27 June 2022

Kia ora

Your Official Information Act request, reference: GOV-018561
Thank you for your email of 31 May 2022, asking for the following information under the Official Information Act 1982 (the Act):

> *Please send me all policy, procedure and any other relevant document that is used by ACC's treatment injury cover team to assess claims for treatment injury. Please specifically include any of the same documents that focus on disease progression as a result of a failure to treat.*

Please find attached documentation to assess claims for Treatment Injury's
We have provided you with the following policies and process documents in Attachment one:

- Assess claim for cover (treatment injury) policy
- Causal link policy
- Cover criteria for treatment injury policy
- Context of treatment policy
- Issue cover decision (treatment injury)
- Necessary part of ordinary consequence of treatment policy
- Treatment injury exclusions from cover policy

Please note that the staff named in the documents attached are subject matter contacts for internal queries, they are not staff who created or updated the policy.

Please find attached documentation to related to disease progression as a result of a failure to treat
We have provided you with the following guidelines and process documents in Attachment two:

- Scenarios for treatment injury guidelines
- Additional Clinical questions guidance: failure within the provision of treatment document

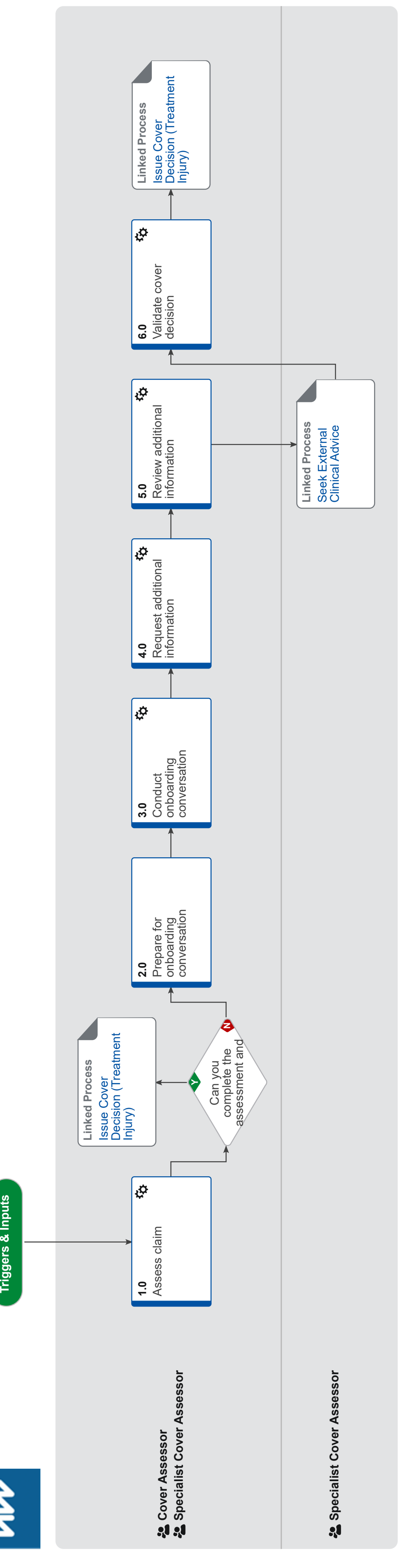
If you're concerned about this response, please get in touch
You can email me at GovernmentServices@acc.co.nz.

If you are not happy with this response, you can also contact the Ombudsman via info@ombudsman.parliament.nz or by phoning 0800 802 602. Information about how to make a complaint is available at www.ombudsman.parliament.nz

Ngā mihi

Sara Freitag
Acting Manager Official Information Act Services
Government Engagement & Support

Assess Claim for Cover (Treatment Injury) v20.0



Assess Claim for Cover (Treatment Injury) v20.0

Summary

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

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

Owner

Expert

Procedure

1.0 Assess claim

Cover Assessor, Specialist Cover Assessor

a Consider Risk of Harm questions.

Risk of Harm Guidance 1.0.pdf

NOTE **What if I believe there is a risk of harm?**
The risk of harm data will be entered when you update the Treatment injury tab in Eos and will be processed via the Create Report for Risk of Harm Review Group process linked below.

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

PROCESS Create Report for Risk of Harm Review Group

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

NOTE **What if there is a request for treatment on the claim, ACC18, ARTP, weekly compensation request or other requests i.e. dental treatment, hearing aids, prosthesis and district nursing care?**
1. Ensure that an ENT05 Cover decision pending letter is sent out to the client. This letter advises the client that as cover is yet to be determined, we are not able to consider an application for entitlement, unless cover is awarded on their claim. Ensure that you forward date the task associated with the request to the legislative date on the claim.

2. Create 'Follow-up cover' task and add in the description [Complex claim, please assess].

3. Set priority on the task as 'high' if:
a) the client requires a critical decision,
b) the client needs more than a week off work,
c) there is an ARTP on file,
d) the claim is on the complex list,
e) we determine the client needs some sort of other urgent assistance

4. Change the target date of the task to the lodgment date

5. Transfer 'Follow-up cover' task to TIC-Case Ownership."

c Generate ACC2184 Cover decision tool if required.

NOTE **When is ACC 2184 is required?**
ACC 2184 is required if ANY or ALL of these criteria apply:
• It is a complex claim
• A detailed timeline of the events is required
• Any tier 3 internal or external opinion is required

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

ACCEPT or DECLINE (delete one) - (state the injury being accepted)
DATE OF INJURY:
ACC 45
ACC 2152
BACKGROUND
ANALYSIS
ADVICE
RESEARCH

d Confirm this is a newly lodged claim.

