Supplier; and

3.4.3. The Supplier may provide Treatment and arrange Post Discharge/Post Procedure Care as described in Part B clause 3.4.1 and 3.4.2 above for a Client Resident outside the Specified Area provided that such Treatment does not impact on the Supplier's ability to provide Treatment and arrange Post Discharge/Post Procedure Care for any Client Resident in the Specified Area; and

3.4.4. Note that funding for Treatment provided to Clients Resident outside the Specified Area as described in Part B Clause 3.4.3 above will be considered to be a cross boundary flow. ACC deems a cross boundary flow to be a cost in respect of the Specified Area in which that Treatment takes place EXCEPT that where the Supplier has an agreement which includes more than one Specified Area and the Supplier provides Treatment in one of those Specified Areas for a Client who is Resident outside that Specified Area but who is Resident in one of the other Specified Areas in the Supplier's agreement, funding for that Treatment will be deemed by ACC to be a cost in respect of the Specified Area in which the Client is Resident.

3.5. Admitted Client not Treated by End of Term

Despite any other clause in this Contract, if an Admitted Client has not been discharged from Post Discharge / Post Procedure Care prior to the Date of Expiry or earlier Termination Date, the Supplier shall continue to provide Treatment and ACC shall pay the Supplier for such Services, as if the Contract had not ended.

4. SERVICE LOCATIONS (PART A CLAUSE 4)

4.1. The Supplier will provide Services only at the locations specified in Part A, Clause 4.

4.2. Each Service Location will hold and maintain the certification/accreditation listed at Part A, clause 4.

5. SERVICE REQUIREMENTS

5.1. Commencement and Ending of Services for Client

5.1.1. The Services that ACC purchases may not commence until ACC has approved funding for the Treatment (refer "Funding Approval Process" in Part B Clause 7). The Services end when:

(a) A written Referral of the Client to the original Referrer has been completed following a transfer of clinical responsibility and care; and

(b) Appropriate documentation has been completed (e.g. Referral, Notice of Discharge, Operation Note) and received electronically by ACC.

5.2. Definition of "Services"

"Services" means all and any part of the Treatment and Outpatient Post-Discharge/Post Procedure Care Services described below and other services described elsewhere in this Contract, to be provided for Clients subject to and in accordance with provisions of this Contract, and includes:

5.2.1. All incidental services which a reasonable and responsible supplier of similar services would provide to meet the physiological, cultural, spiritual and social needs of Clients receiving the Services, for example interpreter services

5.2.2. Access to education about prevention and should be focused on rehabilitation consistent with the goals and strategic directions of ACC

provided always that they are Elective Services.

5.3. Treatment

5.3.1. Commencement and Ending

Treatment is initiated by receipt of an ARTP and ACC funding approval pursuant to Part B Clause 7; and ends after Discharge, Referral to Post Discharge/Post Procedure Care or on a Significant Complication Transfer of Care, and when appropriate documentation has been completed and submitted electronically.

5.3.2. Definition of "Treatment"

Treatment includes, but is not limited to:

(a) anaesthetic pre-assessment including completion of a pre-surgical anaesthetic form. Where the Client has co-morbidities the Supplier will ensure that the Client is seen under the Clinical Services contract by a vocationally registered Anaesthetist (preferably the vocationally registered Anaesthetist who will attend the proposed surgery). Where the co-morbidities are identified as requiring services outside the normal services for this type of surgery the Supplier will apply for funding for a Non-Core Procedure in accordance with clause 7;

(b) surgical treatment on an inpatient or day patient basis as is appropriate for the type of treatment, and the circumstances of the Client;

(c) post procedure care before discharge;

(d) delivery of all associated care and treatment by a team of professionals including medical, nursing, physiotherapy, anaesthetist, occupational therapy, social work, technical and (on an inpatient basis only) allied health professionals, as well as Referral to, and assessment by, other types of Suppliers / Providers during the treatment, as required;

(e) all consumables, implants, supplies, standard hotel type costs, transfer costs, laboratory (pathology) tests, diagnostic imaging services, pharmaceutical items (including pre-operative pharmaceuticals), and other associated items to perform the treatment;

(f) availability and use of a range of equipment appropriate to the specialty, level of service and the treatment being provided;

(g) short term Equipment for Independence if required by Clients prior to or on Discharge to achieve a suitable rehabilitation outcome from the treatment, for up to six weeks post-Discharge Date (for example, a shower stool, walking frame, crutches or a wheelchair);

(h) any Orthotics (and any associated Orthoses) if required by Clients prior to or on Discharge to achieve a suitable rehabilitation outcome from the treatment, for up to six weeks post-Discharge Date (for example, splints, shoulder braces);

(i) clinical support services to a level appropriate for the type of treatment to be provided, as outlined in the Guide to Role Delineation of Health Services in New Zealand, Crown Health Enterprise Monitoring Unit (September 1993); and

(j) any administrative matters as would normally be required to allow the Supplier to monitor the outcome of treatment. Recording of service outcomes in clinical notes and/or through internal information systems to allow the Supplier or ACC to evaluate the Service.

5.4. Outpatient Post Discharge / Post Procedure Care

5.4.1. Commencement and Ending

Post Discharge/Post Procedure Care for a Client begins following Discharge from a facility where Treatment has been carried out, and ends six weeks after Discharge. On expiry of the six week period the Supplier will arrange a Referral of the Client from the care of the Provider back to the Client's original Referrer or General Practitioner (whichever is appropriate).

5.4.2. Post Discharge/Post Procedure Care

Post Discharge/Post Procedure Care includes but is not limited to:

(a) any necessary and appropriate follow-up and care by the Provider, other staff or subcontractors to the Supplier, provided in Provider clinics on an Outpatient (but not inpatient or day patient) basis, but excluding services listed under Clause 13;

(b) provision of any short term Equipment for Independence up to six weeks post Discharge Date if not already provided in the Treatment phase; and

(c) any Orthotics (and any associated Orthoses) required for up to six weeks post Discharge Date; and

(d) any necessary administrative matters required by this Contract including, but not limited to:

(i) producing the invoice;
(ii) entering NHI data (if relevant);
(iii) arranging further follow up;

(iv) monitoring outcomes, recording of Service outcomes in clinical notes and/or through internal information systems to allow the Supplier or ACC to evaluate the Service

(e) where the Provider identifies that a Client will require inpatient rehabilitation following Treatment, advising the DHB prior to the transfer and arranging for such inpatient rehabilitation to be provided by the DHB nearest to the Client's home (Note: such inpatient rehabilitation will be provided as a community admission under ACC's contract with DHBs for non-acute inpatient rehabilitation and requires the Rehabilitation supplier to obtain prior approval from ACC).

5.4.3. Further Provider Level Care

(a) If, at the end of the six-week Post-Discharge period, further specialist follow-up care is required, this may be provided only under the Clinical Services contract, or under the applicable regulations.

(b) A further ARTP and funding approval from ACC will be required before the Supplier may proceed with further Treatment for a Client after the six-week Post-Discharge period.

5.5. Resources

The Supplier must have a multidisciplinary team which includes:

5.5.1. A medical team led by a qualified surgeon, with the appropriate level of training and experience. Ideally two surgeons working closely together should form the core of the surgical team in the specialty to ensure adequate backup and opportunity for peer review;

5.5.2. An Anaesthetist who will ensure that pre assessments are undertaken on all Clients using a pre-anaesthetic form; and who will make final recommendations on HDU/ICU access for those Clients deemed to need that level of care;

5.5.3. A nursing team led by a registered nurse with specialised surgical experience;

5.5.4. Theatre staff who are sufficiently skilled to provide the necessary assistance during each surgery to maintain safe clinical practice;

5.5.5. Other allied staff including physiotherapists, occupational therapists, social workers and technicians with appropriate specialty experience and qualifications;

5.5.6. Ongoing staff education programmes or access to education programmes aimed at keeping staff up to date with developments in the field as an integral part of the service;

5.5.7. Access to 24 hour emergency cover provided by qualified staff. Procedures must be in place for people re-presenting with complications following day surgery. Clients will be given written instructions and an explanation of how to gain access to after-hours medical attention in the event of complications arising. All Clients who have had day surgery will be contacted within 24 hours of discharge by a member of the day unit staff;

5.5.8. A contingency plan to maintain continuity of Service in the event of temporary or permanent loss to the Supplier of any key personnel.

5.6. Credentialing Programme

5.6.1. The Supplier will have a credentialing programme which:

(a) is consistent with the Ministry of Health Credentialing Framework for New Zealand Health Professionals 2010 (or any replacement document); and

(b) applies to all Named Providers; and

(c) requires each Named Provider applying for credentialing to provide two referees who:

(i) Practice in a similar scope of practice as the Named Provider; and

(ii) Have recent experience working in a collegial relationship with the Named Provider; and

(d) ensures a Named Provider applying for a credential is able to demonstrate collegial support by:

(i) Identifying the peer group the Named Provider uses to review clinical audit data

(ii) Providing names of local medical personnel who can support the Named Provider in their practice in an emergency situation and for providing backup cover; and

(e) discourages isolated practice; and

(f) provides for collection of data specific to the Named Provider including:

(i) Case mix

(ii) Complications

(iii) Quality and outcome data; and

(g) requires any Named Provider who is an orthopaedic surgeon intending to provide Red List services to provide an independent referee report from an NZOA nominated orthopaedic surgeon with a similar sub-specialty interest to that of the Named Provider.

5.6.2. The Supplier will provide evidence of the credentialing programme and the Named Providers who have been credentialed under the credentialing programme to ACC annually or when there have been any significant changes to the credentialed status of a Named Provider or on request from ACC.

5.7. Electronic Communication

ARTPs, Notices of Discharge, Operation Notes, and Referrals must be received or sent electronically.

6. NAMED PROVIDERS

6.1. Named Providers

6.1.1. Names

The Supplier will utilise the services of only:

(a) the Providers named in Part A Clause 3.1 (the "Named Providers") in the course of providing Services for Clients which are Core Procedures or Non-Core Procedures;

(b) the Providers named in Part A Clause 3.2 (the "Named Red List Providers") in the course of providing Services for Clients which are Red List Procedures.

6.1.2. Addition of Providers

The Supplier may make a written request to ACC for a Provider to be added to the list of Named Providers or the list of Named Red List Providers.

All Named Providers and Named Red List Providers must have vocational registration. Registrars cannot, under any circumstances, be Named Providers or Named Red List Providers. However, Registrars can provide Treatment under the direct supervision of a Named Provider in accordance with the policies and

protocols that exist within the facility within which the Treatment is being given.

ACC may in its sole discretion accept or decline each such request with or without conditions, by providing written notification to the Supplier.

If a request is accepted under this clause, the Provider shall be deemed added to the list of Named Providers or the list of Named Red List Providers, whichever is applicable, from the date of ACC's written notification to the Supplier.

6.1.3. Proper Consideration

If the Supplier is approached by a properly qualified Provider seeking the Supplier's support to be included in the list of Named Providers, the Supplier must give reasonable and proper consideration to that request in accordance with the law including, without limitation, the Commerce Act 1986.

6.1.4. Removal of Providers

Either party may provide written notification to the other party that a Named Provider or a Named Red List Provider is to cease to be a Named Provider or a Named Red List Provider under this Contract. The Provider shall be deemed to cease to be a Named Provider or a Named Red List Provider 5 (five) business days after receipt of the notice. ACC shall not issue such a notice arbitrarily.

6.1.5. Named Red List Providers

Each Named Red List Provider may only provide Red List services for Clients whose personal injury relates to that Provider's selected sub-speciality or sub-specialities as listed in Part A Clause 3.2.

A Provider may only be named as a Red List Provider if the Provider has successfully completed the appropriate process as required by ACC. This process may change from time to time and is outlined on ACC's Provider Website.

7. FUNDING APPROVAL PROCESS

7.1. Application for ACC Funding Approval

7.1.1. Process Limited

An application for funding approval, except for a Treatment Injury Procedure, may be made only for Core or Red List Procedures which are included in Part A Clause 5 or for Non-Core procedures in accordance with Part B Clause 7.1.4.

An application for funding approval for a Treatment Injury Procedure may be made under this Contract only in accordance with Part B Clause 7.1.5.

The Supplier will not accept any Referrals that are not approved by ACC in accordance with Part B Clause 7.1.3 to 7.1.5.

7.1.2. Approval Process

The Supplier will forward the following information to the Treatment Assessment Centre, Dunedin (formerly known as the Elective Services Centre) for all applications for funding approvals under this Part B Clause 7:

(a) The ARTP;

(b) The date that the Supplier received the ARTP;

(c) Contract number of this Service Schedule;

(d) Proposed month for the Procedure;

(e) Any other information reasonably required by ACC.

The Supplier will forward this information in electronic format. The list of

appropriate electronic addresses is available on ACC's Provider Website.

The Supplier will use the ARTP document on the ACC Provider website. This is the only version that will be accepted by ACC.

ACC will then determine the application in accordance with Part B Clauses 7.1.3 to 7.1.5 as applicable.

7.1.3. Core or Red List Procedure Approval Process

ACC will consider the Client's cover and entitlement upon receipt of an application for funding approval. ACC will advise the Supplier and Client in writing of its funding decision, and if approved, the approval number and any change in the Priority Category.

Part A Clause 5 contains the agreed prices for Red List Procedures. In addition to the agreed prices, the Supplier may submit a quotation for the price prior to the Procedure or submit an invoice for the Procedure using the codes and descriptions in the Additional Resources list on the ARTP.

Where the main component of a Procedure is equivalent to a Core Procedure but additional service items are required (examples of additional service items may include, but are not limited to, 2nd Surgeon Consultant, extra ward stay, HDU care if deemed clinically appropriate), the Supplier must apply for the approval of the procedure, or invoice the procedure, as a Core Procedure with the additional service items listed as ESR units.

If the Supplier applies for approval of price prior to a Procedure where the main component of a Procedure is equivalent to a Core Procedure but additional service items are required, the Supplier must provide clinical information with these requests to support costs. ACC may decline an application for approval as a Non-Core Procedure and approve the Procedure as a Core Procedure with additional service items,

If the Supplier submits an invoice for a Procedure as a Non-Core Procedure where the main component of a Procedure is equivalent to a Core Procedure but additional service items are required, the Supplier must provide clinical information with the invoice to support costs. ACC may decline to pay an invoice for such a Procedure as a Non-Core Procedure and instead approve and pay for the Procedure as a Core Procedure with additional service items,

The Supplier will forward the following information to the Treatment Assessment Centre, or such other location advised by ACC, in addition to the information required under Part B Clause 7.1.2:

Any additional information, including reports, for the purposes of considering the Client's cover and entitlement to ACC funding or for the purposes of invoice processing.

7.1.4. Non-Core Procedures

(a) Non-Core Procedures Approval Process

When any Non-Core Procedure is recommended the Supplier will forward the following information to the Treatment Assessment Centre, or such other location advised by ACC, in addition to the information required under Part B Clause 7.1.2:

(i) A completed ARTP ensuring the Non-Core Units pricing sheet is completed with an accurate estimate of potential procedure and

implant costs;Any additional information, including reports, reasonably requested by ACC for the purposes of considering the Client's cover and entitlement to ACC funding or for the purposes of invoice processing.

(b) ACC will advise the Supplier and Client in writing of its funding decision, and if approved, the approval number and any change in the Priority Category.

7.1.5. Treatment Injury Procedures

When a Treatment Injury Procedure is recommended the Supplier will forward to the Treatment Assessment Centre or such other location advised by ACC, in addition to the information required under Part B Clause 7.1.2:

(a) Such information as is required in accordance with Part B Clauses 7.1.3 to 7.1.4 (whichever category the proposed Treatment Injury Procedure falls into);

(b) Notification that the Procedure for which funding approval is sought is a Treatment Injury Procedure.

On receipt of an application for funding approval for a Treatment Injury Procedure:

(a) ACC will process the application in accordance with Part B Clauses 7.1.3 to 7.1.4 (whichever category the proposed Treatment Injury Procedure falls into);

(b) If ACC approves the application the Supplier will receive confirmation from ACC that ACC will pay the price approved or agreed with the Supplier in accordance with Part B Clauses 7.1.3 to 7.1.4 (whichever category the proposed Treatment Injury Procedures falls into) if cover is subsequently granted to the Client in respect of the injury which is the subject of the Treatment Injury Procedure

7.2. If Funding Approved

7.2.1. On receiving ACC's advice that funding has been approved, the Supplier will promptly contact the Client to arrange a mutually appropriate date for Admission or attendance for Treatment. When that date has been agreed, the Supplier will confirm the booking in writing to the Client.

7.2.2. If ACC advises the Supplier that funding has been approved for a Procedure under Part B Clause 7.1.4 and the Supplier and ACC are unable to negotiate a price for the Procedure; ACC will require the Supplier to Refer the Client to another supplier approved for the purpose by ACC.

7.3. If Funding Declined

If ACC advises the Supplier that funding has been declined the Client will not be eligible for Services, and payment will not be made to the Supplier, under this Contract.

7.4. Retrospective Funding Approval for Alternative Unanticipated Treatment Or Alternative Treatment

7.4.1. Application of Clause

This clause will apply if, on commencing a Procedure approved by ACC under Part B Clauses 7.1 and 7.2, a Provider concludes, for clinical reasons, that an alternative unanticipated Procedure or an alternative Procedure is necessary and is more appropriate for the treatment of the Client's personal injury for which cover

has been accepted by ACC under the AC Act 2001.

If a Provider reaches this conclusion, the alternative unanticipated Procedure or alternative Procedure may be carried out, and the Supplier may forward to ACC a detailed invoice and application for retrospective funding approval as described in Part B Clause 7.4.2.

7.4.2. Application

Such an application for retrospective funding approval must include:

(a) Name and details, including MBS-E Code, of the alternative unanticipated Procedure or alternative Procedure;

(b) Clinical reasons, and any other reasons, why the alternative unanticipated Procedure or alternative Procedure was necessary and more appropriate;

(c) Any other information ordinarily required from the Supplier to enable ACC to complete the approval process.

7.4.3. Consideration of Application

ACC will:

(a) Consider such an application as if the alternative unanticipated Procedure or alternative Procedure had not yet been carried out, in accordance with all applicable provisions of this Contract;

(b) Advise the Supplier in writing of ACC's decision regarding ACC funding for the Treatment. The advice will be deemed to have been received by the Supplier 2 (two) business days after dispatch from ACC by courier or fax, and will be effective from the date the Procedure was performed.

7.4.4. Prices

This Part B Clause 7.4.4 applies if ACC approves the unanticipated Procedure.

(a) If the alternative unanticipated Procedure or alternative Procedure is listed in Part A Clause 5 ACC will pay the price provided for that Procedure in Part A Clause 5.

(b) If the alternative unanticipated Procedure or alternative Procedure is:

(i) Not listed in Part A Clause 5; and
(ii) A Procedure on ACC's Core Procedure List,
ACC will pay the Market Price for the Procedure.

(c) If the alternative unanticipated Procedure or alternative Procedure is:

(i) Not listed in Part A Clause 5 and
(ii) Not a Procedure on ACC's Core Procedure List,

The Supplier will forward a completed Non-Core Units table (from the ARTP form) to the Treatment Assessment Centre, or such other location advised by ACC, and ACC will negotiate with the Supplier about what price to pay in respect of the Procedure.

7.5. No Payment Outside Approval Process

ACC will not pay the Supplier for any Treatment or Post Discharge/Post Procedure Care where Treatment is carried out prior to funding approval, or, in respect of a Treatment Injury Procedure, where ACC has not subsequently granted cover for the injury.

7.6. Funding Approval Lapses

7.6.1. Where the Client has not been Admitted within twelve months of the date of ACC's decision to approve funding, the funding approval will lapse. A new ARTP must be submitted to request further approval.

7.6.2. ACC will not pay the Supplier for any Services provided to Clients when Part B Clause 7.6.1 applies unless a new ACC funding approval has been received.

8. PRIORITY CATEGORY TIMEFRAMES AND DEFINITIONS

8.1. The Supplier will ensure that any recommended Treatment for a Client, will be completed within:

8.1.1. the Priority Category timeframe described in the Client's ARTP (specified as "High" if the Client meets one or more of the criteria set out in Part B Clause 8.2 (a) to (d) or leaving blank if "Routine" Priority Category) measured from the date of ACC's decision to approve funding; or

8.1.2. such earlier time as ACC may advise, if the Priority Category changes pursuant to Part B Clause 8.2 below.

8.2. ACC Input into "Priority Category" for Treatment

ACC may request a change to the Client's Priority Category if the Client meets, or no longer meets, one or more of the following criteria:

(a) The Client's current condition is likely to deteriorate rapidly if the proposed treatment is not carried out within 30 days;

(b) The Client is at risk of losing their job because they are unable to continue in paid employment while waiting on the requested treatment and the proposed treatment is likely to reverse/improve the relevant loss of function;

(c) The Client was employed at the time of the accident and is receiving weekly compensation from ACC;

(d) The Client will require paid assistance (home help or attendant care) to assist with activities of daily living if the proposed treatment is not carried out within 30 days.

8.3. Monitoring of Priority Category Timeframe Requirements

The ability of the Supplier to meet Clinical Priority timeframe requirements is a critical factor in the contract monitoring framework.

8.4. Notification of Failure to Meet Priority Category Timeframe Requirements

Where:

8.4.1. ACC and the Supplier are unable to agree on a change to the Priority Category following a request by ACC under Part B Clause 8.2 above; or

8.4.2. the Supplier is not able to meet, or foresees that it may be unable to meet, the Clinical Priority timeframe for a Client or Clients;

The Supplier will immediately notify the Case Manager responsible for each particular Client and/or the Treatment Assessment Centre. ACC may, at its sole discretion, either endeavour to agree with the Supplier and the relevant Client an extension of the Clinical Priority timeframe, or, work with Suppliers to make alternative arrangements for the Treatment of the Client.

9. SIGNIFICANT COMPLICATION TRANSFER OF CARE

IN THE EVENT A CLIENT SUFFERS A SIGNIFICANT COMPLICATION AFTER ADMISSION, THE SUPPLIER WILL:

9.1.1. Arrange a Significant Complication Transfer of Care;

9.1.2. Report to the Case Manager in accordance with Part B Clause 10.3; and

9.1.3. Be entitled to charge ACC in accordance with Part B Clause 18.6.

10. DISCHARGE INFORMATION

10.1. Notice of Discharge

10.1.1. Purpose

The purpose of a Notice of Discharge is to provide ACC with information on individual Clients, to monitor the completion of Treatment and to provide evidence of appropriate co-ordinated discharge planning.

For the avoidance of doubt, in the event of staged episodes of Treatment requiring more than one Admission, a Notice of Discharge is required in relation to each discrete surgical episode.

10.1.2. To Whom

ACC may require a Notice of Discharge in terms of Part B Clause 10.1.4 to be sent by the Supplier in electronic form. If required, relevant information regarding Treatment is to be sent to the original Referrer and the Client's General Practitioner (where the General Practitioner is not the original Referrer).

10.1.3. Time Limit

A Notice of Discharge, if required, is to be received by the recipients listed in Part B Clause 10.1.2 above, within 2 (two) business days of Discharge of each Client.

10.1.4. Contents

A Notice of Discharge must contain the following information about a Client:

(a) Client name, date of birth and address;

(b) ACC claim number;

(c) Injury diagnosis;

(d) The name of the responsible Provider;

(e) Name and MBS-E Code for the Procedure for which the Client was Admitted as well as any unintended surgery/Procedure or Treatment that was required and/or any special unexpected difficulties or Significant Complication encountered;

(f) Date of Admission;

(g) Date of Discharge or transfer; and

(h) Information on arrangements for support, community and Outpatient treatments and follow up consultations; and

(i) The expected date for return to work and/or normal activities of daily living.

10.2. Referral for Support Services on Discharge

Where the Supplier identifies that a Client requires home and community support services after discharge the Supplier will submit a completed Referral for Support Services on Discharge form (ACC705) to the nearest ACC Short Term Claim Centre as soon as the need is identified. Consideration of post-Discharge needs will commence at Admission.

10.3. Significant Complication Transfer of Care

If a Significant Complication Transfer of Care occurs, the Supplier will, within 2 (two) business days, send a written report to the Case Manager, the original Referrer, and the Client's General Practitioner (where the General Practitioner is not the original Referrer) which identifies the Client and describes the Significant Complication and subsequent steps taken by the Supplier (including the Transfer of Care). If the Transfer of Care occurred prior to Discharge, this report will be accompanied by a Notice of Discharge.

11. CONTRACT AMOUNT

11.1. Maximum Payable for Services Under This Contract

11.1.1. Contract Amount

The amount specified in Part A Clause 2.1 ("the Contract Amount") will be the maximum total amount payable under this Contract for all Services (excluding Implants) provided under it, notwithstanding any other provision of this Contract or the relevant period specified in Part A Clause 2. Before the end of any period specified in Part A Clause 2, ACC will notify the Supplier of the Contract Amount for the next period. This notification will have the effect of adding the Contract Amount for that period to Part A Clause 2 but will not require a variation of this Contract.

Where the Supplier is providing Services in more than one Specified Area, the amount payable in respect of Services in any Specified Area (excluding Implants) is limited to the amount shown for that Specified Area in Part A Clause 2.2, notwithstanding the maximum total Contract Amount shown in Part A Clause 2.1.

Prices for Implants required during Procedures will not form part of the Contract Amount nor be subject to any maximum amount payable.

11.1.2. Estimated Maximum Monthly Instalments

(a) The Supplier will provide an estimate of maximum amounts of monthly instalments (excluding Implants) that will be invoiced to ACC during each month for Services under this Contract (the "Instalment Table").

(b) The Supplier will provide the Instalment Table to ACC:

(i) By 30 April 2017 for the period from 1 May 2017 to 30 June 2018.

(c) The Supplier may apply to ACC to vary the current Instalment Table at any time and, if ACC agrees, the Instalment Table will be amended as agreed in writing.

11.1.3. Distribution of Volume/Price to Correspond with Instalment Table

Upon the basis that ACC forwards to the Supplier (under Part B Clauses 7.1.2 and 7.1.3) sufficient numbers of funding approvals for Treatment at times that will enable this, the Supplier will provide the Services such that the distribution of volume and price across each month of the Term of this Contract will result in amounts of monthly instalments invoiced to ACC for Services (excluding Implants) that are equivalent to the corresponding maximum monthly instalments specified in the Instalment Table EXCEPT THAT in any Quarter the Supplier may provide the Services such that the distribution of volume and price will result in amounts of monthly instalments invoiced to ACC for Services (excluding Implants) that are equivalent to no more than 110% of the total of the corresponding maximum monthly instalments for that Quarter specified in the Instalment Table.

If the Supplier invoices ACC for Services (excluding Implants) in any Quarter that are greater than 100% but no more than 110% of the total of the corresponding maximum monthly instalments for that Quarter specified in the

Instalment Table the Supplier will:

(a) advise ACC of this by the last business day of the month following the end of the Quarter; and

(b) take all required steps to reduce its invoicing for Services (excluding Implants) to ACC so that by the end of the following Quarter, the Supplier's total invoiced amount for Services (excluding) provided in both Quarters is no more than the total of the corresponding maximum monthly instalments for the two Quarters specified in the Instalment Table taking into account any previous months underspend.

Prices invoiced to ACC will be recorded in respect of the monthly instalment for the month of the Client's Discharge Date, regardless of when the invoice is raised or received by ACC.

11.1.4. Reduction of Contract Amount

If, for any reason:

(a) the Term of this Contract ends prior to the Date of Expiry (by early termination under Clause 20 of the Standard Terms and Conditions, or otherwise); or

(b) the Supplier at any time during the Term of this Contract:

(i) is unable to procure the services of a material number of the Providers (original or substituted) named or added under Part B Clause 6.1; or
(ii) loses access to facilities material to the provision of the Services under this Contract; or
(iii) invoices the Services (excluding Implants) for any Quarter an amount that is greater than 110% of the total of the corresponding maximum monthly instalments for that Quarter specified in the Instalment Table; or

(c) such as legislative or Government policy changes, there is a reduction in the number of new claims receiving Services under this Contract or if ACC is able to forecast such a reduction;

then ACC, at its sole discretion, may correspondingly reduce the Contract Amount, and the estimated maximum monthly instalments payable for the remaining Term.

11.2. Manage Case Mix

The Supplier shall manage its case mix to optimise its efficiencies, subject to complying with the requirements of the Clinical Priority timeframes and other requirements of this Contract.

11.3. Sufficient Resources

In any event, the Supplier will take sufficient steps to ensure that, subject to receiving sufficient funding approvals, physical and human resources will be available to complete Services (excluding Implants) equating to the entire Contract Amount by the end of the Term of this Contract

11.4. No ACC Obligation to Ensure Minimums

However, despite anything stated or implied in this Schedule, ACC is under no obligation to forward funding approvals for Treatment to the Supplier so as to enable any minimum number of Procedures to be carried out over the Term of this Contract or any part of it or to ensure that all or any part of the Contract Amount, maximum monthly instalments, Implant prices or any of the Procedure prices become payable to the Supplier at any time or at all.

12. SERVICE SPECIFIC REQUIREMENTS

12.1. Organisational Quality Standards

In addition to the requirements specified in Clause 27 of the Standard Terms and Conditions, the Supplier will meet the following requirements:

12.1.1. Hold current certification with the Ministry of Health under the Health and Disability Services (Safety) Act 2001; and/or

12.1.2. If not required by the Ministry of Health to hold current certification with the Ministry of Health under the Health and Disability Services (Safety) Act 2001, hold current accreditation with the NZS8164:2005 Standard for Day-stay Surgery and Procedures

12.1.2.1. Suppliers who only hold accreditation under NZS8164:2005 are also required to provide ACC with the following:

12.1.2.1.1. Policies/protocols for the transfer of patients who require overnight or high level care that is not available at the facility; and

12.1.2.1.2. Evidence of how the Supplier ensures policies and procedures minimise the risk of infection (i.e. compliance with the NZS 8134.3.2008 Health and Disability Services (Infection Prevention and Control) Standards)

12.1.3. Have comprehensive written policies, protocols, guidelines and procedures that guide staff in all aspects of the provision of clinical services;

12.1.4. Have a Quality Improvement Programme that includes collection of a Patient Reported Experience Measure as described in Part B Clause 15.1;

12.1.5. Ensure that Services are provided in accordance with the Health & Disability Sector standards (Code of Health and Disability Services Consumers Rights 1996);

12.1.6. Ensure that only Named Providers who are working within their vocational scope of practice, and that hold a current certificate of practice, provide services.

12.1.7.

The Supplier will provide ACC, upon request, with evidence that these requirements are met.

12.2. Budget Management

12.2.1. The Supplier will stay within their allocated Contract Amount in accordance with their estimated maximum monthly instalments. ACC will monitor spend by quarterly review of performance to budgets and provide monthly updates of spend reports to align performance to budget, as required.

12.3. Philosophy

The following underlying philosophies apply to this service specification:

12.3.1. Package of Care – the Supplier will provide all necessary and appropriate services deemed necessary to carry out the Service as a package of care for the total price set out in this Contract for the applicable Procedure from the time of a Client's first visit to the Supplier's facility through the operative and day stay or inpatient stay until six weeks from that date of discharge.

12.3.2. Multi-disciplinary Management - the Supplier will have a multidisciplinary team of clinicians who jointly treat and assess Clients.

12.3.3. Minimally Invasive Techniques - ACC encourages the recommendation and use of minimally invasive techniques.

12.3.4. Increase in Day Surgery – ACC supports the trend towards a greater proportion of surgery being undertaken on a day case basis where this is clinically appropriate.

12.3.5. Referrals to and from other Providers – the important role of consultation and access to a second opinion are acknowledged and unnecessary barriers to these should be avoided.

12.3.6. Financial Access to Services – no co-payment will be charged to a Client for the Services provided under this Contract.

12.3.7. Reduced Length of Stay – ACC supports reduced length of stay. Where appropriate, home care arrangements shall be made available where patient safety is not risked.

13. EXCLUSIONS

13.1. The following Services are not purchased under this Service Schedule but may be purchased by ACC under other contracts or under Regulations, if required:

13.1.1. Client and escort transport and escort accommodation costs as a result of the provision of Assessment or follow-up Treatment;

13.1.2. Home-help provision;

13.1.3. Attendant Care;

13.1.4. Childcare;

13.1.5. Outpatient allied health follow-up care (post Discharge Date);

13.1.6. Long term Equipment for Independence or Orthotics (i.e. Equipment for Independence or Orthotics which will be required for longer than six weeks post Discharge Date);

13.1.7. Prosthetics (i.e. artificial limbs);

13.1.8. Diagnostic imaging services required after Discharge Date;

13.1.9. Outpatient and community nursing services

13.1.10. Inpatient rehabilitation following Treatment and

13.1.11. Pharmaceuticals required after Discharge.

14. PERFORMANCE MEASURES

The performance measures in Table 4 represent initial key service areas that ACC will monitor to help assess service delivery. It is anticipated that the performance measures will evolve over time to reflect collective priorities. Feedback on performance measures will be through the Engagement and Performance Manager network to allow the Supplier the opportunity to address any areas of concern.

Table 4 – Performance Measures

Total volume	Measure
1. Volume of ACC surgeries performed by	(a) 75% of High priority surgery is provided

Total volume	Measure
Supplier	within 1 month of the date of ACC's decision to approve surgery; (b) 80% of Routine priority surgery is provided within 6 months of the date of ACC's decision to approve surgery
Measure of surgeries performed by body site	(a) Average days by facility and surgeon for High priority surgery to be undertaken post approval; (b) Average days by facility and surgeon for Routine priority surgery to be undertaken post approval.

Where there are factors outside the control of the Supplier which impact on the Supplier's ability to meet these targets, then the Supplier and ACC may agree in writing to amend or waive these targets for a specified period.

15. QUALITY INDICATOR REPORTING REQUIREMENTS

15.1. The Supplier will submit a Biannual report against the Quality Indicators set out in the ACC Elective Surgery Quality Indicators Manual (the Manual) by the relevant date for each indicator. ACC will email a copy of the manual to the supplier. A summary of these Quality Indicators is outlined in Table 5 below. In the event of any dispute or disagreement between the definition of the Quality Indicator outlined in Table 5 and the Quality Indicators set out in the Manual, the Quality Indicators in the Manual takes precedence).

15.1.1. Reporting requirements (including where to send reports, format for reporting and frequency) are contained within the Manual.

15.1.2. ACC acknowledges the Supplier may require some time to establish systems to be able to collect and report on all the information outlined in the table below and the Manual. Where this is the case, the Supplier can supply the minimum information as outlined in Table 5 below. If the Supplier is unable to meet any of the report requirements/or timeframes the Supplier will advise their Local Engagement and Performance Manager in the first instance.

15.1.3. Where applicable, ACC will collaborate with other Government Agencies to support the Supplier and ACC quality indicator reporting. This is on the basis the Supplier has provided the same information to the Government Agency (or Agencies), has agreed to allow ACC to access this information and is consistent with the Quality Indicators set out in the Manual.

15.1.4. Feedback on performance against Quality Indicators will be through the Engagement and Performance Manager network to allow the Supplier the opportunity to address any areas of concern.

Table 5 – Quality Indicator Reporting

No.	Quality Indicator	Frequency	When
1.	Access to elective surgery by clinical priority	6 monthly	Reported by ACC.
2.	Unplanned or unexpected returns to the operating room during same patient admission.	6 monthly	22nd January 2018* 20th July 2018
3.	Cancellation of elective surgery by the hospital	6 monthly	

No.	Quality Indicator	Frequency	When
	during admission.		* Please note, the first report will cover 8 months due to the term of this contract (beginning 1 May 2017)
4.	Unplanned or unexpected transfers to a higher level of care or for additional diagnosis and treatment	6 monthly	
5.	Day Stay surgery turns into unplanned overnight stays	6 monthly	
6.	Perioperative deaths before discharge	6 monthly	
7.	Patient reported experience measure	Annually	20th July 2018

15.2. Feedback Reporting

15.2.1. ACC will work with the Supplier on the quality of the data and any feedback reporting following the reporting periods.

15.3. Reports required under this Service Schedule will be provided in accordance with Table 6 – Reporting Requirements

Table 6 – Reporting Requirements

Information	Explained in	Responsibility	To go to	By when
Notice of Discharge	Part B Clause 10.1	Supplier	Treatment Assessment Centre, or such other location advised by ACC Original Referrer and Client's GP (where the GP is not the original Referrer)	Within two business days of Discharge
Invoice and Operation Note	Part B Clause 18.10 and 18.11	Supplier	Treatment Assessment Centre or such location advised by ACC	In accordance with Part B Clause 18.10 and 18.11
Performance Measures	Part B Clause14	ACC	Shared with Supplier via Engagement and Performance Manager	Quarterly
Quality Indicator Reporting	Part B Clause 15.1	Supplier	ACC	In accordance with Table 5 Clause 15.15
Significant Complication	Part B Clause 10.3	Supplier	ACC	Within two business days of a Significant Complication
Accreditation and Compliance	Part B Clause 12.1	Supplier	ACC	Upon request by ACC

16. OPERATIONAL CONTACT

16.1. During the Term of this Contract the Supplier will nominate a person (as specified in Part A, Clause 7) to be the main contact for ACC who will:

16.1.1. Have primary responsibility for relationships with ACC and the operation of this Service on a day to day basis;

16.1.2. Be proactive in informing ACC of issues with provision of Services as outlined;

16.1.3. Raise issues and suggest solutions regarding this Service;

16.1.4. Ensure that the Service is operated in accordance with this Service Schedule;

16.1.5. Represent the Supplier in discussions on performance; and

16.1.6. Ensure that ACC is advised promptly when the person's contact details change.

17. RELATIONSHIP MANAGEMENT

17.1. To ensure the continuing effective operation of the service, formal working relationships are to be maintained as defined in Table 3 – Relationship Management.

18. PRICES, PAYMENT AND INVOICING

18.1. The table in Part A Clause 5 contains the Procedures that may be performed under this Contract, and the agreed purchase price for each. ACC agrees to pay the prices set out in Table 1 – Service Items and Prices for Procedures provided in accordance with this Contract.

18.2. Any Implant required during a Procedure may be charged for in addition to the purchase price in accordance with Part B Clause 18.8 below.

18.3. The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, the Client or other person for Services under this Contract.

18.4. Applicable Price

The Supplier will invoice ACC for Services provided to a Client using the Prices that applied on the Client's Discharge Date following Treatment.

18.5. Prices of Multiple Procedures per Theatre Session

If two Procedures are carried out or are to be carried out during the same theatre session, the total price for all such Procedures will not be the sum of the prices of the respective Procedures shown in Part A Clause 5 but will be:

(a) the price of the most expensive of the Procedures; plus

(b) 40% of the price of each of the other Procedure/s.

If three or more Procedures are carried out or are to be carried out during the same theatre session, the total price for all such Procedures will not be the sum of the prices of the respective Procedures but the Procedures are deemed to be a Non-Core Procedure and the price will be agreed in accordance with the process set out in Part B Clause 7.1.4. Where a Procedure forms part, or is a subset, of a more comprehensive Procedure, ACC will only pay for the more comprehensive Procedure

18.6. Significant Complication

At the point of a Significant Complication Transfer of Care (whether internal, or to another supplier), charges to ACC for Treatment will cease. If, at this point, the Supplier

had not completed all Services for a Client, the Supplier shall be entitled to charge a pro-rata proportion of the relevant Procedure price/s.

The proportion will take into account such factors as the length of time and level of resources committed to the Client. The proportions and prices shall be agreed with the Client's Case Manager, or the Treatment Assessment Centre, prior to submitting an invoice.

If agreement cannot be reached within a reasonable period of time, the dispute shall be referred to the Supplier's Contracts Manager and the delegated manager within the Treatment Assessment Centre for resolution. If the dispute is unable to be resolved at that level within a reasonable period of time either party can refer the dispute for resolution under the procedures described in Clause 19 of the Standard Terms and Conditions.

18.7. Treatment Injury Procedure

Where funding approval has been given for a Treatment Injury Procedure under Part B Clause 7.1.5 the price approved for that Treatment Injury Procedure will not be paid by ACC to the Supplier unless ACC subsequently approves the claim for cover for the injury in respect of which the Treatment Injury Procedure was undertaken.

18.8. Implants Price in Addition To Procedure Price

18.8.1. Evidence of Cost

(a) ACC will pay the Supplier's cost price. Documentary evidence of the cost is required if the total cost of the Implant/s used for a Client is $8,000 or greater (excluding GST). Documentary evidence will include but is not limited to the invoice on which the Supplier pays for the Implant/s or the Supplier's agreed schedule of Implant prices

(b) ACC, at its discretion, may audit the price of any Implants in accordance with this Contract.

18.8.2. Supplier to Minimise Implant Cost

The Supplier is obliged to minimise the cost of Implants having regard to issues of quality and performance and shall demonstrate that it has made all reasonable enquiries of the market when required by ACC. The Local Engagement and Performance Manager may wish to discuss or review existing process or policies that the Supplier has put in place to minimise or work towards minimising the cost of Implants.