NOTE **What if the claim is a re-assessment and the information is not new?**
• If there is no new information on file, and we did not re-open the claim, add a contact to note this. Call the client to advise. This process ends.
• If there is no new information on file, and we re-opened the claim, go to 'Issue Cover Decision' process.
PROCESS Issue Cover Decision (Treatment Injury)

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

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

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

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

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

Cover criteria for medical misadventure Policy

NOTE **What if the claim is a duplicate?**
Go to Identify and link duplicate claims.
PROCESS Identify and Link Duplicate Claims :: Treatment Injury

NOTE **What if you identify the claim is consequential to another claim?**
Refer to Consequential Injury Claims Policy
PROCESS Consequential Injury Claims Policy

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

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

NOTE **What should be written in the contact?**
Claim checked for PICBA, AE (accredited employer), consequential claims, reassessment, duplicate claims - nil found. No evidence of a mental injury on ACC45, ACC2152 or other lodging documents ie ACC18, ACC21.
If one of the above claim types is identified, document this clearly in the contact and if relevant the associated claim number.

f Determine whether the client has suffered a personal injury.

NOTE **What if the client did not suffer a personal injury?**
Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.
PROCESS Issue Cover Decision (Treatment Injury)

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

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

Mental Injury Because of a Physical Injury Policy

Statutory timeframes for mental injuries Policy

Treatment injury mental injury Policy

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

Context of Treatment Policy

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

Context of treatment refers to the registered profession of the health provider who gave, provided or directed the treatment either in New Zealand or overseas.

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

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

PROCESS Assess Claim for Cover :: PICBA

NOTE What if the injury occurred as a result of treatment received overseas?

Any personal injury caused by treatment outside New Zealand is coverable Section 22(3) and (4), only if:
• the injured person is a New Zealand resident when they were treated, and
• the injury is suffered on or after 1 July 2005, and
• the treating practitioner is equivalent to a New Zealand Registered Health Professional (the ‘equivalency standards’), and
• the injury is one they would get cover for in New Zealand

In simple terms there is cover for a Treatment Injury caused by treatment overseas but only for those who are ordinarily resident at the time of treatment.

- Context of treatment
- Cover Criteria for Treatment Injury Policy
- Request Clinical Records for Treatment Injury
- When to use an interpreter Policy
- Criteria for injury occurring outside New Zealand Policy

NOTE What if the treatment received overseas by a health provider who did not meet the equivalency standards?

If there is does not meet the equivalency test noted in Context of Treatment policy, then consider the claim under the PICBA cover criteria.

- Assess claim for cover: PICBA

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

NOTE What if there is no direct causal link?

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

PROCESS Issue Cover Decision (Treatment Injury)

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

- Necessary Part or Ordinary Consequence of Treatment Policy

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

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

PROCESS Issue Cover Decision (Treatment Injury)

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

- Treatment Injury Exclusions from Cover Policy

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

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

PROCESS Issue Cover Decision (Treatment Injury)

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

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

- Next Generation Case Management landing page

m Updating Eos with relevant information

NOTE **What do you document in the 'contacts/task' following/during assessment of the claim?**
As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

Causal Link Policy

Can you complete the assessment and issue cover decision?

Cover Assessor, Specialist Cover Assessor

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

NO.... Continue

2.0 Prepare for onboarding conversation

Cover Assessor, Specialist Cover Assessor

NOTE **What if you're a Cover Assessor and you think you cannot complete the assessment because it's a complex claim?**
Go to Activity 4.0 in 'Triage and Allocate Claim (Treatment Injury)' process.
PROCESS Triage and Allocate Claim (Treatment Injury)

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

NG GUIDELINES Obtain Verbal or Written Authority

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

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

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

NOTE **What if verbal consent is appropriate?**
In Skype, during the call with the client, play the pre-recorded consent message:
1.Select "Invite More People" in the top right hand corner of the active call window
2. Enter the extension for the Verbal Consent Recording: 50013 and press OK
3. You will appear in a Conference with the Verbal Consent Recording and the Client
4. Once the consent recording has finished playing, it will automatically leave the phone conference

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

Refer to the process below for more information.
PROCESS Obtain Client Authority to Collect Information

NOTE **What if you need to request consent to lodge a mental injury claim?**
• obtain client's consent.
• inform the client they will receive a declined decision regarding the mental injury claim.
• advise we will reopen the claim to investigate once we have made a decision on their physical injury.

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

NOTE **What if the client requires an Authority to Act?**
Refer to the process below prior to conducting the onboarding conversation.
PROCESS Obtain Authority to Act (ATA)

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

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

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

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

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

NOTE **What if the client does have language or cultural needs?**
To find resources to support a client with language and cultural needs, refer to the following documents.

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

3.0 Conduct onboarding conversation

Cover Assessor, Specialist Cover Assessor

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

NOTE **How many contact attempts should be made?**
Claim lodged with ONLY ACC45 which does not fulfill complex claim criteria for direct allocation to Specialist Cover Assessor.

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

Claim lodged with ACC45 and ACC2152 or additional clinical notes

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

NOTE **What if you are unable to contact the client after making the above contact attempts?**
Go to Activity 3.0 Update necessary records within the Issue Treatment injury cover decision process and decline the claim.
PROCESS Issue Cover Decision (Treatment Injury)

b Follow the 'TI Onboarding conversation' guide.

- TI Onboarding conversation

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

NOTE **What if you identify the client's condition is rapidly deteriorating?**
• In Eos, in 'General' tab, tick Triage indicator.
• In Eos, in 'Confirm cover decision' task, update the description to note [Critical decision is required - client's condition is rapidly deteriorating].

NOTE **What if the client has not given consent to continue to investigate the claim during the Onboarding conversation?**
If the client does not give consent to continue the investigation, document this in Eos and proceed to Issue Cover Decision (Treatment Injury) procedure.
PROCESS Issue Cover Decision (Treatment Injury)

NOTE **What if a client mentions self-harm or suicide?**
Refer to NG GUIDELINES Managing Threat of Self-harm Calls for guidance.

NG GUIDELINES Managing Threat of Self-harm Calls

NOTE **What if the employer is a registered AEP participant and the client's injury is related to work?**
If the client mentions their employer and you identify the employer is a registered AEP participant, advise the client their claim will be managed by their employer's Third Party Administrator and someone will be in touch with them soon.

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

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

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

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

This process ends here.
PROCESS Identify and Transfer Work-Related Injury Claim to Accredited Employer (AE)

Accredited employers list (for work-related claims only)

Participating Accredited Employers (Non-work claims only)

d Complete outstanding actions.

NOTE **What if you need to lodge an additional claim for mental injury?**
After the client onboarding conversation where you have obtained consent from the client to lodge this claim
• generate and fill out the Referral for New Claim Lodgement
• email the complete form to hamilton.registration@acc.co.nz (ensure you specify the date of lodgement is the date ACC received the claim, not the day you first spoke with the client).

Referral for New Claim Lodgement

4.0 Request additional information

Cover Assessor, Specialist Cover Assessor

a Follow the appropriate process below for requesting additional information.

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

NOTE **What if you require clinical records/report or ACC2152?**
If you require an ACC 2152 from the relevant provider go to Request Clinical Records process step
PROCESS Request Clinical Records for Treatment Injury

NOTE **What do I need to consider when writing questions to a provider?**
Refer to the 'Clinical questions guide'.

Clinical questions guide

NOTE **What if you require internal clinical, medical or technical guidance including hotline or written?**
Please go to 'Seek Internal Guidance' process.
PROCESS Seek Internal Guidance

NOTE **What if you require external clinical advice?**
Go to 'Request External Clinical Advice (ECA) Report' process.
PROCESS Seek External Clinical Advice

NOTE **What if you require an archived physical claim file?**
Go to 'Retrieve Archived Physical Claim Files' process.
PROCESS Retrieve Archived Physical Claim Files

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

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

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

Attach the ACC612 document to the task
• Select ‘document’ tab
• Select ‘link’
• Select ‘clear’ in the associated documents date range
• Select ACC612 Audiometric Report for Hearing Loss
• Select 'OK'

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

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

ENT memorandum.docx

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE **What if a mental injury assessment is required?**

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

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

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

Psychiatric assessment memorandum template

Psychiatric assessment memorandum example

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

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

PROCESS Arrange Medical Case Review (MCR) Assessment

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

How to manage legislative timeframes Policy

NOTE **What if you need to advise of extension or request extension agreement?**
Go to 'Extend Cover Decision Timeframe' process.
PROCESS Extend Cover Decision Timeframe

c Updating Eos with relevant information

NOTE **What do you document in the 'contacts' following/during assessment of the claim?**
As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

5.0 Review additional information

Cover Assessor, Specialist Cover Assessor

a Review new information to make a cover decision.

NOTE **What if you need more information?**
Go back to activity 4.0 Request additional information.

NOTE **How do you review the ENT assessment?**
Refer to the guide below.

Review ENT assessment

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

NOTE **What are the next steps following a mental injury assessment (once the client has undergone an independent psychiatric review?**
Proceed to 4.0, a, Request Additional Information, note 5 - What if you require written internal clinical, medical or technical guidance (Tier 3). Complete a referral for Psychology - TIMI.

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

NOTE **What if you need to extend the timeframe up to 9 months (extension request)?**
Go to 'Extend Cover Decision Timeframe' process.
PROCESS Extend Cover Decision Timeframe

NOTE **What if the client has not responded to you or not returned the extension letter to ACC agreeing to extend timeframes?**
Follow up with the client via a phone call with two attempts, two different days and times. If consent to continue to investigate is not received ACC is to issue a decision 5 business days prior to legislative decision due date. Go to the process below.
PROCESS Issue Cover Decision (Treatment Injury)

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

NOTE **What if you're a Cover Assessor and think the claim should be assessed by a Specialist Cover Assessor or the claim might require External Clinical Advice?**
• discuss the claim with a Practice Mentor first to agree on which role is best suited to continue with assessment.
• if the claim needs to be transferred to a Specialist Cover Assessor, go to the note 'What if it is a complex claim?' at step 4.0e in 'Triage and Allocate Claim (Treatment Injury)' process.
PROCESS Triage and Allocate Claim (Treatment Injury)

c Updating Eos with relevant information

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

6.0 Validate cover decision

Cover Assessor, Specialist Cover Assessor

a Review 'Claim validation framework guide'.

Claim validation framework guide

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

NOTE **What if you're unsure of the decision?**

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

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

PROCESS Seek Internal Guidance

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

Cover Assessor, Specialist Cover Assessor

Causal Link Policy v10.0

Summary

Objective
Use this guidance to help you establish a causal link between the treatment and the injury.