18.9. GST Invoice

18.9.1. The Supplier is entitled to raise a separate GST invoice for each Client following the completion of the service. To ensure efficient payment processing by ACC, this invoice will contain information consistent with that received in the ACC purchase order which initiated the Service, particularly with regard to service codes.

18.9.2. The GST invoice will be in the form of XML transactions transmitted to ACC either directly or using the XMLBuilder application supplied by ACC.

18.10. The Supplier's invoice will contain the following details

18.10.1. That the invoice is addressed to ACC;

18.10.2. The Supplier's name, address and ACC Supplier number;

18.10.3. The GST number of the Supplier;

18.10.4. The words "Tax Invoice" in a prominent place;

18.10.5. An invoice number;

18.10.6. The invoice date;

18.10.7. The relevant ACC purchase order number;

18.10.8. The name of the Contract and the contract number;

18.10.9. The name and claim number of the Client receiving the Service;

18.10.10. The name of Procedure, MBS-E code and Procedure code for the Procedure (where applicable);

18.10.11. The name of Named Provider(s) delivering the Services and ACC provider registration number;

18.10.12. The name of the facility where surgery was performed;

18.10.13. An itemised list of any unique supplies used, including price; and

18.10.14. The date on which the Service was provided, or if more appropriate, the start and end date, and the length of inpatient stay (where applicable).

The Supplier's invoice may also contain the theatre time for surgical treatment.

18.11. Operation Note

The Supplier will send a copy of the Operation Note for the Procedure with the invoice. The Operation Note will contain all usual details recorded as a matter of good clinical practice including the New Zealand Medical Council number or Dental Council of New Zealand number of the Provider, whichever is applicable.

18.12. Timeframes for Invoicing

An invoice charging for Services incidental to:

18.12.1. Treatment and Post Discharge/Post Procedure Care shall be forwarded with or after any Notice of Discharge has been sent to ACC;

18.12.2. A Significant Complication Transfer of Care shall be forwarded after agreement on the pro-rata Procedure price and with or after the required report/s have been sent to ACC (pursuant to Part B Clause 18.6).

18.13. Payment

Acceptable invoices received by the 5th of the month will be paid on or before the 20th of the same month. Invoices received after the 5th of the month will be paid the following month.

Advice of payment will be forwarded under separate cover, detailing the individual invoices that make up the lodgement.

If any invoices cannot be approved for payment, ACC will advise the Supplier, detailing the reasons why payment cannot be approved, and what steps need to be taken by the Supplier to obtain approval. After these steps have been taken, payment will then be made within 10 business days of approval being given.

ACC will not pay for a Service where the invoice for that Service is not submitted within 12 months of the date the Service was provided.

19. CONTINUOUS SERVICE IMPROVEMENT AND CO-DESIGN

19.1. ACC is committed to continuously improving the quality of services provided to its clients and to achieving its strategic priorities. ACC will seek opportunities to collaborate with Suppliers to refine service delivery using a process of continuous improvement. The Supplier is expected to:

19.1.1. Work in partnership with ACC in refining its services using a process of continuous improvement;

19.1.2. Collaborate with ACC in any service co-design initiatives either initiated by the supplier or ACC;

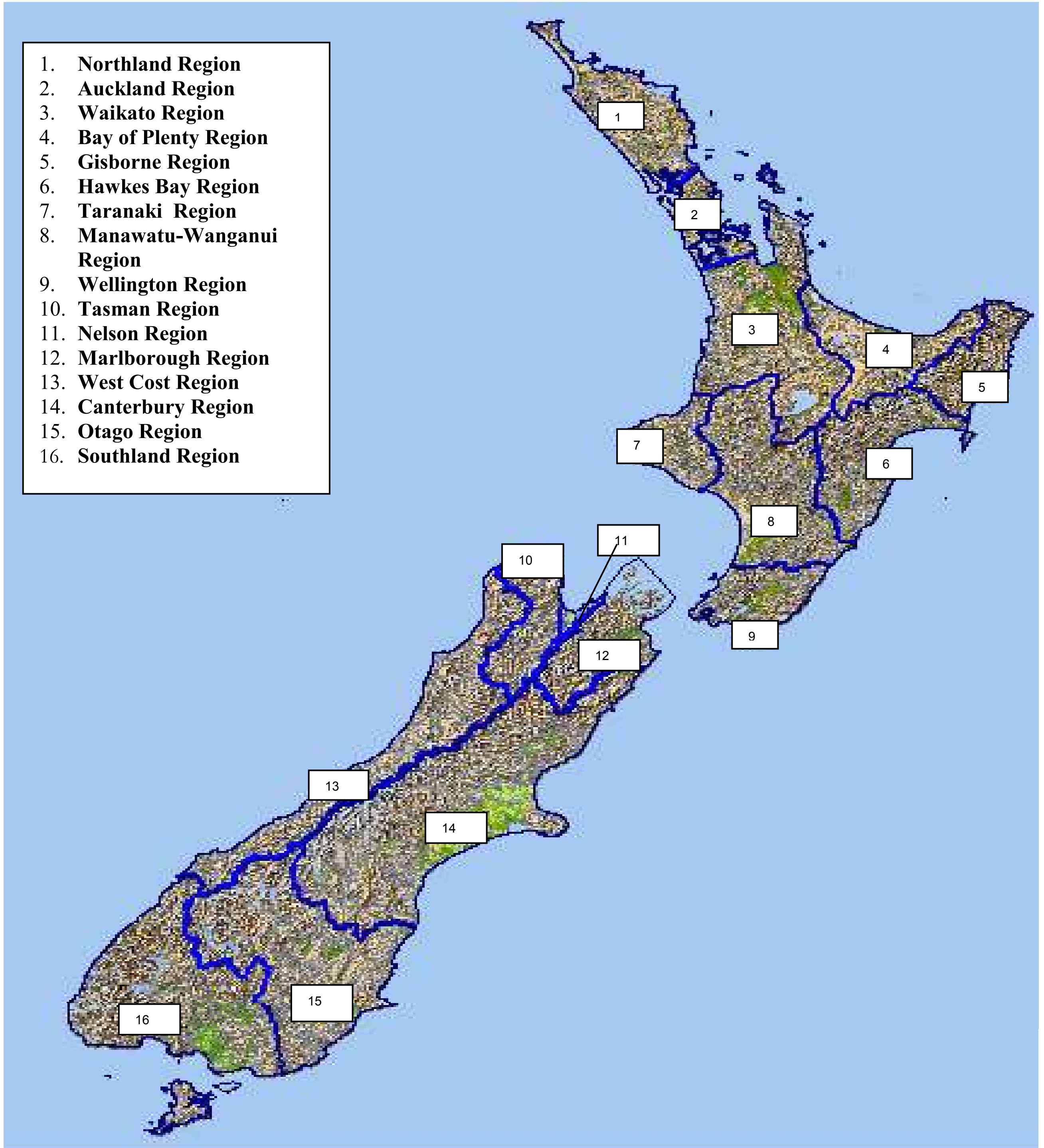
19.1.3. Support ACC to identify innovative ways that contribute towards improved service delivery for its clients;

19.1.4. Complete ACCs annual survey of all Suppliers

20. APPENDICES

APPENDIX ONE

MAP OF SPECIFIED AREAS



APPENDIX TWO

DEFINITIONS

In this Service Schedule, unless the context otherwise requires:

"**ACC Core Procedure List**" means the Procedure List made up of ACC's Core and Red List Procedures set out in the Table of Procedure Prices at Part A Clause 5 which may be updated from time to time;

"ACC Elective Surgery Quality Indicators Manual" means the document referred to in clause 15 as provided by ACC from time to time. This manual is a guide to the set of quality measures that are to be reported to ACC and are intended to provide assurance that ACC's suppliers are providing safe care to ACC clients;

"**ACC's Provider Website**" means the website provided by ACC which contains information for providers, as advised by ACC from time to time. Note that at 1 July 2015 the website is: http://www.acc.co.nz/for-providers;

"**Admission**" means the documentation process by which a person becomes resident in a Health Care Facility; and "Admitted" has a corresponding meaning;

"**Adverse Event**" means an unexpected event which affects the patient's outcome;

"**Assessment Report and Treatment Plan**" and "**ARTP**" is the report completed on the template specified by ACC from time to time, available on ACC's Provider Website, required to have been prepared and signed by a Provider as a result of an assessment of a Client;

"**Community Services**" includes (without limitation) services such as physiotherapy, occupational therapy, speech therapy, orthotics and prosthetics, social work, dietetics, district nursing, personal care, home help and meals on wheels, when those services are provided outside a Health Care Facility setting;

"**Contract Amount**" has the meaning defined in Part B Clause 11.1.1;

"**Discharge**" means the process of documentation that changes the admission status of a Client whereby the Client leaves the inpatient or day patient facilities of the supplier having received Treatment;

"**Discharge Date**" has a corresponding meaning;

"**Elective Services**" means Personal Health Services which are Services in terms of this Contract but which are not "Acute Treatment" or "Public Health Acute Services within the meaning of section 6(1) of the AC Act.;

"**Equipment for Independence**" means a manufactured item that is likely to assist a Client to achieve his or her optimal independence in daily living or which is required by a Client for reasons of safety. Examples include shower stools, crutches, walking frames, wheel chairs, etc;

"**Health Care Facility**" means a place which may be permanent, temporary or mobile (excluding rest homes, supervised hostels, half-way houses and staff residences) which people attend, or are resident in, for the primary purpose of receiving Personal Health Service;

"**High**" means less than one month (but not within seven days of the date the decision was made by the assessing Provider that the Admission was necessary or the date of Referral for treatment by the assessing Provider);

"**Implant**" refers to medical and surgical implant devices or biological items that are placed inside or on the surface of the body. They may replace or supplement body parts or functions, deliver medication, or provide support to organs and tissues. They may be permanent or temporary. Examples may include but are not limited to:

- joint replacement prosthesis
- cement and cement restrictors (**Note:** the further discussion is required with ACC for these items)
- plates, screws, wires, staples, pins
- intramedullary rods and nails
- customised implants (e.g. hip, pelvis, skull, TMJ)

- anchors, tapes, fibre-wires, endo-buttons
- mesh: absorbable and non-absorbable
- allografts: bone, tendon, corneas
- bio-absorbable screws and plates
- bio products used to control bleeding or reduce scarring (e.g. Floseal, Duraseal, Duragen, Tisseel)
- other specialised products - Suture wrap, Integra skin
- intrathecal pumps, nerve stimulators, urinary sphincters, cochlear implants
- breast and testicular implants
- implant specific equipment (where applicable and as required).

"**Implant specific equipment**" refers to specialised, implant specific equipment that is required for either the insertion or removal of the implant. These are normally an integral component of the implant system, are single use items, unique to the implant system and are invoiced as part of the total implants supplier invoice. ACC will currently accept these as part of the implant invoiced costs and they are not classed as part of normal or unique supply costs. Please refer to the Elective Surgery Operational Guideline for more detailed information of what ACC consider as inclusions and exclusion for implant cost. "**Market Price**" means the average agreed price for a particular Procedure of ACC's contracted providers in the relevant Region;

"**MBS-E Code**" means Medical Benefit Schedule – Extended coding which are procedure codes which relate to the ICD10-AM Diagnostic Codes which is the International Statistical Classification of Diseases and Related Health Problems 10th Revision as set out in Appendix Three;

"**Named Provider**" means a Provider listed in Part A Clause 3 and any other Provider deemed added to this Contract pursuant to clause 6.1.2, who has not ceased to be a Named Provider pursuant to Part B Clause 6.1.4;

"**Non-Core Procedure**" means a Procedure which is not on ACC's Core Procedure List and cannot be fairly and reasonably matched to a Procedure on ACC's Core Procedure List;

"**Notice of Discharge**" means the notice required under Part B Clause 10.1 to be provided to ACC upon Discharge;

"**Operation Note**" means the surgeon's record of the procedure performed which is recorded in the patient's hospital file;

"**Orthosis**" means an addition to any existing bodily segment. Examples include splints, shoulder braces etc; and "**Orthoses**" has a corresponding meaning;

"**Orthotics**" means the fitting and fabrication of Orthoses or related technical aids used to support or correct the function of the trunk and upper and lower extremities;

"**Outpatient**" means a patient who is not admitted but receives treatment, therapy, advice, diagnostic or investigatory procedures or pre-admission assessment at a Health Care Facility and who leaves within three hours of the start of consultation;

"**Outpatient Clinic**" means a scheduled administrative arrangement enabling Outpatients to receive Outpatient Services at a Health Care Facility (NZHIS Guide 1996/97 p.66);

"**Outpatient Services**" means Personal Health Services provided to an Outpatient;

"**Personal Health Services**" means goods, services, and facilities provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose; and includes goods, services, and facilities provided for related or incidental purposes (New Zealand Public Health and;

"**Post Discharge/Post Procedure Care**" includes the Services referred to in Part B Clause 3.4;

"**Priority Category**" means the High or Routine category for any recommended Treatment selected by the assessing Provider based on the definitions outlined in Part B clause 8.2 and recorded in the Client's ARTP; or as deemed by ACC based on the same definitions;

"**Procedure**" includes a surgical procedure or service which is included in Part A Clause 5 or is agreed under Part B Clause 7.1.4;

"**Provider**" means either:

1. Medical Practitioner other than a General Practitioner who holds or is deemed to hold vocational registration that is relevant, or, in the reasonable opinion of a General Practitioner, likely to be relevant, to the injury suffered or apparently suffered by the Client; or

2. an oral maxillo-facial surgeon vocationally registered with the Dental Council of New Zealand;

"**Quarter**" means the following periods in each year during the Term of this Contract:

1 July to 30 September, 1 October to 31 December, 1 January to 31 March, and 1 April to 30 June.

"**Red List**" means ACC's list of procedures which ACC categorises under this heading from time to time as being relatively low volume/high cost procedures which are undertaken by Named Red List Providers only at specified facilities and which are denoted as Red List procedures in the Table of Procedure Prices at Part A Clause 5;

"**Referrer**" means the Medical Practitioner or another provider of Personal Health Services who requests that the Provider provide an Assessment of or medical services for the Client and, if appropriate Treatment or, where the context otherwise requires, means the Provider where it requests that a Medical Practitioner accept a transfer of clinical responsibility for a Client or requests that another provider of Personal Health Services provide an Assessment of or medical services for the Client and, if appropriate, Treatment; and "**Referral**" and "**Referred**" have a corresponding meaning;

"**Region**" means one of regions made up of the 16 areas shown on the map at Appendix One as follows:

- Auckland/Northland Region made up of Auckland and Northland
- Waikato/Bay of Plenty Region made up of Waikato and Bay of Plenty
- Bays Region made up of Hawke's Bay and Gisborne
- Central/North West Region made up of Taranaki, Manawatu-Wanganui, Wellington, Nelson,
- Marlborough and Tasman
- Canterbury/West Coast Region made up of Canterbury and West Coast
- Southland/Otago Region made up of Southland and Otago;

"**Resident**" means the Client's usual residential address at the date of consultation as set out in the ARTP;

"**Routine**" means less than six months (but not within seven days of the date the decision was made by the assessing Specialist that the Admission was necessary or the date of Referral for treatment by the assessing Provider);

"**Services**" has the meaning defined in Part B Clause 5.2;

"**Significant Complication Transfer of Care**" means the transfer of clinical responsibility for the care and treatment of the Client because of a Significant Complication in connection with the medical condition of the Client to one of the following (whichever is most appropriate for the Client):

- a DHB; or
- a medical, nursing and ancillary team internally within the Provider, if that complication is within the Provider's expertise and if the Provider is publicly funded by the Ministry of Health to provide the necessary care and Treatment as if they were "public health acute services" within the meaning of the AC Act and without charge to the Client or ACC;

"**Significant Complication**" means a medical complication which arises unexpectedly after Admission and is of such a nature that the Client's clinical priority becomes that of requiring "public health acute services" within the meaning of the AC Act or services or treatment that would be "public health acute services" if provided in a hospital and health service. A Significant Complication is not covered in the Services specified in this Contract. An example of a Significant Complication includes, but is not limited to where a significant medical complication arises unexpectedly, or because of an underlying medical condition that is

not related to an ACC claim (for example, a significant asthma attack that has resulted in a pneumothorax, or a myocardial infarction);

"**Specified Area**" means one of the areas specified at Part A Clause 4, being an area or areas shown on the map at Appendix One;

"**Theatre Time**" means the period of elapsed time (in minutes) from the commencement of the anaesthetic (induction) or entry to the Operating Room to the exit from the Operating Room or transfer to Post Anaesthetic Care Unit. This period does not include time waiting in the anaesthetic room or anteroom, nor does it include the time from insertion of a regional block to entry to the Operating Room;

"**Treatment**" includes the Services referred to in Part B Clause 5.3.2;

"**Treatment Injury Procedure**" means a Procedure for an injury arising out of medical treatment for which a claim for cover for treatment injury or medical misadventure has been lodged with ACC but a decision on cover for that injury has not been made by ACC at the date the application for funding approval is made.

APPENDIX THREE

Clauses which take precedence over Standard Terms and Conditions

For the Services described in this Service Schedule Clauses 10.1 to 10.7 of the Standard Terms and Conditions do not apply. Clause 18 of this Service Schedule applies to Prices, Payment and Invoicing.

SERVICE SCHEDULE FOR CLINICAL SERVICES – INCLUDES IN-ROOMS PROCEDURES

CONTRACT NO: CLSXXXB

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING CLINICAL SERVICES

The Term for the provision of Clinical Services is the period from 1 July 2016 ("Commencement Date") until the close of 30 June 2020 (the "Date of Expiry") or such earlier date upon which the period is lawfully terminated or cancelled.

2. SERVICE LOCATION (Part B, clause 5)

«TLAs».