Background
For a claim to have cover for a treatment injury there must be a causal link between the treatment and the injury. See Scenarios for treatment injury and the Accident Compensation Act 2001, Section 33.

Owner

Expert

Policy

1.0 Determining the link between the cause and effect

a When determining a causal link you must consider the following questions using your clinical knowledge and all available case information:

• Did the cause precede the effect? How long did it take for the effect to appear?
• Is there a strong relationship between the cause and effect?
• Has the relationship between cause and effect been observed repeatedly, by different people and in different times and places?
• Does a variation in cause produce a variation in effect?
• Is the relationship between cause and effect consistent with clinical knowledge?
• Does the removal of the cause result in a decreased risk?
• Does one cause produce one effect?

Causal link cannot be established where:

• the personal injury is wholly or substantially caused by an underlying health condition
• the personal injury is the result of unreasonably withholding or delaying consent to undergo treatment.

2.0 Unreasonably withholding or delaying consent to undergo treatment

a A person can only make a reasonable decision not to consent to the recommended treatment when they have enough information to make an informed decision. Before declining cover under this provision, check that the client had enough information at the time they withheld their consent.

You must fully examine the client's reasons for withholding or delaying their consent. In some situations the decision may have been reasonable, given all the circumstances of the treatment.

3.0 Failure to provide treatment, or to provide treatment in a timely manner

a To determine cover for a personal injury due to failure to provide treatment, or failure to provide treatment in a timely manner, the injury must meet the following criteria:

• there has been a failure to provide treatment or to provide treatment in a timely manner

• there is a personal injury, over and above the natural consequences of the underlying condition for which the treatment was sought

• had the condition been diagnosed or treatment received earlier, the personal injury would have been prevented or lessened.

See Accident Compensation Act 2001, Section 33(1)(d).

To assess whether there has been a failure to provide treatment, or a delay to treat or diagnose in a timely manner, you must consider the following factors:

• based on the client's presentation, including complexity of presentation and any co-morbidities present, and clinical knowledge at the time of treatment, should a different diagnosis reasonably have been made, or a different treatment path reasonably have been undertaken, at an earlier point in time in the case of delay?

• if a different diagnosis or treatment path was indicated, and if it had been followed, would this, on the balance of probabilities, have led to a different outcome, i.e. would it have prevented or altered the progression of the injury?

Accident Compensation Act 2001, Section 33, Treatment
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100942.html

4.0 Do not apply hindsight

a You must investigate what treatment was actually required, based on the client's presentation at the time rather than on what was subsequently proved to be the case with the benefit of hindsight.

NOTE **Example**
In the case of Baker 70/2009, Mrs Baker presented to her General Practitioner (GP) with flu-like illness including headache and vomiting. Her GP provided treatment according to her presentation. Her health deteriorated over several weeks and she was eventually diagnosed with herpes simplex encephalitis (HSE), which resulted in Mrs Baker suffering from right visual field defect and right-sided hyperaesthesia. Treatment for HSE was not required for Mrs Baker's original presentation, as this diagnosis was only discovered after the drastic step of a brain biopsy

b In summary, just because a client goes on to have a more severe diagnosis confirmed at a later date, this does not automatically mean that there was a delay or failure to treat the client for that diagnosis at the time of the original presentation, if there were no indications pointing to the more severe condition at that time.

Cover criteria for treatment injury Policy v10.0

Summary

Objective
Use this guidance to determine cover for Treatment Injury claims.

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

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

Owner

Expert

Policy

1.0 Rules

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

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

- Cover criteria for personal injury Policy
- Context of Treatment Policy
- Causal Link Policy
- Necessary Part or Ordinary Consequence of Treatment Policy
- Treatment Injury Exclusions from Cover Policy

2.0 Date of injury

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

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

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

- Accident Compensation Act 2001, Section 38, Date on which person is to be regarded as suffering treatment injury
  http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100956.html
- Accident Compensation Act 2001, Section 53, Time for making claim
  http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100979.html

3.0 Clinical trials

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

• the client did not agree in writing to participate in the trial

• an ethics committee, which was approved by the Heath Research Council of New Zealand or the Director General of Health, approved the trial and was satisfied that is was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled.

4.0 Third party infections

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

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

- Accident Compensation Act 2001, Section 32, Treatment injury
  http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100934.html
- Accident Compensation Act 2001, Section 18A, Partner (and partner in relation to deceased claimant)
  http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100670.html

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5.0 Overseas treatment

a When a client receives treatment overseas and suffers a personal injury irrespective of whether the injury occurs overseas or in NZ (on or after 1/7/05) the client:
• must be ordinarily resident in New Zealand at the date they received their treatment
• must have received treatment that led to the treatment injury from a treatment provider that has the same or equivalent qualifications to that of a registered health professional

Consultation with an External Clinical Advisor may be required to peer review the overseas Registered Health Provider credentials and the treatment that was provided.

- Criteria for a valid overseas practising certificate for providers who caused a treatment injury
- Cover acceptance criteria for a treatment injury claim when the treatment occurred in New Zealand but the resulting treatment injury is identified overseas
- Cover acceptance criteria for a treatment injury claim when the treatment occurred overseas
- List of approved qualifications
  https://www.mcnz.org.nz/assets/Policies/1f8183e705/List-of-approved-qualifications-for-locum-tenens-specialist-appointme
- World directory of medical schools
  https://search.wdoms.org/
- Seek External Clinical Advice

b For consequential injuries resulting from treatment received overseas (eg treatment for an already covered injury) the treatment provider does not need to meet the registered health provider equivalent qualifications.