3. NAMED PROVIDERS (Part B, clause 10)

Last name	First name	Speciality or category of professional registration/ vocational registration	New Zealand Medical Council number or Dental Council of New Zealand number	ACC provider number/HPI	Facility

4. SERVICE ITEMS AND PRICES

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
Clinical Service Assessments							
			CS100	CS10	Simple Assessment (Initial)	$168.14	Per face-to-face consultation
			CS200	CS20	Complex Assessment (Initial)	$257.62	Per face-to-face consultation
			CS250	CS25	Simple Pre-operative Anaesthetic Assessment (Initial)	$168.14	Per face-to-face consultation (**pre operatively only** - Surgical ARTP must be approved prior to this assessment being undertaken)
			CS260	CS26	Complex Pre-operative Anaesthetic Assessment – (Initial)	$257.62	Per face-to-face consultation (**pre operatively only** - Surgical ARTP must be approved prior to this assessment

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
							being undertaken)
			CS400	CS40	Second Opinion Assessment	$168.14	Per face-to-face consultation
			CS500	CS50	Reassessment	$168.14	Per face-to-face consultation
			CS61	CS61	Subsequent Assessment (Simple)	$113.88	Per face-to-face consultation
			CS62	CS62	Subsequent Assessment (Complex)	$168.14	Per face-to-face consultation
			CS70	CS70	Anaesthetic long distance consultation	$58.11	Per Call
			CS83	CS83	Neurophysiological consultation	$475.01	Neurophysiological study and consultation
			CS84	CS84	Simple Neurophysiological Follow up	$158.97	Simple Neurophysiological Follow up and consultation
			CS85	CS85	Complex Neurophysiological Follow up	$475.01	Complex Neurophysiological Follow up and consultation
			CS900	CS90	Second Opinion Assessment (Complex)	$257.62	Per face-to-face consultation
Pre operative Clinical Based Procedures (approved surgical request required)							
			CSD1	CSD1	Echocardiogram (Echo)	$511.65	Per test (**pre operatively only** - Surgical ARTP must be approved prior to this test being undertaken)
			CSD2	CSD2	Stress Echo	$890.37	Per test (**pre operatively only** - Surgical ARTP must be approved prior to this test being undertaken)
			CSD3	CSD3	Respiratory Spirometry	$84.95	Per test (**pre operatively only**- Surgical ARTP must be approved prior to this test being undertaken) In circumstances where this is required in a non pre-operative situation approval must be sought from ACC.
			CSD4	CSD4	Exercise Treadmill	$403.38	Per test (**pre operatively only** – Surgical ARTP must be approved prior to this test being undertaken)
			ECG	ECG	Electrocardiogram	$58.11	Per test (**pre operatively only** – Surgical ARTP must be approved prior to this test being undertaken)
Clinical Service Diagnostic Procedures							
			CSD10	CD10	Flow and residual test	$122.18	Per test in addition to consultation
			CSD40	CD40	OCT scan – unilateral	$210.89	Per test in addition to consultation
			CSD41	CD41	OCT scan – bilateral	$256.65	Per test in addition to

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
							consultation
			CSD42	CD42	Visual Field Test- unilateral	$74.85	Per test in addition to consultation
			CSD43	CD43	Visual Field Test- bilateral	$95.88	Per test in addition to consultation
			CSD44	CD44	Orthoptic assessment - child	$124.67	Per test in addition to consultation
			CSD45	CD45	Orthoptic assessment - adult	$144.21	Per test in addition to consultation
			CSD46	CD46	Fluorescein angiography	$490.59	Per test in addition to consultation
Clinical Service Treatment							
			CST1	CST1	Removal of wire/screws	$19.36	In addition to consultation
			CST21	CT21	Reapplication of plaster casts/thermoplastic splints above knee	$180.76	Per application in addition to consultation
			CST22	CT22	Reapplication of plaster casts/thermoplastic splints above elbow	$150.63	Per application in addition to consultation
			CST31	CT31	Reapplication of plaster casts/thermoplastic splints below knee	$150.63	Per application in addition to consultation
			CST32	CT32	Reapplication of plaster casts/thermoplastic splints below elbow	$130.52	Per application in addition to consultation
			CST4	CST4	Injections or Joint Aspiration	$25.82	In addition to consultation
			CST5	CST5	Isolated Nerve Block	$19.36	In addition to consultation
			CST6	CST6	Regional block (not LA) or compartment pressure monitoring	$129.15	In addition to consultation
Prior Approval required for Second or subsequent epidural injections only.			CST9	CST9	Caudal/Lumbar epidural injection (limit one per claim). Second or subsequent epidural injections require prior approval and requests should be sent on an ARTP to escmednotes@acc.co.nz with the service item code in the subject line.	$548.71	Includes consultation and all consumables for the service.
			CST10	CT10	Complex Injection	$59.79	Per injection and includes consumables.
			CST11	CT11	Closed reduction of displaced/fracture of nasal bones	$612.16	Includes consultation
			CST12	CT12	Flexi Cystoscopy	$660.21	Per Procedure – includes consultation

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
			CST13	CT13	Flexi Cystoscopy (with dilatation)	$910.77	Per Procedure – includes consumables and consultation
			CST14	CT14	Flexi Cystoscopy (with 300 units Botulinum Toxin)	$2,781.65	Per Procedure – includes consultation and 300 units of Botulinum Toxin
			CST15	CT15	Supra Pubic Catheter Insertion	$496.11	Per Procedure – includes consultation
			CST16	CT16	Supra Pubic Catheter Change	$496.11	Per Procedure – includes consultation
			CST17	CT17	Removal of foreign bodies (not eye (under local)	$418.19	Includes consultation
			CST23	CT23	Revision of Scar/s < 5cm	$644.20	Includes consultation
			CST24	CT24	Revision of Scar/s 5-10cm	$971.84	Includes consultation
			CST25	CT25	Revision of Scar/s 10-20cm	$1,221.74	Includes consultation
			CST26	CT26	Minor finger surgery (stump revision/cyst)	$418.19	Includes consultation
			CST27	CT27	Repair/reconstruction of nail bed	$461.98	Includes consultation
			CST28	CT28	Excision post traumatic inclusion cyst	$633.11	Includes consultation
			CST40	CT40	Lid/Adnexa - lid surgery – minor	$690.44	Includes consultation
			CST41	CT41	Removal foreign body - eye	$365.15	Includes consultation
			CST42	CT42	YAG Laser Capsulotomy	$413.30	Includes consultation
			CST60	CT60	Tympanostomy/ Myringotomy	$533.12	Includes consultation
			CST61	CT61	Myringoplasty - simple +/- patch	$1,207.42	Includes consultation
			CST80	CT80	Laser treatment – (for dermatologists and plastics only)	$947.15	Includes consultation
Medical Case Reviews and Medical Single Discipline Assessments							
			CSM1	CSM1	Standard Medical Case Review (MCR) **This service must be requested by ACC.**	$1,051.96	Per Medical Case Review
			CSM2	CSM2	Complex Medical Case Review (MCR) **This service must be requested by ACC.**	$1,562.90	Per Medical Case Review
			CSA1	CSA1	Standard Medical Single Discipline Assessment (SDA) **This service must be requested by ACC.**	$641.45	Price per Medical Single Discipline Assessment
			CSA2	CSA2	Complex Medical Single	$937.08	Per Medical Single

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
					Discipline Assessment (SDA) **This service must be requested by ACC.**		Discipline Assessment
			CSN1	CSN1	Non-attendance fee is payable when a Client fails to attend a scheduled appointment for a MCR without giving two working days prior notification to the Service Provider. The Service Provider must notify the Client's Claims Manager.	$456.75	Per Client (Max 1)
			CSU	Un-booked appointment time	Un-booked Appointment time is payable when a Supplier travels to an area outside their usual service area at the request of ACC and there is an unfilled appointment time within the block booking. Only payable for appointments which are never filled and where the Non-Attendance fee cannot be claimed. Maximum of 4 hours per day.	$132.65	per hour or part thereof

5. RELATIONSHIP MANAGEMENT (Part B, clause 16)

Level	ACC	Supplier	Frequency
Client	ACC Client Service Staff	Individual staff or operational contact	
Branch	Branch Manager	Operational contact	
Region	Designated Engagement and Performance Manager	Operational contact	

6. ADDRESSES FOR NOTICES

NOTICES FOR ACC TO:

ACC Health Procurement (for deliveries)
19 Aitken Street
Wellington 6011
ACC Health Procurement (for mail)
P O Box 242
Wellington 6140
Marked: "Attention: Procurement Specialist"
Phone: 0800 400 503

Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

(insert street address including postcode) (for deliveries)
(insert postal address including postcode) (for mail)
marked: “Attention (contact person)
Phone:
Mobile:
Fax:
Email:

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APPENDIX ONE – DEFINITIONS AND INTERPRETATION

B. SERVICE SPECIFICATIONS FOR CLINICAL SERVICES

1. PURPOSE

1.1. ACC wishes to purchase Clinical Services.

1.2. The purposes of the Service are:

- 1.2.1. To provide face-to-face specialist assessment and treatment services for Clients who have an accepted claim for cover. The assessment must be related to the injury for which the Client has cover and require a specialist opinion; and
- 1.2.2. To restore Clients' health to the maximum extent practicable; and
- 1.2.3. To allow Suppliers to carry out a procedure as part of the assessment (in accordance with Clause 10); or
- 1.2.4. To provide face-to-face specialist assessment for Clients who have an accepted claim for cover or have been referred by ACC for an assessment which may help determine cover; and
- 1.2.5. Determine the cause of a Client's on-going symptoms or condition; and/or
- 1.2.6. Make recommendations for onward investigations, treatment and rehabilitation.

2. SERVICE OBJECTIVES

2.1. ACC will measure the success of this Service based on the following objectives:

- 2.1.1. Clients receive an appropriate and timely assessment and/or treatment service;
- 2.1.2. Every Client other than those referred for a Medical Case Review or Medical Single Discipline Assessment has an Assessment Report and Treatment Plan (ARTP) emailed or sent electronically to ACC that identifies the Client's rehabilitation needs and all options for addressing these needs.
- 2.1.3. Every Client referred for a Medical Case Review or Medical Single Discipline Assessment has an Assessment Report emailed or sent electronically to ACC.
- 2.1.4. Clients receive clinic based procedures which do not require prior approval within 28 days of the Assessment that determined the need for the procedure/s; and
- 2.1.5. ACC receives reports within the timeframes set out in this Service Specification.

3. PROVIDERS OF CLINICAL SERVICES

3.1. Service Providers must be:

(a) Appropriately qualified Medical Practitioners who are registered under the Medical Council of New Zealand who hold a vocational scope of practice in at least one of the following areas;

- Anaesthesia
- Cardiology
- Cardiothoracic surgery
- Dermatology
- General surgery
- Gynaecology
- Internal medicine
- Musculoskeletal medicine
- Neurosurgery
- Occupational medicine

- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Paediatric surgery
- Paediatrics
- Pain medicine
- Palliative medicine
- Plastic and reconstructive surgery
- Rehabilitation medicine
- Sports medicine
- Urology
- Vascular surgery, or

(b) Appropriately qualified Dental Practitioners who are registered under the Dental Council of New Zealand who hold a vocational scope of practice in one of the following areas;

- Oral surgery
- Oral and maxillofacial surgery

3.2. The procedures in this Service Schedule must be carried out by a Specialist who holds the appropriate vocational registration to enable them to provide the procedure. Tables 1-7 of this Service Schedule include the type of treatment providers that can undertake each procedure.

4. SERVICE COMMENCEMENT

4.1. Eligibility for Service

4.1.1. The Supplier will provide Clinical Services Assessments and/or Treatment only to eligible Clients who have been referred to the Supplier in accordance with this Clause 4.

4.1.2. ACC will not pay the Supplier for services provided and/or for time spent with a person who does not fulfil the criteria outlined in Clause 1.2.1, or where funding is not approved in accordance with Part B, Clause 10, or where prior approval (if required) is not received.

4.1.3. Clinical Services may not be provided while a Client's covered injury is being managed acutely by any treatment provider.

4.1.4. Specialist follow up and care provided to an ACC Client within six weeks of the client being discharged from Elective Surgery is covered within the cost of the funding package for the Elective Surgery procedure and will not be invoiced against the Clinical Services contract.

4.2. Referral process

4.2.1. Referrals for all Services except Medical Case Reviews and Medical Single Discipline Assessments may only be received from:

(a) A Vocationally Registered Medical Specialist; or

(b) The Client's General Practitioner; or

(c) Any other "treatment provider" within the meaning of section 6(1) of the AC Act 2001;

(d) ACC

4.2.2. Referrals for Medical Case Reviews and Medical Single Discipline Assessment may only be received from ACC.

4.2.3. ACC will not pay for services where Clients self refer or are referred other than by a treatment provider described in clause 4.2.1. or clause 4.2.2 (whichever is relevant).

4.2.4. The Supplier may decline a referral if:

(a) The Supplier cannot meet timeframes as set out in clause 7.1; or

(b) The Supplier does not have an appropriate medical specialist available in relation to the injury; or

(c) The Supplier considers that the referral is more appropriately managed under the Vocational Medical Services Service Schedule because:

- It includes consideration of a Client's employment as a major factor of the assessment; or
- Assessment by an occupational medicine specialist of work restrictions, limitations, fitness for work, the ability to engage in employment or the ability to participate in vocational rehabilitation is required.

4.2.5. The Supplier will notify the referrer (and the ACC case owner where ACC is not the referrer) if a referral is declined.

4.3. Prior Approval

4.3.1. ACC funding approval is required for the procedures specified below. Provision of the Services must not commence before funding approval has been received from ACC:

(a) Lid/Adnexa – lid surgery – minor (CST40)

(b) Laser treatment (CST80)

(c) Revision of Scar/s (CST23, CST24 or CST25)

(d) Minor finger surgery - stump revision/cyst (CST26)

(e) Excision post traumatic inclusion cyst (CST28)

(f) Tympanostomy/Myringotomy (CST60)

(g) Myringoplasty - simple +/- patch. (CST61)

(h) Caudal/Lumbar Epidural Injections – second or subsequent only (CST9)

4.3.2. Where ACC approval is required the Supplier must submit an ARTP to ACC in accordance with Part B, Clause 10. In addition to the procedures above, ACC may, from time to time, specify by notice and/or on the ACC website that particular Assessment and/or Treatment Services also require prior approval in accordance with Part B, Clause 10.

4.3.3. For Medical Case Reviews and Medical Single Discipline Assessments, ACC will request these directly and will provide confirmation of funding approval in the referrals.

5. FACILITY LOCATION (PART A, CLAUSE 3)

5.1. The Service will be provided in the Supplier's facility/facilities named in Part A Clause 3. Any change to the facility/facilities named in Part A, Clause 3 must be approved by ACC in writing.

6. SERVICE REQUIREMENTS

6.1. The Supplier will provide Clinical Services in accordance with this Service Schedule which include as appropriate components as described in Clause 7.

6.2. Electronic Communication

Where such systems are available, and from a date notified by ACC, referrals must be received or made using electronic referral forms.

7. SERVICE SPECIFIC QUALITY REQUIREMENTS

7.1. In addition to the requirements specified in the Standard Terms and Conditions, the Supplier will:

7.1.1. Provide evidence to ACC on request to confirm ongoing compliance with the Rooms/Office Based Surgery and Procedures New Zealand Standard 8165:2005.

(a) Suppliers undertaking Room Based Procedures are required to provide evidence of accreditation by an external auditor of compliance with the Rooms/Office Based Surgery and Procedures, New Zealand Standard 8165:2005.

7.1.2. Ensure the Initial Assessment occurs within six weeks of receipt of referral. Where the Supplier cannot meet this obligation they must refer the Client to another specialist who has capacity to meet this requirement unless ACC and the Supplier agree a different timeframe.

7.1.3. Ensure the following timeframes are met for Medical Case Reviews and Medical Single Discipline Assessments:

(a) Contact the Case Owner within one business days of receiving the referral

(b) Contact the Client within two business days of receiving the referral

(c) Notify the Case Owner within three business days of receiving the referral in the event the supplier has been unable to contact the Client

(d) Meet with the Client and perform the clinical examination within eight business days of receiving the referral letter unless otherwise agreed with ACC

(e) Notify the Case Owner within one business day if the Client fails to keep their appointment

(f) Provide a copy of the report and invoice to the Case Owner within eight business days from the date of the clinical examination.

7.2. Definition of Clinical Services

"Clinical Services" means all and any part of the Services described in this Service Schedule to be provided to Clients, subject to and in accordance with the provisions of this Agreement.

7.2.1. Clinical Services as set out in Clauses 8.1 and 8.2 provided by the Supplier must include (without limitation):

(a) A clinical history and examination of the Client by a Named Provider or a suitably qualified specialist under the direction of a Named Provider;

(b) A multi-disciplinary perspective to assess aspects of the health of the Client that are directly relevant to determining the most appropriate rehabilitation or treatment options(s);

(c) Arranging access to necessary pathology services and diagnostic imaging services including but not limited to; radiology, MRI and CT scanning, and incorporating the results of those tests in the ARTP;

(d) All nursing assessment and nursing treatment provided at the time of the consultation;

(e) Discussion between the Client and the Named Provider concerning suitable treatment options, including non-surgical (conservative) treatment where

appropriate. Non-surgical Treatment options, where these are likely to be as effective or more effective than surgical treatment options, are to be promoted for that Client unless those non-surgical treatments have been tried and have failed to produce the rehabilitation outcomes desired by the Client and ACC;

(f) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service; and

(g) Appropriate clinical record documentation, including a copy of the ARTP and any referral documentation to support the referral of the Client;

(h) Documentation of referral back to the original Referrer, where the original Referrer is a Medical Practitioner; or on to another Supplier for further treatment.

7.2.2. Medical Case Reviews (as set out in clause 8.3) provided by the Supplier must include:

(a) A review of clinical information including any contemporaneous notes related to the Client and provided with the referral;

(b) A clinical history and examination of the Client;

(c) A diagnosis/es including differentials

Note: Further investigations may be required to reach a diagnosis. The Named Provider may refer directly for these and receive the results prior to the completion of the Medical Case Review report. This may or may not necessitate a second consultation with the Client. Where investigations and/or a second consultation are required, the Named Provider will notify the case owner accordingly;

(d) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service;

(e) Appropriate clinical record documentation, including a Medical Case Review report that is provided to ACC and demonstrates clinical reasoning and provides a rationale for decisions reached;

7.2.3. A Medical Case Review for the purposes of obtaining clarity about a diagnosis/es, which must include an explanatory rationale for the diagnosis/es reached. This is particularly important if the opinion on diagnosis/es differs from that of another treatment provider involved in the case;

7.2.4. A Medical Case Review for the purposes of obtaining clarity about causation, which must include:

(a) A statement on the mechanism of injury used to assess causation in the specific case. If this differs from that obtained by ACC (as expressed in the referral document) an explanation of the difference must be provided;

(b) A statement on general causation with explanatory rationale. General causation requires a recognition by the scientific community that the mechanism of injury could cause the diagnosis/es (this might be with reference to the peer-reviewed literature and/or a statement on biomechanical plausibility);

(c) A statement confirming whether or not the specific Client and/or specific circumstances of this case would confer an exception to the general scientific

understanding. If this is an exception, an explanatory rationale must be provided;

(d) A statement on specific causation with explanatory rationale. Specific causation requires an assessment as to whether the specified mechanism of injury caused the diagnosis/es in this particular case; and

(e) If there is evidence for general and specific causation, a statement as to why this explanation is considered more likely than alternative possible causes of the same condition, including it being idiopathic;

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

(a) whether or not the personal circumstances of the client in relation to their employment led to exposure that caused the injury,

(b) circumstances of the property or characteristics of employment or non-employment activities that caused or contributed to the injury

(c) the risk of the client suffering this injury compared to others in the workplace undertaking and not undertaking the same employment tasks and to others who are employed in that type of environment.

7.2.6. A Medical Case Review may include a discussion with the Client concerning medical fitness for work, including:

(a) Any restrictions/limitations and/or accommodation that may assist with enhancing medical fitness for work;

(b) Recommendations for further investigations, treatment and/or rehabilitation; and

(c) Specific questions deemed relevant to the case by ACC.

7.2.7. Medical Single Discipline Assessments as set out in clause 8.3 provided by the Supplier must include:

(a) A review of clinical information, including any relevant Client notes provided with the referral;

(b) A clinical history and examination of the Client. This must include a specific discussion with the Client about the Client's rehabilitation progress to date, with mention of any specific rehabilitation undertaken to date;

(c) Diagnosis/es including any differentials;

(d) A discussion with the Client on treatment and/or rehabilitation options and impacts appropriate for the diagnosis/es

- Where further investigations may be required in order to determine the most appropriate treatment and/or rehabilitation options for a Client, the Named Provider may refer directly for these and receive the results prior to the completion of the Single Discipline Assessment report. This may or may not necessitate a second consultation with the Client. Where investigations and/or a second consultation are required, the Named Provider will notify the case owner accordingly;

(e) Specific recommendations for any further investigations, treatment and/or rehabilitation with explanatory rationale;

(f) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service; and

(g) Appropriate clinical record documentation, including a Medical Single Discipline Assessment report, which is provided to ACC and demonstrates clinical reasoning and provides a rationale for decisions reached.

8. CLINICAL SERVICES CONSULTATIONS

8.1. The following Clinical Service consultations do not require prior approval and are detailed in Table 1.

8.1.1. Initial Assessment (to be used for first Assessment only).

An Initial Assessment can be either Simple or Complex. Taking into account clinical best practice and the complexity of the Client's injury:

(a) An Initial Assessment (Simple) is expected to take up to 45 minutes; and

(b) An Initial Assessment (Complex) is expected to take over 45 minutes.

An Initial Assessment is a face-to-face initial assessment for a Client which includes provision of a treatment plan that outlines the following:

(a) Expected duration for Clinical Services Assessments and/ or treatment, and

(b) Anticipated treatment, and

(c) Any referrals required, and

(d) The Client's capacity for return to normal function, employment

Note: An Initial Assessment can only be carried out once for a Client for each claim and does not include an assessment by a vocationally registered Anaesthetist.

8.1.2. Second Opinion Assessments.

A Second Opinion Assessment can be either Simple or Complex. Taking into account clinical best practice and complexity of the Client's injury:

(a) A Second Opinion Assessment (Simple) is expected to take up to 45 minutes; and

(b) A Second Opinion Assessment (Complex) is expected to take over 45 minutes.

A Second Opinion Assessment is a face-to-face assessment for a Client by a second Specialist (including, without limitation, a vocationally registered Anaesthetist) following an Initial Assessment where:

(a) The initial Specialist is unable to recommend treatment, or has reservations about recommending treatment; and

(b) The initial Specialist has requested in writing a Second Opinion Assessment from the second Specialist.

This type of assessment will be paid for:

(a) Under this Agreement if the second Specialist is a Named Provider; or

(b) Under the appropriate regulations if the Specialist is not named in any current Clinical Services contract with ACC.

The initial Specialist remains responsible for the provision of the ARTP to ACC, and for including any recommendation made by the second Specialist in the ARTP, unless otherwise agreed between the Specialists that the care of the Client should be transferred to the second Specialist.

8.1.3. Subsequent Assessments

A Subsequent Assessment can be either Simple or Complex. Taking into account clinical best practice and complexity of the Client's injury:

(a) A Subsequent Assessment (Simple) is expected to take up to 30 minutes; and

(b) A Subsequent Assessment (Complex) is expected to take over 30 minutes.

A Subsequent Assessment is a subsequent face-to-face assessment for a Client where:

(a) An Initial Assessment (Simple or Complex) or a Second Opinion Assessment (Simple or Complex) was unable to be satisfactorily completed without obtaining diagnostic tests of the Client, and

(b) The primary purpose is to enable the Specialist to discuss the results of such tests with the Client and explore the Client's resulting treatment and rehabilitation options; and

(c) The consultation takes place on a different day from the Initial Assessment (Simple or Complex) or Second Opinion Assessment (Simple or Complex).

OR

(a) The Subsequent Assessment is required after an Initial Assessment (Simple or Complex) or Second Opinion Assessment (Simple or Complex); and

(b) The primary purpose is for the provision of necessary on-going management and/or conservative treatment recommended in an initial non surgical ARTP;

OR

(a) A Subsequent Assessment is required by one Named Provider to review the management of the personal injury which was initiated by another Medical Practitioner;

OR

(a) The Client has not reached the rehabilitation milestones or outcomes predicted in the initial ARTP;

AND

The Subsequent Assessment may result in further recommendations for treatment (e.g. surgery) for which a surgical ARTP is required.

8.1.4. Reassessment

This is a subsequent face-to-face Simple or Complex Assessment for a Client by the Service Provider who carried out the Initial Assessment:

(a) The Client must have been discharged from the care of the Service Provider who carried out the Initial Assessment and their care transferred back to the original Referrer;

(b) A Reassessment cannot occur within 12 months of the Initial Assessment for that claim;

(c) The Client must be referred back to the Service Provider for the Reassessment in accordance with Clause 4.2.

Note: This is not a pre organised Assessment by the Service Provider who carried out the Initial Assessment.

8.1.5. Neurophysiological consultation

This is a neurophysiological consultation performed by an Internal Medicine Specialist. It includes the administration of the primary nerve conduction study.

8.1.6. Simple and Complex Neurophysiological Follow ups

(a) This is a Simple Neurophysiological Follow up consultation performed by an Internal Medicine Specialist. This Follow up includes checking for innervation in selected muscles or repeating a section of the nerve conduction study.

(b) A Complex Neurophysiological Follow up is equivalent to an initial study and is expected to take over 45 minutes.

Table 1 – Clinical Service Assessments (no prior approval required)

Procedure	Code	Definition	Treatment Provider
Simple Assessment (Initial)	CS100	Simple Assessment (First assessment only) – per face-to-face consultation	Specialist
Complex Assessment (Initial)	CS200	Complex Assessment (First assessment only) – per face-to-face consultation	Specialist
Second Opinion Assessment (Simple)	CS400	Second Opinion Assessment (Simple) – per face-to-face consultation	Specialists Anaesthetist
Reassessment	CS500	Reassessment– per face-to-face consultation	Specialist (same specialist who provided initial assessment)
Subsequent Assessment (Simple)	CS61	Subsequent Assessment (Simple) – per face-to-face consultation	Specialist
Subsequent Assessment (Complex)	CS62	Subsequent Assessment (Complex) – per face-to-face consultation	Specialist
Neurophysiological consultation	CS83	Neurophysiological study and consultation	Internal Medicine Specialist
Simple Neurophysiological Follow up	CS84	Simple Neurophysiological follow up and consultation	Internal Medicine Specialist
Complex Neurophysiological Follow up	CS85	Complex Neurophysiological follow up and consultation	Internal Medicine Specialist
Second Opinion Assessment (Complex)	CS900	Second Opinion Assessment (Complex) – per face-to-face consultation	Specialist Anaesthetist

8.2. The following Clinical Service consultations can only be undertaken pre-operatively and a surgical ARTP must have been approved prior to the assessments being undertaken.

8.2.1. Simple and Complex Pre-operative Anaesthetic Assessments.

A Pre-operative Anaesthetic Assessment can be Simple or Complex. Taking into account clinical best practice and the complexity of the Client's injury:

(a) A Simple Pre-operative Anaesthetic Assessment is expected to take up to 45 minutes; and

(b) A Complex Pre-operative Anaesthetic Assessment is expected to take over 45 minutes.

Simple and Complex Pre-operative Anaesthetic Assessments can only be undertaken pre-operatively and a Surgical ARTP must have been approved prior to this assessment being undertaken.

Note: The Client must be referred for a Complex Pre-operative Anaesthetic Assessments by the treating Named Provider.

These Assessments are face to face initial assessments for a Client to allow for pre-operative planning, performed by a vocationally registered Anaesthetist (preferably the same person who will attend the proposed surgery) to enable assessment of the Client's medical condition and to facilitate planning for intra-operative and post-operative care.

The Simple Pre-operative Anaesthetic Assessment will be undertaken for:

(a) Those Clients with co-morbidities likely to pose anaesthetic risk; and/or

(b) Non-Core Complex/Unpredictable Procedures, where the Client will be expected to require Intensive Care Unit care post-surgery; and/or

(c) Clients with identified significant anxiety regarding anaesthesia.

The Complex Pre-operative Anaesthetic Assessment will be undertaken for:

(a) Clients with a personal injury of unusual complexity; and/or

(b) Clients requiring a more complex level of investigation than would usually be required for a Simple Pre-operative Anaesthetic Assessment; and/or

(c) Those Clients with co-morbidities likely to pose anaesthetic risk; and/or

(d) Non-Core Complex/Unpredictable Procedures, where the Client will be expected to require Intensive Care Unit care post-surgery; and

The outcome of the assessment will include informing the Client of post surgery management such as high dependency or intensive case management. The Anaesthetist will inform the surgeon of the post operative plan.

8.2.2. Anaesthetic long distance consultation

(a) This is a telephone consultation for a Client by a vocationally registered Anaesthetist (preferably the same person who will attend the proposed surgery) to enable assessment of the Client's medical condition, following review of the pre-anaesthetic form. The consultation shall facilitate planning for intra-operative and post-operative care.

(b) The consultation is ***not*** a substitute for a clinical examination to determine anaesthetic status; or is it a simple introductory call as the purpose of this is to improve the service to Clients who live some distance from the clinic.

Table 2 – Clinical Service Consultations (pre-operatively only)

Procedure	Code	Definition	Treatment Provider
Simple Pre-operative Anaesthetic Assessment (Initial)	CS250	Simple Pre-operative Anaesthetic Assessment (Initial) - Per face-to-face consultation (pre operatively only)	Anaesthetist
Complex Pre-operative Anaesthetic Assessment –(Initial)	CS260	Complex Pre-operative Anaesthetic Assessment –(Initial) - Per face-to-face consultation (pre operatively only)	Anaesthetist
Anaesthetic long distance consultation	CS70	Anaesthetic long distance consultation – Per Call (pre-operatively only)	Anaesthetist

8.3. The following Clinical Service consultations must have been requested and approved by ACC prior to the assessment being undertaken.

8.3.1. Standard Medical Case Review and Complex Medical Case Review.

A Medical Case Review can be Standard or Complex. Taking into account the complexity of the Client's presentation:

(a) A Standard Medical Case Review is expected to take up to 3.5 hours; and

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

8.3.2. Standard Medical Single Discipline Assessment and Complex Medical Single Discipline Assessment.

A Medical Single Discipline Assessment can be Standard or Complex. Taking into account the complexity of the Client's presentation:

(a) A Standard Medical Single Discipline Assessment is expected to take up to 2.5 hours; and

(b) A Complex Medical Single Discipline Assessment is expected to take more than 2.5 hours, as the Client's case information includes several opinions representing conflicting options for treatment or rehabilitation; or the Medical Single Discipline Assessment will be undertaken in two parts whilst results of investigations are obtained.

8.3.3. If on referral a Service provider believes the Client is exceptionally complex over and above the cost available under a Complex category, please contact ACC to discuss.

Table 3 – Medical Case Reviews and Medical Single Discipline Assessments

Procedure	Code	Definition	Treatment provider
Medical Case Review (Standard)	CSM1	Medical review to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Case Review (Complex)	CSM2	Medical review taking more than 3.5 hours to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Single Discipline Assessment (Standard)	CSA1	Medical assessment to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist
Medical Single Discipline Assessment (Complex)	CSA2	Medical assessment taking more than 2.5 hours to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist

9. ASSESSMENT REPORT AND TREATMENT PLAN

9.1. Service Providers are required to maintain clinical notes at the completion of the consultation with the Client.

9.1.1. If Surgical Treatment is required an ARTP must be completed for prior approval for clinic based and Elective Surgery.

9.1.2. All reports/notes/letters or summarised comprehensive letters related to Client's assessments are required to be submitted electronically to ACC via electronic transmission as arranged with ACC (e-business with ACC). This can be the same reports/notes/letters or summarised comprehensive letters that are provided to the General Practitioner or referring specialist.

9.1.3. ACC will not be charged any additional fee for the provision of reports/notes/letters or summarised comprehensive letters when requesting information contained within these documents following a consultation that has been performed under this Agreement.

9.1.4. Where a client has a complex injury and requires multiple Subsequent Assessments, the Supplier will ensure that there is a treatment plan in the clinical notes detailing the expected rehabilitation outcome.

9.2. When a surgical ARTP is required

9.2.1. A surgical ARTP is required when surgery is recommended by the Named Provider. The Named Provider will prepare and submit a surgical ARTP to ACC on completion of:

(a) An Assessment/Reassessment (and a Second Opinion Assessment or Complex Second Opinion Assessment, if applicable); and

(b) A Subsequent Visit where the Specialist recommends surgical treatment.

9.2.2. To Whom

An ARTP recommending surgery will be forwarded to ACC's Treatment Assessment Centre (TAC) by the Elective Surgery Supplier. These documents should be sent electronically via HealthLink or to ARTPS4ESU@acc.co.nz.

Relevant information regarding recommended treatment will be forwarded to the Client's General Practitioner.

9.2.3. By When

The ARTP will be forwarded within 7 working days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).

9.2.4. Contents of Surgical ARTP

The ARTP document on the ACC Provider Website is the only version that is ACC approved and is the only version of the ARTP that will be accepted by ACC.

9.3. Non – surgical intervention

If non-surgical intervention e.g. Pain Management or other rehabilitation is recommended, a copy of reports/notes/letters or a summarised comprehensive letter outlining the recommendation must be submitted to ACC electronically.

9.3.1. By When

The non-surgical recommendation will be forwarded within 7 working days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).

9.3.2. Unless otherwise agreed with ACC, the Supplier will make any referrals for associated services (e.g. pathology services and diagnostic imaging services) electronically if directed to do so by ACC.

10. PROCEDURES

10.1. Treatment Clinic Based Procedures that do not require prior approval.

10.1.1. A Named Provider may carry out one of the Treatment Clinic Based Procedures named below in Table 4 during an Assessment and invoice ACC for the cost of the procedure only.

10.1.2. The consultation price is included in the procedure price and cannot be claimed in addition to the procedure price.

Table 4 – Clinic Based Procedures

Procedure	Code	Definition	Treatment Provider
Flexi Cystoscopy	CST12	Flexi Cystoscopy	Urologist
Flexi Cystoscopy (with dilatation)	CST13	Flexi Cystoscopy (with dilatation)	Urologist
Flexi Cystoscopy (with 300 units Botulinum Toxin)	CST14	Flexi Cystoscopy (with 300 units Botulinum Toxin.)	Urologist
Supra Pubic Catheter Insertion	CST15	Supra Pubic Catheter Insertion	Urologist
Supra Pubic Catheter Change	CST16	Supra Pubic Catheter Change	Urologist
Reduction of fractured nose	CST11	Closed reduction of displaced/fracture of nasal bones performed under local anaesthetic. This type of reduction will be performed for fractures of the nasal bones that are limited in size and complexity. NOTE: This treatment must not take place earlier than 7 days from the date of injury	Otolaryngologist
Caudal/Lumbar epidural injection	CST9	Caudal/Lumbar epidural injection. This is not to be used as an ongoing treatment and is limited to one per claim. Second or subsequent epidural injections require approval and should be sent on a ARTP to escmednotes@acc.co.nz along with relevant documents. 'CST9 Injection' should be included in the email subject line.	Orthopaedic Surgeon Anaesthetist
Neurophysiological consultation	CS83	A nerve conduction test is an electrodiagnostic test of the integrity of the peripheral nerves to assist in the diagnosis of nerve entrapment syndrome or polyneurophathies. It involves placing an electrical stimulator over a nerve and measuring the time required for an	Neurologist Neurosurgeon

Procedure	Code	Definition	Treatment Provider
		impulse to travel over a measured segment of the nerve.	
Simple Neurophysiological Follow up consultation	CS84	A subsequent neurophysiological consultation	Neurologist Neurosurgeon
Complex Neurophysiological Follow up consultation	CS85	A subsequent neurophysiological consultation	Neurologist Neurosurgeon
Removal of foreign bodies (not eye)	CST17	Removal of foreign bodies (not eye)	Orthopaedic Surgeon Plastic and Reconstructive Surgeon
Repair/reconstruction of nail bed	CST27	Repair and/or reconstruction of nail bed	Orthopaedic Surgeon
Removal foreign body – eye	CST41	Removal of foreign body from the eye	Ophthalmologist
YAG Laser Capsulotomy	CST42	YAG Laser Capsulotomy	Ophthalmologist

10.2. The procedures in Table 5 are claimed in addition to a consultation and do not require prior approval.

10.2.1. Each Procedure must be carried out by a Specialist who is a treatment provider of a type named in Table 5 as being able to provide that procedure.

10.2.2. The Facility where the procedure is to be carried out must meet the requirements identified in Part B, clause 5.

10.2.3. The completion of the ARTP must include the expected outcome of the procedure and the timeline for the result of the procedure.

10.2.4. No prior approval is required to carry out these Clinic Based Procedures.

Table 5 – Clinic Based Procedures

Procedure	Code	Definition	Treatment Provider
Removal of wire/screws	CST1	**Note: ACC must have funded the insertion of wire/screws**	Orthopaedic Surgeon
Simple injection	CST4	Injections or joint aspiration	Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Isolated nerve block	CST5	The transmission of nerve impulses is interrupted by injecting a local anaesthetic around a nerve	Anaesthetist Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Regional block (not LA) or compartment pressure monitoring	CST6	Regional block (not LA) or compartment pressure monitoring	Anaesthetist Orthopaedic Surgeon
Complex Injection	CST10	Injection of steroid and/or local anaesthetic into joint or bursa or tendon sheath	Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Reapplication of plaster casts/thermoplastic	CST21	Reapplication of plaster casts/thermoplastic splints above knee	Nurse under supervision of an Orthopaedic Surgeon

Procedure	Code	Definition	Treatment Provider
splints above knee			
Reapplication of plaster casts/thermoplastic splints above elbow	CST22	Reapplication of plaster casts/thermoplastic splints above elbow	Nurse under supervision of an Orthopaedic Surgeon
Reapplication of plaster casts/thermoplastic splints below knee	CST31	Reapplication of plaster casts/thermoplastic splints below knee	Nurse under supervision of an Orthopaedic Surgeon
Reapplication of plaster casts/thermoplastic splints below elbow	CST32	Reapplication of plaster casts/thermoplastic splints below elbow	Nurse under supervision of an Orthopaedic Surgeon
Flow and residual test	CSD10	Test focused on the bladder's ability to empty steadily and completely	Urologist
Optical Coherence Tomography (OCT) scan (unilateral and bilateral)	CSD40 and CSD41	Measurement of the thickness of the macula, the tissue make-up of the nerve fibre layer or to analyze individual layers of the retina. OCT is also used to analyse the optic nerve head in glaucoma	Ophthalmologist Medical Orthoptist
Visual Field Test-unilateral (ophthalmology)	CSD42	Determining a patients peripheral vision (side) vision.- one eye	Ophthalmologist Medical Orthoptist
Visual Field Test-bilateral (ophthalmology)	CSD43	Determining a patients peripheral vision (side) vision.- two eyes	Ophthalmologist Medical Orthoptist
Orthoptic assessment (for a child or an adult)	CSD44 and CSD45	Assessment of the eye movements and binocular vision disorders	Ophthalmologist Medical Orthoptist
Fluorescein angiography	CSD46	Test used to assess the health of certain blood vessels in the eye. In this test, fluorescein dye is injected into a vein in the arm and photographs are taken of the eye as the dye circulates.	Ophthalmologist Medical Orthoptist

10.3. Treatment Clinic Based Procedures that require compliance with the Rooms/Office Based Surgery and Procedures, New Zealand Standard 8165:2005 are contained in Table 6.

(a) Each Procedure must be carried out by a Specialist who is a treatment provider of a type named in Table 6 below as being able to provide that procedure.

(b) Each Procedure requires ACC prior approval before it can be undertaken.

(c) The Consultation price for these procedures is included in the procedure price and cannot be claimed in addition to the procedure price.

(d) The Facility where the procedure is to be carried out must meet the requirements identified in Part B, Clause 5.

(e) These procedures can only be undertaken by suppliers who have satisfactorily completed the Rooms/Office Based Surgery and Procedures, New Zealand Standard 8165:2005 in accordance with Clause 7.1.1 of this Service Schedule

(f) These procedures must be undertaken under local anaesthesia without intravenous sedation.

(g) The completion of the ARTP must include the expected outcome of the procedure and the timeline for the result of the procedure.

(h) The list of procedures may be reviewed at any time in consultation with the sector to determine if the approval requirements are appropriate. Any changes as a result of such a review will be notified to the Supplier by notice and will not require a variation to this Service Schedule but will amend Tables 1, 2 3, 4, 5,6 and 7.

10.3.1. Approval process

The Supplier will forward the following information in an electronic format to the Treatment Assessment Centre (via HealthLink Mailbox ACCEARTP or via email to ARTPS4ESU@acc.co.nz) for all applications for funding approvals:

(a) The ARTP;

(b) Contract number of this Service Schedule;

(c) Proposed date for the Procedure;

(d) Sufficient information for ACC to make a funding decision, and

(e) Any other information reasonably required by ACC

Requests for scar revision procedures and laser treatment must be accompanied by a coloured digital photograph/s.

ACC will then determine the application.

10.3.2. If funding is approved

On receiving ACC's advice that funding has been approved, the Supplier will promptly contact the Client to arrange a mutually appropriate date for attendance for Treatment.

Where the Supplier has been advised of approval and the approved treatment has not commenced within three months of the date of the approval, the approval will lapse and the Supplier will be required to make a new application for approval.

Where the approval has lapsed ACC will not pay the Supplier for any Services provided to Clients unless a new approval has been received.

10.3.3. If funding is declined

The Client will not be eligible for the Service/s, and payment will not be made to the Supplier.

ACC will fund one Subsequent Assessment under this Agreement to determine a further treatment plan

Table 6 – Treatment Clinic Based Procedures (prior approval required)

Procedure	**Code**	**Definition**	**Treatment Provider**
Lid /Adnexa – lid surgery - minor	CST40	Minor eye lid surgery	Ophthalmologist Plastic and Reconstructive Surgeon
Laser treatment	CST80	Laser treatment for scar management	Plastic and Reconstructive Surgeon and Dermatologist
Revision of Scar/s	CST23 CST24 CST25	Revision of scar/s any body site. These are funded according to incision length.	Plastic and Reconstructive Surgeon
Minor finger surgery	CST26	Minor finger surgery	Orthopaedic Surgeon

Procedure	Code	Definition	Treatment Provider
(stump revision/cyst)			
Excision post traumatic inclusion cyst	CST28	Excision post traumatic inclusion cyst	Plastic and Reconstructive Surgeon
Tympanostomy/Myringotomy	CST60	Surgical incision into the eardrum and insertion of grommet	Otolaryngologist
Myringoplasty - simple +/- patch	CST61	Procedure to close a hole in the eardrum	Otolaryngologist

10.4. Pre operative Clinic Based Procedures

10.4.1. A Named Provider may carry out one of the Pre operative Clinic Based Procedures named below in Table 7 during an Assessment and invoice ACC for the cost of the Procedure and Assessment in accordance with this Service Schedule.

10.4.2. Each Procedure must be carried out by a Specialist who is a treatment provider of a type named in Table 7 as being able to provide that procedure.