- Cover for injuries suffered outside New Zealand Policy
- Determining overseas equivalent of Registered Health Professional
- Comparable country for overseas claim
- Consequential Injury Claims Policy

Context of Treatment Policy v12.0

Summary

Objective
Refer to this guidance to help you determine whether a client is eligible for treatment injury cover because their injury occurred in the context of treatment and they sought or received treatment from, or at the direction of, one or more registered health professionals (RHP).

Owner

Expert

Policy

1.0 Seeking treatment

a A client is considered to have been seeking treatment when:

- there is a direct interaction between the client and an RHP, including telephone advice
- the RHP is acting in their professional capacity.

This does not include:

- informal advice given in a social situation
- treating family members or friends outside of the usual clinical setting, eg while tramping or travelling.

2.0 Receiving treatment

a A client is considered to have received treatment when:

- they underwent treatment, or there was an exchange of clinical advice between the client and one or more RHP

- a non-RHP provides treatment at the direction of an RHP.

3.0 At the direction of an RHP

a Treatment is considered to have been given by a non-RHP under an RHP's supervision or guidance when:

- it forms part of a treatment plan set by an RHP and supports the ongoing treatment provided by the RHP

- the RHP retains responsibility for the specific intervention and the patient

- the specific intervention is within the RHP's scope of practice

- the RHP exercises clinical judgment that directs the specific intervention by the non-RHP, including the way it's administered.

Supervision or guidance does not include formal or informal referrals to non-RHPs.

NOTE **Example**
A trainee physiotherapist causes an injury while manipulating a patient's limb. If the trainee is being supervised by a qualified physiotherapist, this is considered to be working at the direction of an RHP

4.0 Treatment received overseas

a In cases where the treatment received overseas the provider of the treatment needs to meet the equivalent standards to that of an RHP in New Zealand ('equivalency standards').
• If treatment is from a country WITH a comparable healthcare system, then this will only require a copy of their practicing certificate.
• If treatment is provided by country that is NOT considered a comparable healthcare system, this will require further investigation to determine if the provider meets the equivalency standards

- Comparable country for overseas claim
- Determining overseas equivalent of Registered Health Professional

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

a The Accident Compensation (Definitions) Regulations 2019 moved the key definitions of 'registered health professional' and 'treatment provider' and associated definitions from the Accident Compensation Act 2001 to standalone regulations.

- Registered health professional list applicable on or after 01 October 2019
- Registered health professional list applicable before 01 October 2019

b The Accident Compensation (Definitions) Regulations 2019 took effect on 01/10/2019.

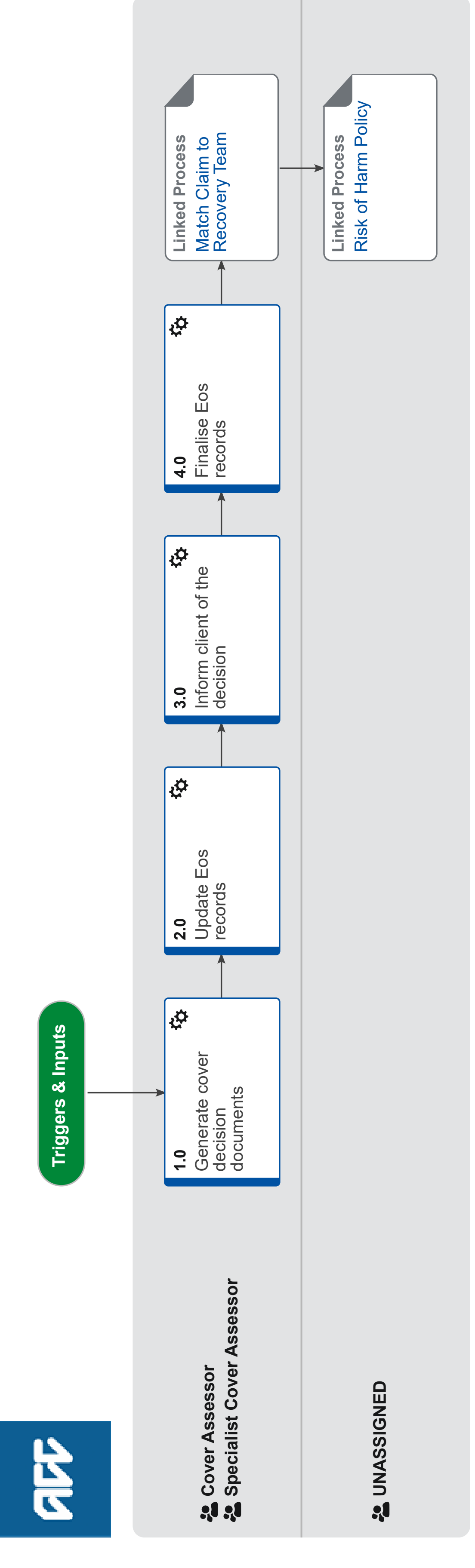
c When assessing cover for Treatment Injury, we need to determine the date of injury based on when a person first seeks treatment for the signs or symptoms of their injury. So a claim may be lodged after 1/10/2019, but have an earlier date of injury.

d The relevant date to consider whether someone was an RHP is the date of the treatment. If a client claims after 01/10/2019 for an event occurring earlier the amendment does not apply. The changes are not retrospective.