10.4.3. The Facility where the procedure is to be carried out must meet the requirements identified in Part B, Clause 5.

10.4.4. A surgical Assessment Report - Treatment Plan (ARTP) must have been approved by ACC before any Pre operative Rooms Based Procedure in Table 7 (relating to "fit for surgery") is undertaken

Table 7 - Pre operative Clinic Based Procedure (surgical ARTP must be approved prior to undertaking)

Procedure	Code	Definition	Treatment Provider
Echocardiogram (Echo)	CSD1	Ultrasound scan of the heart (for clients pre-operatively only)	Cardiologist Cardiac Sonographer
Stress Echocardiogram (Stress Echo)	CSD2	Stress induced by exercise machine or Pharmacological agent if machine stress not appropriate and recorded via ultrasound (for clients pre-operatively only)	Cardiologist Cardiac Sonographer Technician
Respiratory Spirometry	CSD3	Pulmonary function test, which measures the volume of air inspired or expired as a function of time (for clients pre-operatively only)	Cardiologist Respiratory Technician
Exercise treadmill	CSD4	Machine exercise while being monitored for ECG and Blood Pressure (for clients pre-operatively only)	Cardiologist Technician
Electrocardiogram (ECG)	ECG	An electrocardiogram is a recording of the electrical activity of the heart. This procedure fee can be charged when an ECG is undertaken off site (i.e. not as part of the Assessment) The referring Named Provider is responsible for ensuring the treatment provider to whom they refer the Client has suitably qualified and trained staff to undertake the procedure and that all quality and safety standards are met. NOTE: District Health Boards (DHBs) are responsible for ECGs related to public health acute services. NOTE: When this diagnostic test is	Medical Staff Technician

Procedure	Code	Definition	Treatment Provider
		undertaken as part of : (a) A preoperative anaesthetic assessment OR (b) Part of a cardiology assessment second opinion it is considered as a component of that Assessment and included in the price for that Assessment	

11. NAMED PROVIDERS

11.1. Names

The Supplier will utilise the services of only the Specialists named in, Part B, clause 3 (the "Named Providers") in the course of providing Clinical Services for Clients.

11.2. Addition of Specialists

The Supplier may, at any time during the Term of this Agreement, make a written request to ACC Health Procurement for a Specialist to be added to the Named Providers.

ACC may in its sole discretion accept or decline each such request, with or without conditions, by providing written notification to the Supplier.

If a request is accepted under this clause, the Specialist shall be deemed added to the Named Providers from the date of ACC's written notification to the Supplier.

11.3. Removal of Specialists

The Supplier may, at any time during the Term of this Agreement, provide written notification to ACC Health Procurement that a Named Provider is to cease to be a Named Provider under this Agreement. The Specialist shall cease to be a Named Provider five working days after receipt of the Supplier's notice by ACC Health Procurement. The Supplier shall not issue such a notice arbitrarily.

ACC may, at any time during the Term of this Agreement, provide written notification to the Supplier that a Named Provider is to cease to be a Named Provider under this Agreement. The Specialist shall cease to be a Named Provider five working days after receipt of ACC's notice by the Supplier. ACC shall not issue such a notice arbitrarily.

12. SERVICE EXIT

12.1. This Service is complete when:

12.1.1. The Supplier completes one of the assessments identified in Part A, Clause 4 and an ARTP for the assessment carried out is completed and sent to the appropriate people, clinical notes have been completed and correspondence with the referrer has been sent; or

12.1.2. When the transfer of clinical responsibility and care of the Client to the original referrer, the Client's General Practitioner or another specialist, has occurred;

12.1.3. Whichever is the later date.

13. EXCLUSIONS

13.1. The following Services are not purchased under this Service Schedule but may be purchased under other Service Schedules.

13.1.1. Diagnostic imaging service

13.1.2. Clinical Psychiatric Services and Psychological Services

13.1.3. Public Health Acute Services

13.1.4. Pain Management Services

13.2. Outpatient Post Discharge / Post Procedure Care following Elective Surgery

13.2.1. Post Discharge/Post Procedure Care for a Client following Elective Surgery begins following Discharge from a facility where Treatment has been carried out, and ends six weeks after Discharge. Any necessary and appropriate follow-up and care required during this period is the responsibility of the Elective Surgery supplier and should not be invoiced against the Clinical Services contract.

13.2.2. If, at the end of the six week post discharge period, further specialist follow up care is required, this may be only provided under the Clinical Services contract or under the applicable regulations.

13.2.3. ACC will undertake regular monitoring of invoices against the Clinical Services Contract, and has the right to seek repayment of services undertaken during this six week post discharge period that have been invoiced to ACC.

14. LINKAGES

14.1. The Supplier will ensure that linkages are maintained with the following Services:

14.1.1. ACC Client Service Staff

14.1.2. Health Professionals

14.1.3. Other Services as appropriate to meet the Client's needs.

15. PERFORMANCE REQUIREMENTS

15.1. The Supplier's performance will be measured as shown in Table 8 – Performance Measurement

Table 8 – Performance Measurement

Objective	Performance measure	Target	Data Source
1. Service Provision	Procedures are carried out by Medical Specialists who hold registration in the appropriate vocational scope of practice	100% of Procedures are carried out by a Specialist who is a treatment provider of the type names in the Service Schedule as being able to provide that procedure.	• Supplier supplies evidence to ACC in accordance with Clause 11. • Clinical Notes
2. Quality intervention	Facilities are clinically appropriate for performance of covered procedures	100% of facilities meet the quality requirements of Rooms/ Office Based Surgery and Procedure Standards New Zealand 8165:2005 if undertaking	• Supplier supplies evidence to ACC

Objective	Performance measure	Target	Data Source
		the rooms based procedures.	
3. Cost effective	Services are necessary, appropriate and not excessive in number or duration.	100% of Clinic Based Surgical Procedures performed are clinically necessary and appropriate	• Clinical notes • Operative notes • Benchmark reports monitoring the number of procedures performed by other Providers
4. Early intervention	Surgery is performed within necessary time frame to allow for maximum rehabilitation	100% of Clients will have their Clinic Based Surgical Procedure within 28 days of the Assessment that determined the need for the procedure/s (this is for procedures which do not require prior approval)	• ARTP • Operative notes • Invoice
5. Prompt and accurate information submitted to ACC	Complete and accurate information provided to enable assessment of quality of service received	100% of documentation received within scheduled time frame	• ARTP • Operative notes • Discharge summary • Invoice

15.2. Service Improvement Process

15.2.1. ACC and the Supplier will consider the information reported under Clause 15 and other relevant information on a regular basis.

15.2.2. Discussion between the Supplier and ACC will occur to better understand the information and decide if performance could be expected to change or if there are other factors that provide a reasonable basis for the identified performance.

15.2.3. If a change in performance is deemed appropriate then further analysis and a follow-up discussion will be undertaken three months after the initial discussion between the Supplier and ACC.

15.2.4. If a change is observed such that performance is within appropriate parameters then the performance monitoring process will provide feedback to the Supplier.

15.2.5. If a change in performance is still deemed appropriate a performance improvement plan will be documented that includes the required action(s) by either party and the time frames for this to occur.

15.2.6. Further analysis and discussion will occur at the end of the period stated in the performance improvement plan. If no change is observed ACC may issue a notice of breach of contract in accordance with Part 1 Schedule 2 Clause 9.1.

16. REPORTING REQUIREMENTS

16.1. The Supplier will report information following the format required by ACC as set out in the *Operational Guidelines* which can be downloaded from the ACC website.

16.2. Each Medical Case Review and Medical Single Discipline Assessment report will include:

16.2.1. The Named Provider’s qualifications and statement of impartiality as a non-treating practitioner;

16.2.2. Any facts and assumptions on which the opinions and recommendations of the Named Provider are based;

16.2.3. Reasons for the opinions and recommendations made by the Named Provider;

16.2.4. References to any literature or other material used or relied on in support of the opinions and recommendations expressed; and

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

16.3. Reports will be provided in accordance with Table 9 – Reporting Requirements

Table 9 – Reporting Requirements

Information	Frequency	When	Responsibility
Surgical ARTP	For all Clients for whom surgery is recommended by the Named Provider	Within seven business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).	Supplier via the Elective Surgery Contract Holder
Non surgical ARTP (include referrer details)	For all clients for who a non-surgical intervention is recommended	Within 7 working days of the Specialist completing the consultation	Supplier
Discharge summary	Following each discharge	Within two working days of discharge	Supplier
Invoice and operative note	Following each discharge	Within 3 months of procedure	Supplier
Medical Case Review report	For all Clients who are referred for a Medical Case Review	Within eight business days of the Specialist completing the consultation	Supplier
Medical Single Discipline Assessment report	For all Clients who are referred for a Medical Single Discipline Assessment	Within eight business days of the Specialist completing the consultation	Supplier

17. RELATIONSHIP MANAGEMENT

17.1. To ensure the continuing effective operation of the service, formal working relationships are to be maintained as defined in Part A, Clause 5.

18. PAYMENT AND INVOICING

18.1. Services prices are defined for this Service in. Part A, Clause 4.

18.2. ACC agrees to pay the prices set out in Part A, Clause 4.

18.3. The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, the Client or other person for Services under this agreement.

APPENDIX ONE - DEFINITIONS AND INTERPRETATION

In this Service Schedule, unless the context otherwise requires:

"Assessment Report and Treatment Plan" and **"ARTP"** is the report issued when requesting elective surgery, as described in Part B, Clause 9 available on the Provider website. http://www.acc.co.nz/for-providers/elective-surgery/index.htm

"Complex Assessment" has the meaning defined in Part B, clause 8.1.1;

"Complex Medical Case Review" has the meaning defined in Part B, clause 8.3.2;

"Complex Medical Single Discipline Assessment" has the meaning defined in Part B, clause 8.3.2;

"Complex Second Opinion Assessment" has the meaning defined in Part B, clause 8.1.2;

"Consumables" are those single use Medical Consumables that are required for the treatment of the Client.

"Treatment Assessment Centre" means the centre where all surgical ARTP's are submitted (formally known as the Elective Services Centre/Unit). These should be submitted via HealthLink Mailbox ACCEARTP or via email to ARTPS4ESU@acc.co.nz

"Named Provider" means a Provider listed in Part A, Quick Reference Information, Part B, clause 3 and any other Provider deemed added to this Agreement, who has not ceased to be a Named Provider;

"Operational Guidelines" is the document produced by ACC from time-to-time to reflect the processes and procedures that should be followed in support of this Service;

"Pre-operative Anaesthetic Assessment - Simple" has the meaning defined in Part B, clause 8.2.1;

"Pre-operative Anaesthetic Assessment - Complex" has the meaning defined in Part B, clause 8.2.1;

"Reassessment" has the meaning defined in Part B. clause 8.1.4

"Referrer" means the Medical Practitioner or another "treatment Supplier" within the meaning of section 6(1) of the AC Act or ACC representative who requests that the Supplier provide Clinical Services or medical services for the Client or, where the context otherwise requires, means the Supplier where it requests that a Medical Practitioner accept a transfer of clinical responsibility for a Client or requests that another "treatment Supplier" provide Clinical Services or medical services for the Client and, if appropriate, treatment; and "Referral" and "Referred" has a corresponding meaning;

"Second Opinion Assessment" has the meaning defined in Part B, clause 8.1.2.

"Simple Assessment" has the meaning defined in Part B, clause 8.1.1.

"Standard Medical Case Review" has the meaning defined in Part B, clause 8.3.1;

"Standard Medical Single Discipline Assessment" has the meaning defined in Part B, clause 8.3.1;

"Subsequent Assessment" has the meaning as defined in Part B, clause 8.1.3.

SERVICE SCHEDULE FOR CLINICAL SERVICES – EXCLUDES IN-ROOMS PROCEDURES

CONTRACT NO: «Contract_Number_»

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING CLINICAL SERVICES

The Term for the provision of Clinical Services is the period from 1 July 2016 (“Commencement Date”) until the close of 30 June 2020 (the “Date of Expiry”) or such earlier date upon which the period is lawfully terminated or cancelled.

2. SERVICE LOCATION (Part B, clause 5)

«TLAs»

3. NAMED PROVIDERS (Part B, clause 11)

Last name	First name	Speciality or category of professional registration/ vocational registration	New Zealand Medical Council number or Dental Council of New Zealand number	ACC provider number/HPI	Facility

4. SERVICE ITEMS AND PRICES

Prior Approval required	Includes Consultation	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
Clinical Service Assessments						
		CS100	CS10	Simple Assessment (Initial)	$168.14	Per face-to-face consultation
		CS200	CS20	Complex Assessment (Initial)	$257.62	Per face-to-face consultation

Prior Approval required	Includes Consultation	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
		CS250	CS25	Simple Pre-operative Anaesthetic Assessment (Initial)	$168.14	Per face-to-face consultation (**pre operatively only** - Surgical ARTP must be approved prior to this assessment being undertaken)
		CS260	CS26	Complex Pre-operative Anaesthetic Assessment –(Initial)	$257.62	Per face-to-face consultation (**pre operatively only** - Surgical ARTP must be approved prior to this assessment being undertaken)
		CS400	CS40	Second Opinion Assessment	$168.14	Per face-to-face consultation
		CS500	CS50	Reassessment	$168.14	Per face-to-face consultation
		CS61	CS61	Subsequent Assessment (Simple)	$113.88	Per face-to-face consultation
		CS62	CS62	Subsequent Assessment (Complex)	$168.14	Per face-to-face consultation
		CS70	CS70	Anaesthetic long distance consultation	$58.11	Per Call
		CS83	CS83	Neurophysiological consultation	$475.01	Neurophysiological study and consultation
		CS84	CS84	Simple Neurophysiological Follow up	$158.97	Simple Neurophysiological Follow up and consultation
		CS85	CS85	Complex Neurophysiological Follow up	$475.01	Complex Neurophysiological Follow up and consultation
		CS900	CS90	Second Opinion Assessment (Complex)	$257.62	Per face-to-face consultation
Clinical Services Diagnostic Procedures (approved surgical request required):						
		CSD1	CSD1	Echocardiogram (Echo)	$511.65	Per test (**pre operatively only** - Surgical ARTP must be approved prior to this test being undertaken)
		CSD2	CSD2	Stress Echo	$890.37	Per test (**pre operatively only** - Surgical ARTP must be approved prior to this test being undertaken)
		CSD3	CSD3	Respiratory Spirometry	$84.95	Per test (**pre operatively only**- Surgical ARTP must be approved prior to this test being undertaken) In circumstances where this is required in a non pre-operative situation approval must be sought from ACC.
		CSD4	CSD4	Exercise Treadmill	$403.38	Per test (**pre operatively only** – Surgical ARTP must be approved prior to this test being undertaken)
		ECG	ECG	Electrocardiogram	$58.11	Per test (**pre operatively only** – Surgical ARTP must be approved prior to this test being undertaken)
Clinical Service Diagnostic Procedures						
		CSD10	CD10	Flow and residual test	$122.18	Per test in addition to consultation
		CSD40	CD40	OCT scan – unilateral	$210.89	Per test in addition to consultation

Prior Approval required	Includes Consultation	Service Item Code	Short code for electronic billing	Service Item Definition	2017/18 Prices (Ex GST)	Pricing Unit
		CSD41	CD41	OCT scan – bilateral	$256.65	Per test in addition to consultation
		CSD42	CD42	Visual Field Test-unilateral	$74.85	Per test in addition to consultation
		CSD43	CD43	Visual Field Test-bilateral	$95.88	Per test in addition to consultation
		CSD44	CD44	Orthoptic assessment - child	$124.67	Per test in addition to consultation
		CSD45	CD45	Orthoptic assessment - adult	$144.21	Per test in addition to consultation
		CSD46	CD46	Fluorescein angiography	$490.59	Per test in addition to consultation
Clinical Service Treatment						
		CST1	CST1	Removal of wire/screws	$19.36	In addition to consultation
		CST21	CT21	Reapplication of plaster casts/thermoplastic splints above knee	$180.76	Per application in addition to consultation
		CST22	CT22	Reapplication of plaster casts/thermoplastic splints above elbow	$150.63	Per application in addition to consultation
		CST31	CT31	Reapplication of plaster casts/thermoplastic splints below knee	$150.63	Per application in addition to consultation
		CST32	CT32	Reapplication of plaster casts/thermoplastic splints below elbow	$130.52	Per application in addition to consultation
		CST4	CST4	Injections or Joint Aspiration	$25.82	In addition to consultation
		CST5	CST5	Isolated Nerve Block	$19.36	In addition to consultation
		CST6	CST6	Regional block (not LA) or compartment pressure monitoring	$129.15	In addition to consultation
Prior Approval required for Second or subsequent epidural injections		CST9	CST9	Caudal/Lumbar epidural injection (limit one per claim). Second or subsequent epidural injections require prior approval and requests should be sent on an ARTP to escmednotes@acc.co.nz with the service item code in the subject line.	$548.71	Includes consultation and all consumables for the service.
		CST10	CT10	Complex Injection	$59.79	Per injection and includes consumables.
		CST11	CT11	Closed reduction of displaced/fracture of nasal bones	$612.16	Includes consultation

Prior Approval required	Includes Consultation	Service Item Code	Short code for electronic billing	Service Item Definition	2016/17 Prices (Ex GST)	Pricing Unit
Medical Case Reviews and Medical Single Discipline Assessments						
		CSM1	CSM1	Standard Medical Case Review (MCR) **This service must be requested by ACC.**	$1,051.96	Per Medical Case Review
		CSM2	CSM2	Complex Medical Case Review (MCR) **This service must be requested by ACC.**	$1,562.90	Per Medical Case Review
		CSA1	CSA1	Standard Medical Single Discipline Assessment (SDA) **This service must be requested by ACC.**	$641.45	Price per Medical Single Discipline Assessment
		CSA2	CSA2	Complex Medical Single Discipline Assessment (SDA) **This service must be requested by ACC.**	$937.08	Per Medical Single Discipline Assessment
		CSN1	CSN1	Non-attendance fee is payable when a Client fails to attend a scheduled appointment for a MCR without giving two working days prior notification to the Service Provider. The Service Provider must notify the Client's Claims Manager.	$456.75	Per Client (Max 1)

Prior Approval required	Includes Consultation	Service Item Code	Short code for electronic billing	Service Item Definition	2016/17 Prices (Ex GST)	Pricing Unit
Medical Case Reviews and Medical Single Discipline Assessments						
		CSU	Un-booked appointment time	Un-booked Appointment time is payable when a Supplier travels to an area outside their usual service area at the request of ACC and there is an unfilled appointment time within the block booking. Only payable for appointments which are never filled and where the Non-Attendance fee cannot be claimed. Maximum of 4 hours per day.	$132.65	per hour or part thereof

5. RELATIONSHIP MANAGEMENT (Part B, clause 16)

Level	ACC	Supplier	Frequency
Client	ACC Client Service Staff	Individual staff or operational contact	
Branch	Branch Manager	Operational contact	
Region	Designated Engagement and Performance Manager	Operational contact	

6. ADDRESSES FOR NOTICES

NOTICES FOR ACC TO:

ACC Health Procurement (for deliveries)
19 Aitken Street
Wellington 6011
ACC Health Procurement (for mail)
P O Box 242
Wellington 6140
Marked: "Attention: Procurement Specialist"
Phone: 0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

«Street_Address1»including postcode) (for deliveries)
(insert postal address including postcode) (for mail)
marked: “Attention (contact person)
Phone:
Mobile:
Fax:
Email:

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APPENDIX ONE – DEFINITIONS AND INTERPRETATION

B. SERVICE SPECIFICATIONS FOR CLINICAL SERVICES

1. PURPOSE

1.1. ACC wishes to purchase Clinical Services.

1.2. The purposes of the Service are:

1.2.1. To provide face-to-face specialist assessment and treatment services for Clients who have an accepted claim for cover. The assessment must be related to the injury for which the Client has cover and require a specialist opinion; and

1.2.2. To restore Clients' health to the maximum extent practicable; and

1.2.3. To allow Suppliers to carry out a procedure as part of the assessment (in accordance with Clause 10); or

1.2.4. To provide face-to-face specialist assessment for Clients who have an accepted claim for cover or have been referred by ACC for an assessment which may help determine cover; and

1.2.5. Determine the cause of a Client's on-going symptoms or condition; and/or

1.2.6. Make recommendations for onward investigations, treatment and rehabilitation.

2. SERVICE OBJECTIVES

2.1. ACC will measure the success of this Service based on the following objectives:

2.1.1. Clients receive an appropriate and timely assessment and/or treatment service;

2.1.2. Every Client other than those referred for a Medical Case Review or Medical Single Discipline Assessment has an Assessment Report and Treatment Plan (ARTP) emailed or sent electronically to ACC that identifies the Client's rehabilitation needs and all options for addressing these needs.

2.1.3. Every Client referred for a Medical Case Review or Medical Single Discipline Assessment has an Assessment Report emailed or sent electronically to ACC.