6.0 Links to legislation and regulation

- Accident Compensation Act 2001, section 32, Treatment injury
  http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100934.html
- Accident Compensation (Definitions) Regulations 2019
  http://www.legislation.govt.nz/regulation/public/2019/0194/latest/whole.html#LMS89658

Issue Cover Decision (Treatment Injury) v14.0



Issue Cover Decision (Treatment Injury) v14.0

Summary

Objective
To notify the client about the cover decision.

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

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

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

Owner

Expert

Procedure

1.0 Generate cover decision documents

Cover Assessor, Specialist Cover Assessor

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

NOTE **When is ACC2184 is required?**
ACC 2184 is required if ANY or ALL of these criteria apply:
• It is a complex claim
• A detailed timeline of the events is required
• Any tier 3 internal or external opinion is required

NOTE **What if ACC2184 is not required? (If the claim does not meet the above criteria use the below template)**
In Eos, update the 'Contacts' tab by adding a contact to explain rationale for cover decision made. Include the following:

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

NOTE **What if it is PICBA?**
In Eos, update the 'Contacts' tab by adding a contact to note 'Clinical information assessed - not treatment injury but meets PICBA criteria.'

b Generate appropriate cover decision letter.

NOTE **What if it is PICBA?**
Generate TI60 Decline claim - treatment injury.
If you approve claim for cover, CVR40 will auto-generate and be posted to the client by completing the note in 4.0a.

NOTE **What if there is a claim for mental injury?**
• If you accept cover for physical injury, Supported Recovery Team will assess mental injury caused by physical injury.
• If you decline cover because there is no personal injury, you'll need to discuss with the client and seek the client's permission to re-open the declined mental injury claim. Once re-opened, you will assess it as treatment injury mental injury claim (TIMI)
Ensure that all lodged injuries are declined and that the letter references that the mental injury has been previously declined on the separately lodged claim.
PROCESS Assess Claim for Cover (Treatment Injury)

NOTE **What if you need to issue a revised claim decision (new information received on the claim/additional injury to cover or to decline)?**
• Use the TI50 or TI60 letter.

On the first page of the decision letter, add description:

Revised claim decision

ACC revises the previous cover decision issued in a letter dated _____ in which cover was (word options are: ‘accepted’ or ‘declined’). (Then add a reason for revising cover – this can be one sentence to several sentences depending on the nature/complexity about why revising).

The cover decision as of the date of this letter is a fresh decision with review rights. This decision (word options are: 1. ‘amend’ or 2. ‘revokes and substitutes’) the decision dated ____.

NOTE **Consolidated Treatment Injury Letters**
• TI51 and TI69 have been retired in CMS and have been consolidated into TI50
• TI68, TI72, TI61, TI62, TI64 have been retired in CMS and have been consolidated into TI60

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

2.0 Update Eos records

Cover Assessor, Specialist Cover Assessor

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

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

- Injury outcome status definitions
- Assign an outcome status and an outcome date to an injury code

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

- Treatment Injury tab in Eos - Data fields guide
- Data Tables for Eos Fields
- Risk of Harm Guidance 1.0.pdf

NOTE **What if it is re-assessment?**
In Eos, in the 'Treatment Injury' sub-tab under the 'Injury' tab, update Injury Details, Treatment Context, Cover Decision and Reassessment sections.

NOTE **What if it is PICBA?**
In Eos, in the 'Injury' tab, update 'Accident' sub-tab.

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

e What if the claim is accepted for cover?

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

NOTE **Determine appropriate recovery team.**

PROCESS Match Claim to Recovery Team

NOTE **What if the client does not require any assistance/support from ACC?**
Transfer claim to TIC - Actioned Cases

3.0 Inform client of the decision

Cover Assessor, Specialist Cover Assessor

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

NOTE **How many call attempts do I have to make?**
Two attempts to contact client by phone, on different days and times. Then send the decision letter by email or post.

NOTE **What do you need to cover during your conversation with the client?**
Clearly communicate
- why you're calling
- cover decision made
- rationale for decision
- review rights (if applicable)
- confirm the preferred method of communication for the decision letter
- discuss client's recovery needs (if applicable)
- what happens next (ie letter to be sent, transferring claim to another team, medical certificates required etc.)

Identity Check Policy

NOTE **What if the client requests a copy of their information?**
- If the request is for one document, send a copy to the client directly.
- If there are multiple documents requested, go to 'Complete Client Information Requests' process.

PROCESS Complete Client Information Requests

b Update the decision letter if applicable.

NOTE **Update 'What happens next'.**
Enter appropriate recovery team for transfer of claim.

c Enclose Treatment Injury or Consequential Injury Report if required.

Treatment Injury Cover Assessment Centre: Style writing guide

NOTE **When do you need to enclose the Treatment Injury or Consequential Injury Report?**
You need to enclose the Treatment Injury or Consequential Injury Report if
- it is a decline (regardless of claim's complexity)
- it is a complex claim.

d Set the letter's status to 'Complete'.

e Upload appropriate information sheets on the claim.

NOTE **What are the mandatory information sheets?**
- Kōrero mai - Working together

ACC255 Kōrero mai - Working together

NOTE **What are the non-mandatory information sheets/attachments?**
Determine if attaching the following would help client understand our decision or decide on the next steps:
- Copy of external or internal clinical advice
- Report from treating provider

Privacy Check Before Disclosing Information Policy

NOTE **What if you find information that needs to be redacted?**
Send an email to Recovery Administration (recoveryadmin@acc.co.nz) and include the document to be redacted plus your specific redaction instructions, before adding the redacted document to the document group.

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

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

NG GUIDELINES Sending Letters in NGCM

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

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

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

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

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

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

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

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

NOTE **How many contact attempts should be made?**

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

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

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

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

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

PROCESS Update Client Address

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

Must be a verified email address.

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

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

4.0 Finalise Eos records

Cover Assessor, Specialist Cover Assessor

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

NOTE **What if it is PICBA?**

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

NOTE **What if the claim is withdrawn?**

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

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

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

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

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

NOTE **What if the claim is declined?**

• transfer claim to TIC Actioned Cases department.

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

• Request for Nursing Services - Forward the task to the 'Elective SC – TMT Assessment dept' queue.

• Request for dental treatment - Forward the task to the ‘Dental Claims’ department queue.

• Request for hearing loss treatment or aids - Forward the task to the ‘Hearing Loss Claims’ department queue.

• Request for elective surgery - Forward the task to the ‘Elective SC – Surgery Triage’ department queue.

• Request for Independence Allowance/Lump Sum - Forward the task to the ‘Hamilton SC – IA/Lump Sum’ department queue.

• Request for orthotics - Forward the task to the ‘Hamilton SC – Orthotics’ department queue.

• Request for reimbursement costs

- Travel costs - Forward the task to the ‘Hamilton SC Transport’ department queue
- Pharmaceuticals - Forward the task to the ‘Elective SC – Claimant Reimbursements' department queue.

Move claim to actioned cases (Eos Online Help)

NOTE **What if the claim is a staff claim?**

Transfer the claim to the Staff Claims Unit department queue

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

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

Accidental death team - contact details

NOTE **What if the client's condition is rapidly deteriorating and imminently fatal?**

1) In Eos, create 'General task'
2) Add in the task description - Rapidly deteriorating claimant and record the client's condition, best contact person and method, and any other pertinent information to assist PIC to process the request.
3) Set the target date to the current date
4) Set priority as 'High'
5) Transfer the task to 'Centralised Permanent Injury Compensation - Requests' queue
6) Consider calling the PIC team (ext. 50104) to advise them of the situation.

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

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

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

PROCESS Assess Claim for Cover (Treatment Injury)

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

PROCESS **Risk of Harm Policy**
UNASSIGNED

Necessary Part or Ordinary Consequence of Treatment Policy v12.0

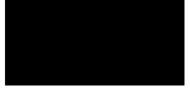
Summary

Objective
Use this guidance to help you determine whether the treatment injury suffered by a client was a necessary part or ordinary consequence of the treatment. This will help you determine cover for a Treatment Injury claim.

1) Necessary part of the treatment
2) Ordinary consequence of treatment
3) Likelihood of injury at a population level
4) Client circumstances
5) Clinical knowledge at the time of treatment
6) Changes in clinical knowledge
7) Clinical experience of the treatment provider
8) Questions to consider when determining whether an injury is an ordinary consequence of treatment
9) Links to legislation

Background
There is no cover for a treatment injury if the personal injury suffered was a necessary part or ordinary consequence of the treatment, taking into account all the circumstances of the treatment. See the Accident Compensation Act 2001, Section 32.

Owner



Expert

Policy

1.0 Necessary part of the treatment

a An injury that is a necessary part of the treatment is one that is an essential component of the treatment process, e.g. an incision performed as part of an operation.

2.0 Ordinary consequence of treatment

a The Court of Appeal in ACC v Ng & others [2020] NZCA 274 interpreted 'not an ordinary consequence' as being an outcome that is outside of the normal range of outcomes, something out of the ordinary which occasions a measure of surprise.

b This is not a precise test and requires a judgement-based approach to each case, based on the specific circumstances of the treatment and the client, such as:

a) the likelihood of injury at a general population level

b) the particular circumstances of the client's case

c) the clinical knowledge at the time of treatment.

NOTE **Example**
Many chemotherapy side effects fall within the expected treatment process and are an established consequence of treatment. However, each case needs to be assessed in light of several factors to determine whether, on balance, the nature and severity of the side effects occasion no surprise.

3.0 The likelihood of injury at a population level

a Data on the risk of a treatment can help identify a baseline probability of injury . This information may come from medical studies, the experience of experts, or other reliable sources..

b It is important to ensure that medical studies and statistics are both reliable and relevant to the circumstances of the client and the treatment. Some studies may lack validity because of their small sample size, for example, or the study group may not be representative of the client's circumstances.

c Factors to consider when referring to studies include:

• The number of cases in the study and whether they are representative of the client's circumstances. For example, a study of risks conducted at a single specialist facility overseas may be of limited relevance to a procedure in New Zealand.

• How authoritative are the studies? Are they endorsed by other experts? Is there a general consensus within that particular field or specialty?

4.0 4.0 Client circumstances

a The likelihood of an injury occurring must be viewed in light of the client's circumstances. Relevant factors are discussed below.

b Duration and severity of the injury

An unusually severe outcome – either in its effect or in its duration – may not be ordinary even though a less significant injury that may commonly occur following that treatment is more likely to be ordinary. In other cases, a severe injury may still be an ordinary consequence of treatment.

NOTE **Example - infections**
A small localised infection at the site of an incision that clears up within a week may be considered an ordinary consequence of treatment for a person with several co-morbidities. Conversely an infected incision that leads to sepsis which has been caused by the treatment may take it beyond what would be considered ordinary.