2.1.4. Clients receive clinic based procedures which do not require prior approval within 28 days of the Assessment that determined the need for the procedure/s; and

2.1.5. ACC receives reports within the timeframes set out in this Service Specification.

3. PROVIDERS OF CLINICAL SERVICES

3.1. Service Providers must be:

(a) Appropriately qualified Medical Practitioners who are registered under the Medical Council of New Zealand who hold a vocational scope of practice in at least one of the following areas;

- Anaesthesia
- Cardiology
- Cardiothoracic surgery
- Dermatology
- General surgery
- Gynaecology
- Internal medicine
- Musculoskeletal medicine
- Neurosurgery
- Occupational medicine

- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Paediatric surgery
- Paediatrics
- Pain medicine
- Palliative medicine
- Plastic and reconstructive surgery
- Rehabilitation medicine
- Sports medicine
- Urology
- Vascular surgery, or

(b) Appropriately qualified Dental Practitioners who are registered under the Dental Council of New Zealand who hold a vocational scope of practice in one of the following areas;

- Oral surgery
- Oral and maxillofacial surgery

3.2. The procedures in this Service Schedule must be carried out by a Specialist who holds the appropriate vocational registration to enable them to provide the procedure. Tables 1-6 of this Service Schedule include the type of treatment providers that can undertake each procedure.

4. SERVICE COMMENCEMENT

4.1. Eligibility for Service

4.1.1. The Supplier will provide Clinical Services Assessments and/or Treatment only to eligible Clients who have been referred to the Supplier in accordance with this Clause 4.

4.1.2. ACC will not pay the Supplier for services provided and/or for time spent with a person who does not fulfil the criteria outlined in Clause 1.2.1, or where funding is not approved in accordance with Part B, Clause 10, or where prior approval (if required) is not received.

4.1.3. Clinical Services may not be provided while a Client's covered injury is being managed acutely by any treatment provider.

4.1.4. Specialist follow up and care provided to an ACC Client within six weeks of the client being discharged from Elective Surgery is covered within the cost of the funding package for the Elective Surgery procedure and will not be invoiced against the Clinical Services contract.

4.2. Referral process

4.2.1. Referrals for all Services except Medical Case Reviews and Medical Single Discipline Assessments may only be received from:

(a) A Vocationally Registered Medical Specialist; or

(b) The Client's General Practitioner; or

(c) Any other "treatment provider" within the meaning of section 6(1) of the AC Act 2001; or

(d) ACC

4.2.2. Referrals for Medical Case Reviews and Medical Single Discipline Assessment may only be received from ACC.

4.2.3. ACC will not pay for services where Clients self refer or are referred other than by those as described in clause 4.2.1 or clause 4.2.2 (whichever is relevant).

4.2.4. The Supplier may decline a referral if:

(a) The Supplier cannot meet timeframes as set out in clause 7.1; or

(b) The Supplier does not have an appropriate medical specialist available in relation to the injury; or

(c) The Supplier considers that the referral is more appropriately managed under the Vocational Medical Services Service Schedule because:

- It includes consideration of a Client's employment as a major factor of the assessment; or
- Assessment by an occupational medicine specialist of work restrictions, limitations, fitness for work, the ability to engage in employment or the ability to participate in vocational rehabilitation is required.

4.2.5. The Supplier will notify the referrer (and the ACC case owner where ACC is not the referrer) if a referral is declined.

4.3. Prior Approval

4.3.1. ACC funding approval is required for the procedures specified below. Provision of the following Services must not commence before funding approval has been received from ACC:

(a) Caudal Lumbar Epidural Injections – second or subsequent only (CST9)

4.3.2. Where ACC approval is required the Supplier must submit an ARTP to ACC in accordance with Part B, Clause 10. In addition to the requirements above, ACC may, from time to time, specify by notice and/or on the ACC website that particular Assessment and/or Treatment Services also require prior approval in accordance with Part B, Clause 10.

4.3.3. For Medical Case Reviews and Medical Single Discipline Assessments, ACC will request these directly and will provide confirmation of funding approval in the referrals.

5. FACILITY LOCATION (PART A, CLAUSE 3)

5.1. The Service will be provided in the Supplier's facility/facilities named in Part A Clause 3. Any change to the facility/facilities named in Part A, Clause 3 must be approved by ACC in writing.

6. SERVICE REQUIREMENTS

6.1. The Supplier will provide Clinical Services in accordance with this Service Schedule which include as appropriate components as described in Clause 7.

6.2. Electronic Communication

Where such systems are available, and from a date notified by ACC, referrals must be received or made using electronic referral forms.

7. SERVICE SPECIFIC QUALITY REQUIREMENTS

7.1. In addition to the requirements specified in the Standard Terms and Conditions, the Supplier will:

7.1.1. Ensure the Initial Assessment occurs within six weeks of receipt of referral. Where the Supplier cannot meet this obligation they must refer the Client to another specialist who has capacity to meet this requirement unless ACC and the Supplier agree a different timeframe.

7.1.2. Ensure the following timeframes are met for Medical Case Reviews and Medical Single Discipline Assessments:

(a) Contact the Case Owner within one business days of receiving the referral

(b) Contact the Client within two business days of receiving the referral

(c) Notify the Case Owner within three business days of receiving the referral in the event the supplier has been unable to contact the Client

(d) Meet with the Client and perform the clinical examination within eight business days of receiving the referral letter unless otherwise agreed with ACC

(e) Notify the Case Owner within one business day if the Client fails to keep their appointment

(f) Provide a copy of the report and invoice to the Case Owner within eight business days from the date of the clinical examination

7.2. Definition of Clinical Services

"Clinical Services" means all and any part of the Services described in this Service Schedule to be provided to Clients, subject to and in accordance with the provisions of this Agreement.

7.2.1. Clinical Services as set out in Clauses 8.1 and 8.2 provided by the Supplier must include (without limitation):

(a) A clinical history and examination of the Client by a Named Provider or a suitably qualified specialist under the direction of a Named Provider;

(b) A multi-disciplinary perspective to assess aspects of the health of the Client that are directly relevant to determining the most appropriate rehabilitation or treatment options(s);

(c) Arranging access to necessary pathology services and diagnostic imaging services including but not limited to; radiology, MRI and CT scanning, and incorporating the results of those tests in the ARTP;

(d) All nursing assessment and nursing treatment provided at the time of the consultation;

(e) Discussion between the Client and the Named Provider concerning suitable treatment options, including non-surgical (conservative) treatment where appropriate. Non-surgical treatment options, where these are likely to be as effective or more effective than surgical treatment options, are to be promoted for that Client unless those non-surgical treatments have been tried and have failed to produce the rehabilitation outcomes desired by the Client and ACC;

(f) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service; and

(g) Appropriate clinical record documentation, including a copy of the ARTP and any referral documentation to support the referral of the Client;

(h) Documentation of referral back to the original Referrer, where the original Referrer is a Medical Practitioner; or on to another Supplier for further treatment.

7.2.2. Medical Case Reviews (as set out in clause 8.3) provided by the Supplier must include:

(a) A review of clinical information including any contemporaneous notes related to the Client and provided with the referral;

(b) A clinical history and examination of the Client;

(c) A diagnosis/es including differentials

Note: Further investigations may be required to reach a diagnosis. The Named Provider may refer directly for these and receive the results prior to the completion of the Medical Case Review report. This may or may not necessitate a second consultation with the Client. Where investigations and/or a second consultation are required, the Named Provider will notify the case owner accordingly;

(d) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service;

(e) Appropriate clinical record documentation, including a Medical Case Review report that is provided to ACC and demonstrates clinical reasoning and provides a rationale for decisions reached;

7.2.3. A Medical Case Review for the purposes of obtaining clarity about a diagnosis/es, which must include an explanatory rationale for the diagnosis/es reached. This is particularly important if the opinion on diagnosis/es differs from that of another treatment provider involved in the case;

7.2.4. A Medical Case Review for the purposes of obtaining clarity about causation, which must include:

(a) A statement on the mechanism of injury used to assess causation in the specific case. If this differs from that obtained by ACC (as expressed in the referral document) an explanation of the difference must be provided;

(b) A statement on general causation with explanatory rationale. General causation requires a recognition by the scientific community that the mechanism of injury could cause the diagnosis/es (this might be with reference to the peer-reviewed literature and/or a statement on biomechanical plausibility);

(c) A statement confirming whether or not the specific Client and/or specific circumstances of this case would confer an exception to the general scientific understanding. If this is an exception, an explanatory rationale must be provided;

(d) A statement on specific causation with explanatory rationale. Specific causation requires an assessment as to whether the specified mechanism of injury caused the diagnosis/es in this particular case; and

(e) If there is evidence for general and specific causation, a statement as to why this explanation is considered more likely than alternative possible causes of the same condition, including it being idiopathic;

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

(a) whether or not the personal circumstances of the client in relation to their employment led to exposure that caused the injury,

(b) circumstances of the property or characteristics of employment or non-employment activities that caused or contributed to the injury

(c) the risk of the client suffering this injury compared to others in the workplace undertaking and not undertaking the same employment tasks and to others who are employed in that type of environment.

7.2.6. A Medical Case Review may include a discussion with the Client concerning medical fitness for work, including:

(a) Any restrictions/limitations and/or accommodation that may assist with enhancing medical fitness for work;

(b) Recommendations for further investigations, treatment and/or rehabilitation; and

(c) Specific questions deemed relevant to the case by ACC.

7.2.7. Medical Single Discipline Assessments as set out in clause 8.3 provided by the Supplier must include:

(a) A review of clinical information, including any relevant Client notes provided with the referral;

(b) A clinical history and examination of the Client. This must include a specific discussion with the Client about the Client's rehabilitation progress to date, with mention of any specific rehabilitation undertaken to date;

(c) Diagnosis/es including any differentials;

(d) A discussion with the Client on treatment and/or rehabilitation options and impacts appropriate for the diagnosis/es

- Where further investigations may be required in order to determine the most appropriate treatment and/or rehabilitation options for a Client, the Named Provider may refer directly for these and receive the results prior to the completion of the Single Discipline Assessment report. This may or may not necessitate a second consultation with the Client. Where investigations and/or a second consultation are required, the Named Provider will notify the case owner accordingly;

(e) Specific recommendations for any further investigations, treatment and/or rehabilitation with explanatory rationale;

(f) Any administrative matters as would normally be required when undertaking the Clinical Services, including the recording of Service outcomes in clinical notes and/or through internal information systems, to allow the Supplier to evaluate the Service; and

(g) Appropriate clinical record documentation, including a Medical Single Discipline Assessment report, which is provided to ACC and demonstrates clinical reasoning and provides a rationale for decisions reached.

8. CLINICAL SERVICE CONSULTATIONS

8.1. The following Clinical Service consultations do not require prior approval and are detailed in Table 1.

8.1.1. Initial Assessment - (to be used for first Assessment only).

An Initial Assessment can be either Simple or Complex. Taking into account clinical best practice and the complexity of the Client's injury:

(a) An Initial Assessment (Simple) is expected to take up to 45 minutes; and

(b) An Initial Assessment (Complex) is expected to take over 45 minutes.

An Initial Assessment is a face-to-face initial assessment for a Client which includes provision of a treatment plan that outlines the following:

(a) Expected duration for Clinical Services Assessments and/ or treatment, and

(b) Anticipated treatment, and

(c) Any referrals required, and

(d) The Client's capacity for return to normal function, employment

Note: An Initial Assessment can only be carried out once for a Client for each claim and does not include an assessment by a vocationally registered Anaesthetist.

8.1.2. Second Opinion Assessments.

A Second Opinion Assessment can be either Simple or Complex. Taking into account clinical best practice and complexity of the Client's injury:

(a) A Second Opinion Assessment (Simple) is expected to take up to 45 minutes; and

(b) A Second Opinion Assessment (Complex) is expected to take over 45 minutes.

A Second Opinion Assessment is a face-to-face assessment for a Client by a second Specialist (including, without limitation, a vocationally registered Anaesthetist) following an Initial Assessment where:

(a) The initial Specialist is unable to recommend treatment, or has reservations about recommending treatment; and

(b) The initial Specialist has requested in writing a Second Opinion Assessment from the second Specialist.

This type of assessment will be paid for:

(a) Under this Agreement if the second Specialist is a Named Provider; or

(b) Under the appropriate regulations if the Specialist is not named in any current Clinical Services contract with ACC.

The initial Specialist remains responsible for the provision of the ARTP to ACC, and for including any recommendation made by the second Specialist in the ARTP, unless otherwise agreed between the Specialists that the care of the Client should be transferred to the second Specialist.

8.1.3. Subsequent Assessments

A Subsequent Assessment can be either Simple or Complex. Taking into account clinical best practice and complexity of the Client's injury:

(a) A Subsequent Assessment (Simple) is expected to take up to 30 minutes; and

(b) A Subsequent Assessment (Complex) is expected to take over 30 minutes.

A Subsequent Assessment is a subsequent face-to-face assessment for a Client where:

(a) An Initial Assessment (Simple or Complex) or a Second Opinion Assessment (Simple or Complex) was unable to be satisfactorily completed without obtaining diagnostic tests of the Client, and

(b) The primary purpose is to enable the Specialist to discuss the results of such tests with the Client and explore the Client's resulting treatment and rehabilitation options; and

(c) The consultation takes place on a different day from the Initial Assessment (Simple or Complex) or Second Opinion Assessment (Simple or Complex).

OR

(a) The Subsequent Assessment is required after an Initial Assessment (Simple or Complex) or Second Opinion Assessment (Simple or Complex); and

(b) The primary purpose is for the provision of necessary on-going management and/or conservative treatment recommended in an initial non surgical ARTP;

OR

(a) A Subsequent Assessment is required by one Named Provider to review the management of the personal injury which was initiated by another Medical Practitioner;

OR

(a) The Client has not reached the rehabilitation milestones or outcomes predicted in the initial ARTP;

AND

The Subsequent Assessment may result in further recommendations for treatment (e.g. surgery) for which a surgical ARTP is required.

8.1.4. Reassessment

This is a subsequent face-to-face Simple or Complex Assessment for a Client by the Service Provider who carried out the Initial Assessment:

(a) The Client must have been discharged from the care of the Service Provider who carried out the Initial Assessment and their care transferred back to the original Referrer;

(b) A Reassessment cannot occur within 12 months of the Initial Assessment for that claim;

(c) The Client must be referred back to the Service Provider for the Reassessment in accordance with Clause 4.2.

Note: This is not a pre organised Assessment by the Service Provider who carried out the Initial Assessment.

8.1.5. Neurophysiological consultation

This is a neurophysiological consultation performed by an Internal Medicine Specialist. It includes the administration of the primary nerve conduction study.

8.1.6. Simple and Complex Neurophysiological Follow ups

(a) This is a Simple Neurophysiological Follow up consultation performed by an Internal Medicine Specialist. This Follow up includes checking for innervation in selected muscles or repeating a section of the nerve conduction study.

(b) A Complex Neurophysiological Follow up is equivalent to an initial study and is expected to take over 45 minutes.

Table 1 – Clinical Service Assessments (no prior approval required)

Procedure	Code	Definition	Treatment Provider
Simple Assessment (Initial)	CS100	Simple Assessment (First assessment only) – per face-to-face consultation	Specialist
Complex Assessment (Initial)	CS200	Complex Assessment (Initial) – per face-to-face consultation	Specialist
Second Opinion Assessment (Simple)	CS400	Second Opinion Assessment (Simple) – per face-to-face consultation	Specialists Anaesthetist
Reassessment	CS500	Reassessment – per face-to-face consultation	Specialist (same specialist who provided initial assessment)
Subsequent Assessment (Simple)	CS61	Subsequent Assessment (Simple) – per face-to-face consultation	Specialist
Subsequent Assessment (Complex)	CS62	Subsequent Assessment (Complex) – per face-to-face consultation	Specialist
Neurophysiological consultation	CS83	Neurophysiological consultation - Neurophysiological study and consultation	Internal Medicine Specialist
Simple Neurophysiological Follow up	CS84	Simple Neurophysiological Follow up and consultation	Internal Medicine Specialist
Complex Neurophysiological Follow up	CS85	Complex Neurophysiological Follow up and consultation	Internal Medicine Specialist
Second Opinion Assessment (Complex)	CS900	Second Opinion Assessment (Complex) – per face-to-face consultation	Specialist Anaesthetist

8.2. The following Clinical Service consultations can only be undertaken pre-operatively and a surgical ARTP must have been approved prior to the assessments being undertaken.

8.2.1. Simple and Complex Pre-operative Anaesthetic Assessments.

A Pre-operative Anaesthetic Assessment can be Simple or Complex. Taking into account clinical best practice and the complexity of the Client's injury:

(a) A Simple Pre-operative Anaesthetic Assessment is expected to take up to 45 minutes; and

(b) A Complex Pre-operative Anaesthetic Assessment is expected to take over 45 minutes.

Simple and Complex Pre-operative Anaesthetic Assessments can only be undertaken pre-operatively and a Surgical ARTP must have been approved prior to this assessment being undertaken.

Note: The Client must be referred for a Complex Pre-operative Anaesthetic Assessments by the treating Named Provider.

These Assessments are face to face initial assessments for a Client to allow for pre-operative planning, performed by a vocationally registered Anaesthetist (preferably the same person who will attend the proposed surgery) to enable assessment of the Client's medical condition and to facilitate planning for intra-operative and post-operative care.

The Simple Pre-operative Anaesthetic Assessment will be undertaken for:

(a) Those Clients with co-morbidities likely to pose anaesthetic risk; and/or

(b) Non-Core Complex/Unpredictable Procedures, where the Client will be expected to require Intensive Care Unit care post-surgery; and/or

(c) Clients with identified significant anxiety regarding anaesthesia.

The Complex Pre-operative Anaesthetic Assessment will be undertaken for:

(a) Clients with a personal injury of unusual complexity; and/or

(b) Clients requiring a more complex level of investigation than would usually be required for a Simple Pre-operative Anaesthetic Assessment; and/or

(c) Those Clients with co-morbidities likely to pose anaesthetic risk; and/or

(d) Non-Core Complex/Unpredictable Procedures, where the Client will be expected to require Intensive Care Unit care post-surgery; and

The outcome of the assessment will include informing the Client of post surgery management such as high dependency or intensive case management. The Anaesthetist will inform the surgeon of the post operative plan.

8.2.2. Anaesthetic long distance consultation

(a) This is a telephone consultation for a Client by a vocationally registered Anaesthetist (preferably the same person who will attend the proposed surgery) to enable assessment of the Client's medical condition, following review of the pre-anaesthetic form. The consultation shall facilitate planning for intra-operative and post-operative care.

(b) The consultation is ***not*** a substitute for a clinical examination to determine anaesthetic status; or is it a simple introductory call as the purpose of this is to improve the service to Clients who live some distance from the clinic.

Table 2 – Clinical Service Consultations (pre-operatively only)

Procedure	Code	Definition	Treatment Provider
Simple Pre-operative Anaesthetic Assessment (Initial)	CS250	Simple Pre-operative Anaesthetic Assessment (Initial) - Per face-to-face consultation (pre operatively only)	Anaesthetist
Complex Pre-operative Anaesthetic Assessment –(Initial)	CS260	Complex Pre-operative Anaesthetic Assessment –(Initial) - Per face-to-face consultation (pre operatively only)	Anaesthetist
Anaesthetic long distance consultation	CS70	Anaesthetic long distance consultation – Per Call (pre-operatively only)	Anaesthetist

8.3. The following Clinical Service consultations must have been requested and approved by ACC prior to the assessment being undertaken.

8.3.1. Standard Medical Case Review and Complex Medical Case Review.

A Medical Case Review can be Standard or Complex. Taking into account the complexity of the Client's presentation:

(a) A Standard Medical Case Review is expected to take up to 3.5 hours; and

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

8.3.2. Standard Medical Single Discipline Assessment and Complex Medical Single Discipline Assessment.

A Medical Single Discipline Assessment can be Standard or Complex. Taking into account the complexity of the Client's presentation:

(a) A Standard Medical Single Discipline Assessment is expected to take up to 2.5 hours; and

(b) A Complex Medical Single Discipline Assessment is expected to take more than 2.5 hours, as the Client's case information includes several opinions representing conflicting options for treatment or rehabilitation; or the Medical Single Discipline Assessment will be undertaken in two parts whilst results of investigations are obtained.

8.3.3. If on referral a Service provider believes the Client is exceptionally complex over and above the cost available under a Complex category, please contact ACC to discuss.

Table 3 – Medical Case Reviews and Medical Single Discipline Assessments

Procedure	Code	Definition	Treatment provider
Medical Case Review (Standard)		Medical review to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Case Review (Complex)		Medical review taking more than 3.5 hours to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Single Discipline Assessment (Standard)		Medical assessment to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist
Medical Single Discipline Assessment (Complex)		Medical assessment taking more than 2.5 hours to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist

9. ASSESSMENT REPORT AND TREATMENT PLAN

9.1. Service Providers are required to maintain clinical notes at the completion of the consultation with the Client.

9.1.1. If Surgical Treatment is required an ARTP must be completed for prior approval for clinic based and Elective Surgery.

9.1.2. All reports/notes/letters or summarised comprehensive letters related to Client's assessments are required to be submitted electronically to ACC via electronic transmission as arranged with ACC (e-business with ACC). This can be the same reports/notes/letters or summarised comprehensive letters that are provided to the General Practitioner or referring specialist.

9.1.3. ACC will not be charged any additional fee for the provision of reports/notes/letters or summarised comprehensive letters when requesting information contained within these documents following a consultation that has been performed under this Agreement.

9.1.4. Where a client has a complex injury and requires multiple Subsequent Assessments, the Supplier will ensure that there is a treatment plan in the clinical notes detailing the expected rehabilitation outcome.

9.2. When a surgical ARTP is required

9.2.1. A surgical ARTP is required when surgery is recommended by the Named Provider. The Named Provider will prepare and submit a surgical ARTP to ACC on completion of:

(a) An Assessment/Reassessment (and a Second Opinion Assessment or Complex Second Opinion Assessment, if applicable); and

(b) A Subsequent Visit where the Specialist recommends surgical treatment.

9.2.2. To Whom

An ARTP recommending surgery will be forwarded to ACC's Treatment Assessment Centre (TAC) by the Elective Surgery Supplier. These documents should be sent electronically via HealthLink or to ARTPS4ESU@acc.co.nz.

Relevant information regarding recommended treatment will be forwarded to the Client's General Practitioner.

9.2.3. By When

The ARTP will be forwarded within 7 business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).

9.2.4. Contents of Surgical ARTP

The ARTP document on the ACC Provider Website is the only version that is ACC approved and is the only version of the ARTP that will be accepted by ACC.

9.3. Non – surgical intervention

If non-surgical intervention e.g. Pain Management or other rehabilitation is recommended, a copy of reports/notes/letters or a summarised comprehensive letter outlining the recommendation must be emailed or electronically submitted to ACC electronically.

9.3.1. By When

The non-surgical recommendation will be forwarded within 7 business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).

9.3.2. Unless otherwise agreed with ACC, the Supplier will make any referrals for associated services (e.g. pathology services and diagnostic imaging services) electronically if directed to do so by ACC.

10. PROCEDURES

10.1. Treatment Clinic Based Procedures that do not require prior approval

10.1.1. A Named Provider may carry out one of the Treatment Clinic Based Procedures named below in Table 4 during an Assessment and invoice ACC for the cost of the procedure only.

10.1.2. The consultation price is included in the procedure price and cannot be claimed in addition to the procedure price.

Table 4 – Clinic Based Procedures

Procedure	Code	Definition	Treatment Provider
Reduction of fractured nose	CST11	Closed reduction of displaced/fracture of nasal bones performed under local anaesthetic. This type of reduction will be performed for fractures of the nasal bones that are limited in size and complexity. NOTE: This treatment must not take place earlier than 7 days from the date of injury	Otolaryngologist
Caudal/Lumbar epidural injection	CST9	Caudal/Lumbar epidural injection. This is not to be used as an ongoing treatment and is limited to one per claim. Second or subsequent epidural injections require prior approval and requests should be sent to on an ARTP to escmednotes@acc.co.nz along with relevant documents. 'CST9 Injection' should be included in the email subject line.	Orthopaedic Surgeon Anaesthetist
Neurophysiological consultation	CS83	A nerve conduction test is an electrodiagnostic test of the integrity of the peripheral nerves to assist in the diagnosis of nerve entrapment syndrome or polyneurophathies. It involves placing an electrical stimulator over a nerve and measuring the time required for an impulse to travel over a measured segment of the nerve.	Neurologist Neurosurgeon
Simple Neurophysiological Follow up consultation	CS84	A subsequent neurophysiological consultation	Neurologist Neurosurgeon
Complex Neurophysiological Follow up consultation	CS85	A subsequent neurophysiological consultation	Neurologist Neurosurgeon

10.2. The procedures in Table 5 are claimed in addition to a consultation and do not require prior approval.

10.2.1. Each Procedure must be carried out by a Specialist who is a treatment provider of a type named in Table 5 as being able to provide that procedure.

10.2.2. The Facility where the procedure is to be carried out must meet the requirements identified in Part B, clause 5.

10.2.3. The completion of the ARTP must include the expected outcome of the procedure and the timeline for the result of the procedure.

10.2.4. No prior approval is required to carry out these Clinic Based Procedures.

Table 5 – Clinic Based Procedures (prior approval not required)

Procedure	Code	Definition	Treatment Provider
Removal of wire/screws	CST1	**Note: ACC must have funded the insertion of wire/screws**	Orthopaedic Surgeon
Simple injection	CST4	Injections or joint aspiration	Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Isolated nerve block	CST5	The transmission of nerve impulses is interrupted by injecting a local anaesthetic around a nerve	Anaesthetist Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Regional block (not LA) or compartment pressure monitoring	CST6	Regional block (not LA) or compartment pressure monitoring	Anaesthetist Orthopaedic Surgeon
Complex Injection	CST10	Injection of steroid and/or local anaesthetic into joint or bursa or tendon sheath	Orthopaedic Surgeon Musculoskeletal Medicine Specialists
Reapplication of plaster casts/thermoplastic splints above knee	CST21	Reapplication of plaster casts/thermoplastic splints above knee	Nurse under supervision of an Orthopaedic Surgeon
Reapplication of plaster casts/thermoplastic splints above elbow	CST22	Reapplication of plaster casts/thermoplastic splints above elbow	Nurse under supervision of an Orthopaedic Surgeon
Reapplication of plaster casts/thermoplastic splints below knee	CST31	Reapplication of plaster casts/thermoplastic splints below knee	Nurse under supervision of an Orthopaedic Surgeon
Reapplication of plaster casts/thermoplastic splints below elbow	CST32	Reapplication of plaster casts/thermoplastic splints below elbow	Nurse under supervision of an Orthopaedic Surgeon
Flow and residual test	CSD10	Test focused on the bladder's ability to empty steadily and completely	Urologist
Optical Coherence Tomography (OCT) scan (unilateral and bilateral)	CSD40 and CSD41	Measurement of the thickness of the macula, the tissue make-up of the nerve fibre layer or to analyze individual layers of the retina. OCT is also used to analyse the optic nerve head in glaucoma	Ophthalmologist Medical Orthoptist
Visual Field Test- unilateral (ophthalmology)	CSD42	Determining a patients peripheral vision (side) vision.- one eye	Ophthalmologist Medical Orthoptist
Visual Field Test- bilateral (ophthalmology)	CSD43	Determining a patients peripheral vision (side) vision.- two eyes	Ophthalmologist Medical Orthoptist
Orthoptic assessment (for a child or an adult)	CSD44CSD45	Assessment of the eye movements and binocular vision disorders	Ophthalmologist Medical Orthoptist

Procedure	Code	Definition	Treatment Provider
Fluorescein angiography	CSD46	Test used to assess the health of certain blood vessels in the eye. In this test, fluorescein dye is injected into a vein in the arm and photographs are taken of the eye as the dye circulates.	Ophthalmologist Medical Orthoptist

10.3. Pre operative Clinic Based Procedures

10.3.1. A Named Provider may carry out one of the Pre operative Clinic Based Procedures named below in Table 6 during an Assessment and invoice ACC for the cost of the Procedure and Assessment in accordance with this Service Schedule.

10.3.2. Each Procedure must be carried out by a Specialist who is a treatment provider of a type named in Table 6 as being able to provide that procedure.

10.3.3. The Facility where the procedure is to be carried out must meet the requirements identified in Part B, Clause 5.

10.3.4. A surgical Assessment Report - Treatment Plan (ARTP) must have been approved by ACC before any Pre operative Rooms Based Procedure in Table 5 (relating to "fit for surgery") is undertaken

Table 6 - Pre operative Clinic Based Procedure (Surgical ARTP must be approved prior to undertaking)

Procedure	Code	Definition	Treatment Provider
Echocardiogram (Echo)	CSD1	Ultrasound scan of the heart (for clients pre-operatively only)	Cardiologist Cardiac Sonographer
Stress Echocardiogram (Stress Echo)	CSD2	Stress induced by exercise machine or Pharmacological agent if machine stress not appropriate and recorded via ultrasound (for clients pre-operatively only)	Cardiologist Cardiac Sonographer Technician
Respiratory Spirometry	CSD3	Pulmonary function test, which measures the volume of air inspired or expired as a function of time (for clients pre-operatively only)	Cardiologist Respiratory Technician
Exercise treadmill	CSD4	Machine exercise while being monitored for ECG and Blood Pressure (for clients pre-operatively only)	Cardiologist Technician
Electrocardiogram (ECG)	ECG	An electrocardiogram is a recording of the electrical activity of the heart. This procedure fee can be charged when an ECG is undertaken off site (i.e. not as part of the Assessment) The referring Named Provider is responsible for ensuring the treatment provider to whom they refer the Client has suitably qualified and trained staff to undertake the procedure and that all quality and safety standards are met. NOTE: District Health Boards (DHBs) are responsible for ECGs related to public health acute services. NOTE: When this diagnostic test is undertaken as part of : (a) A preoperative anaesthetic assessment OR (b) Part of a cardiology assessment	Medical Staff Technician

Procedure	Code	Definition	Treatment Provider
		second opinion it is considered as a component of that Assessment and included in the price for that Assessment	

11. NAMED PROVIDERS

11.1. Names

The Supplier will utilise the services of only the Specialists named in, Part B, clause 3 (the "Named Providers") in the course of providing Clinical Services for Clients.

11.2. Addition of Specialists

The Supplier may, at any time during the Term of this Agreement, make a written request to ACC Health Procurement for a Specialist to be added to the Named Providers.

ACC may in its sole discretion accept or decline each such request, with or without conditions, by providing written notification to the Supplier.

If a request is accepted under this clause, the Specialist shall be deemed added to the Named Providers from the date of ACC's written notification to the Supplier.

11.3. Removal of Specialists

The Supplier may, at any time during the Term of this Agreement, provide written notification to ACC Health Procurement that a Named Provider is to cease to be a Named Provider under this Agreement. The Specialist shall cease to be a Named Provider five business days after receipt of the Supplier's notice by ACC Health Procurement. The Supplier shall not issue such a notice arbitrarily.

ACC may, at any time during the Term of this Agreement, provide written notification to the Supplier that a Named Provider is to cease to be a Named Provider under this Agreement. The Specialist shall cease to be a Named Provider five business days after receipt of ACC's notice by the Supplier. ACC shall not issue such a notice arbitrarily.

12. SERVICE EXIT

12.1. This Service is complete when:

12.1.1. The Supplier completes one of the assessments identified in Part A, Clause 4 and an ARTP for the assessment carried out is completed and sent to the appropriate people (where required), clinical notes or reports have been completed and correspondence with the referrer has been sent; or

12.1.2. When the transfer of clinical responsibility and care of the Client to the original referrer, the Client's General Practitioner or another specialist, has occurred;

12.1.3. Whichever is the later date.

13. EXCLUSIONS

13.1. The following Services are not purchased under this Service Schedule but may be purchased under other Service Schedules.

13.1.1. Diagnostic imaging service

13.1.2. Clinical Psychiatric Services and Psychological Services

13.1.3. Public Health Acute Services

13.1.4. Pain Management Services.

13.2. Outpatient Post Discharge / Post Procedure Care following Elective Surgery

13.2.1. Post Discharge/Post Procedure Care for a Client following Elective Surgery begins following Discharge from a facility where Treatment has been carried out, and ends six weeks after Discharge. Any necessary and appropriate follow-up and care required during this period is the responsibility of the Elective Surgery supplier and should not be invoiced against the Clinical Services contract.

13.2.2. If, at the end of the six week post discharge period, further specialist follow up care is required, this may be only provided under the Clinical Services contract or under the applicable regulations.

13.2.3. ACC will undertake regular monitoring of invoices against the Clinical Services Contract, and has the right to seek repayment of services undertaken during this six week post discharge period that have been invoiced to ACC.

14. LINKAGES

14.1. The Supplier will ensure that linkages are maintained with the following Services:

14.1.1. ACC Client Service Staff

14.1.2. Health Professionals

14.1.3. Other Services as appropriate to meet the Client's needs.

15. PERFORMANCE REQUIREMENTS

15.1. The Supplier's performance will be measured as shown in Table 7 – Performance Measurement

Table 7 – Performance Measurement

Objective	Performance measure	Target	Data Source
1. Service Provision	Procedures are carried out by Medical Specialists who hold registration in the appropriate vocational scope of practice	100% of Procedures are carried out by a Specialist who is a treatment provider of the type names in the Service Schedule as being able to provide that procedure.	• Supplier supplies evidence to ACC (in accordance with Clause 11 • Clinical Notes
2. Cost effective	Services are necessary, appropriate and not excessive in number or duration.	100% of Clinic Based Surgical Procedures performed are clinically necessary and appropriate	• Clinical notes • Operative notes • Benchmark reports monitoring the number of procedures performed by other Providers

Objective	Performance measure	Target	Data Source
3. Early intervention	Clinic based surgical procedures are performed within necessary time frame to allow for maximum rehabilitation.	100% of Clients will have their Clinic Based Surgical Procedure within 28 days of the Assessment that determined the need for the procedure/s (this is for procedures which do not require prior approval)	• ARTP • Operative notes • Invoice
4. Prompt and accurate information submitted to ACC	Complete and accurate information provided to enable assessment of quality of service received	100% of documentation received within scheduled time frame 100% of Medical Case Review reports and Medical Single Discipline Assessment reports meet quality standards for reporting	• ARTP • Medical Case Review report • Medical Single Discipline Assessment report • Operative notes • Discharge summary • Invoice

16. REPORTING REQUIREMENTS

16.1. The Supplier will report information following the format required by ACC as set out in the *Operational Guidelines* which can be downloaded from the ACC website.

16.2. Each Medical Case Review and Medical Single Discipline Assessment report will include:

16.2.1. The Named Provider's qualifications and statement of impartiality as a non-treating practitioner;

16.2.2. Any facts and assumptions on which the opinions and recommendations of the Named Provider are based;

16.2.3. Reasons for the opinions and recommendations made by the Named Provider;

16.2.4. References to any literature or other material used or relied on in support of the opinions and recommendations expressed; and

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

16.3. Reports will be provided in accordance with Table 8 – Reporting Requirements.

Table 8 – Reporting Requirements

Information	Frequency	When	Responsibility
Surgical ARTP	For all Clients for whom surgery is recommended by the Named Provider	Within seven business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).	Supplier via the Elective Surgery Contract Holder
Non surgical ARTP (include referrer details)	For all clients for who a non-surgical intervention is recommended	Within 7 business days of the Specialist completing the consultation	Supplier

Information	Frequency	When	Responsibility
Discharge summary	Following each discharge	Within two business days of discharge	Supplier
Invoice and operative note	Following each discharge	Within 3 months of procedure	Supplier
Medical Case Review report	For all Clients who are referred for a Medical Case Review	Within eight business days of the Specialist completing the consultation	Supplier
Medical Single Discipline Assessment report	For all Clients who are referred for a Medical Single Discipline Assessment	Within eight business days of the Specialist completing the consultation	Supplier

17. RELATIONSHIP MANAGEMENT

17.1. To ensure the continuing effective operation of the service, formal working relationships are to be maintained as defined in Part A, Clause 5.

18. PAYMENT AND INVOICING

18.1. Services prices are defined for this Service in. Part A, Clause 4.

18.2. ACC agrees to pay the prices set out in Part A, Clause 4.

18.3. The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, the Client or other person for Services under this agreement.

APPENDIX ONE - DEFINITIONS AND INTERPRETATION

In this Service Schedule, unless the context otherwise requires:

"Assessment Report and Treatment Plan" and **"ARTP"** is the report issued when requesting elective surgery, as described in Part B, Clause 9 - available on the Provider website. http://www.acc.co.nz/for-providers/elective-surgery/index.htm

"Complex Assessment" has the meaning defined in Part B, clause 8.1.1;

"Complex Medical Case Review" has the meaning defined in Part B, clause 8.3.2:

"Complex Medical Single Discipline Assessment" has the meaning defined in Part B, clause 8.3.2;

"Complex Second Opinion Assessment" has the meaning defined in Part B, clause 8.1.2;

"Consumables" are those single use Medical Consumables that are required for the treatment of the Client;

"Treatment Assessment Centre" means the centre where all surgical ARTP's are submitted (formally known as the Elective Services Centre/Unit). These should be submitted via HealthLink Mailbox ACCEARTP or via email to ARTPS4ESU@acc.co.nz

"Named Provider" means a Provider listed in Part A, Quick Reference Information, Part B, clause 3 and any other Provider deemed added to this Service Schedule, who has not ceased to be a Named Provider;

"Operational Guidelines" is the document produced by ACC from time-to-time to reflect the processes and procedures that should be followed in support of this Service;

"Pre-operative Anaesthetic Assessment - Simple" has the meaning defined in Part B, clause 8.2.1;

"Pre-operative Anaesthetic Assessment - Complex" has the meaning defined in Part B, clause 8.2.1;

"Reassessment" has the meaning defined in Part B. clause 8.1.4;

"Referrer" means the Medical Practitioner or another "treatment Supplier" within the meaning of section 6(1) of the AC Act or ACC representative who requests that the Supplier provide Clinical Services or medical services for the Client or, where the context otherwise requires, means the Supplier where it requests that a Medical Practitioner accept a transfer of clinical responsibility for a Client or requests that another "treatment Supplier" provide Clinical Services or medical services for the Client and, if appropriate, treatment; and "Referral" and "Referred" has a corresponding meaning;

"Second Opinion Assessment" has the meaning defined in Part B, clause 8.1.2;

"Simple Assessment" has the meaning defined in Part B, clause 8.1.1;

"Standard Medical Case Review" has the meaning defined in Part B, clause 8.3.1;

"Standard Medical Single Discipline Assessment" has the meaning defined in Part B, clause 8.3.1;

"Subsequent Assessment" has the meaning as defined in Part B, clause 8.1.3.

Assessment Report and Treatment Plan (ARTP)
Request to Accident Compensation Corporation for Prior Approval for Elective Surgery (ES)

(Specialist Name) Practice Address **Phone:** **Fax:** **Email:**	Send to HealthLink Mailbox: ACCEARTP Email to: artps4esu@acc.co.nz, or Fax to: ACC ES Team on **0800 222 463**

To ensure ACC can make prompt and informed decisions, we need full and accurate information. Please ensure you complete the ARTP form fully, otherwise we will have to return it for your further attention. This may lead to unnecessary delay for your patient.

Client & Claim Details	
Claim Number:	
Full Name:	
Address:	
Date of Birth:	
Telephone (Home):	
Telephone (Mobile):	
Telephone (Work):	
NHI Number:	
Date of Injury:	
Referring Provider:	

History, Examination and Diagnosis	
Type of Assessment *(Simple Assessment/Complex Assessment/Second Opinion/Reassessment/Follow-up visit)*:	
History of the current condition	
Causal Medical Link Between Proposed Treatment & Covered Injury:	
Relevant Pre-Existing Factors *(Relevant medical history, presence of degenerative disease, co-morbidities)*:	
Clinical Examination *(Outline of findings at clinical examination, progress since previous visits and the indicated clinical pathology)*:	
Diagnostic Tests And Imaging *(Provide copies of reports)*:	
Specific Diagnosis:	

Proposed Management & Prognosis	
Prognosis *(Expectations for the client's recovery including expected return to work on modified or alternative duties)*:	
Pre/Post Operative Care *(Expectations for preoperative care and any appropriate postoperative care including physiotherapy, assistive devices, home help or vocational assistance)*:	

Certificate & Specialist Details	
I certify that, on the date shown, I have personally examined and/or treated the Patient. I have discussed the treatment options with the client and advised why the recommendation is the appropriate treatment in this case. The Client (or their representative) has authorised me to provide this information to ACC on their behalf.	
Specialist Name:	
NZMC Number:	
HPI Number (if known):	
Specialist Signature:	
Date Signed:	

Lead Provider Details	
Lead Provider Name:	
Facility:	
Contract Number:	
Lead Provider Notes:	
Contracted or Non Contracted *(Surgery under regulations)*	

Treatment Details	
Date of Consultation:	
Recommended Surgical Treatment:	
Body Site to Be Treated:	
Body Side *(Left, right, both or NA)*:	
Proposed Surgery Date:	
Clinical Priority *(High, Medium, Low)*:	
Likely Length of Hospital Stay *(Days)*:	
Is this Surgery Request a prerequisite to access Medical Insurance? *(Yes/No)*:	

Procedure Details (for each procedure)	
ACC Procedure Code: *(If non core please indicate)*	
Procedure Description:	
ACC Procedure Code 2: *(If non core please indicate)*	
Procedure Description 2:	