NOTE **Example - heart surgery**
A person having cardiac surgery may be at a high risk of a cerebrovascular event during surgery. It is likely that if a cerebrovascular event occurred it is within the normal range of outcomes, and therefore an ordinary consequence of that treatment.

c Underlying patient health considerations

Some people may be more susceptible to suffering adverse outcomes from treatment than others, due to their health condition. This particular criterion requires the decision maker to take into account the particular person's circumstances at the time of treatment.

While a risk of injury may be unexpected for many people undergoing the treatment, a particular person may possess certain clinical features, such as co-morbidities or a predisposition, which increases their risk to such an extent that the injury becomes an ordinary consequence for them.

Conversely, a person may have a lower risk of injury arising from a particular treatment, compared to other people. As a result, the injury may not be an ordinary consequence for that particular person.

d Circumstances of the treatment

Ordinary consequences will also depend on the particular treatment or procedure. Each examination, treatment, or procedure will have its own profile of ordinary consequences.

The facilities available, the urgency and complexity of the treatment, as well as the experience of the attending health professional(s) may also be relevant when determining whether an outcome was an ordinary consequence.

NOTE **Example - emergency surgery**
An urgent procedure may not be able to implement measures that would otherwise be available and would reduce risk. An injury resulting from treatment might be ordinary even though the treatment could have been provided at another facility where better equipment would have been available that would have reduced the risk.

5.0 Clinical knowledge at the time of treatment

a Whether an outcome is considered 'ordinary' needs to be considered in light of the clinical knowledge that existed at the time of the treatment, as recognised by the relevant profession. This includes accepted practice in New Zealand and international knowledge.

b The focus of the assessment is also not based on whether the risk of the outcome was predicted (or could have been predicted) in advance of treatment in a particular client's case. The assessment can take into account facts discovered after treatment has commenced, including complications that were not known when the procedure started.

NOTE **Example**
A client underwent surgery to treat a brain aneurysm. During the procedure the aneurysm ruptured, and the arteries had to be clipped for 40 minutes to control the bleeding leading to an increased risk of cognitive deficits. Clipping times would not normally exceed 15 minutes in this sort of operation and there would only be a small risk of injury. But in this case, the client suffered cognitive deficits as a result of the prolonged clipping. The outcome could be an ordinary consequence, even though it was not predicted before the surgery how long the clipping would be required for.

6.0 Changes in clinical knowledge

a The prevailing medical and scientific knowledge at the time that treatment is taking place is to be taken into account. Advances in clinical knowledge that are acquired after treatment has finished should not be taken into account when making a decision on whether an injury is an ordinary consequence.

b The following table summarises how this is applied.

Clinical knowledge at the time of treatment	Clinical knowledge today	Likely outcome
The injury was considered to be a necessary part or ordinary consequence	Injury is not a necessary part or ordinary consequence of treatment today. Current clinical approaches are more effective at treating the condition. Access to improved treatment techniques or better drugs minimise the chance of the injury occurring.	Ordinary consequence
The injury was not a known occurrence from the particular treatment	Due to more contemporary research, the injury is now known to result from the treatment	Not an ordinary consequence

Clinical knowledge summary table.jpg

c Cover may not be available where clinical knowledge at the time of treatment has been superseded, making an injury not a necessary part or ordinary consequence of treatment.

Cover may be available where there was no clinical knowledge at the time of treatment that an injury could occur, even though clinical knowledge today would make the injury a necessary part or ordinarily consequence of treatment.

NOTE **Example - radiation treatment in the 1980s to treat a tumour, causing damage to surrounding bone and tissue**

Clinical knowledge at the time of treatment	Clinical knowledge today	Outcome
The injury caused by the radiation treatment was not unexpected at that time.	Today, due to new techniques in the administration of radiation, along with new cancer drugs, damage to surrounding tissue and bones would be minimised or prevented entirely. If a client suffered significant tissue damage due to recent treatment this is likely to be considered to be unexpected.	The injury was an ordinary consequence given the procedures available when the radiation treatment was provided.

Radiation treatment example.jpg

NOTE **Example - lithium drugs prescribed to treat depression, resulting in renal failure**

Clinical knowledge over the time of treatment	Clinical knowledge today	Outcome
At the time lithium was first prescribed for the client in 1987, studies did not show that lithium caused significant renal impairment. Lithium treatment had only been available since the 1960s. There were no studies showing what the long-term side effects could be.	Today, lithium is accepted as a cause of chronic kidney disease. The client was diagnosed with end stage renal failure in 2007. Contemporary studies showed an association between lithium taken over a 20-year period and renal failure.	The outcome depends on when the contemporary knowledge became known over the course of treatment. If it was not known until after kidney disease was diagnosed, it is not an ordinary consequence. This is because during the course of the client's treatment, renal failure was not known to result from long term use of lithium.

Lithium drugs example.jpg

7.0 Clinical experience of the treatment provider

a The clinical experience of the treatment provider may sometimes be relevant. For example, where a procedure might carry a significant risk when competently conducted by a general surgeon, even though an expert specialising in the procedure could have performed the same procedure with a lower risk of the injury occurring. It is the risk associated with procedures performed by that generalist that is relevant, not the risk associated with procedures performed by the specialist.

8.0 Questions to consider when considering a treatment injury claim

a What was the treatment the client received that has given rise to the injury?

What is the nature of the injury that is being claimed for?

Are there any medical studies that provide reliable and relevant statistical analysis about the particular injury?

Are these studies relevant to the client's circumstances?

Is the injury unusually severe or long-lasting compared to the medical studies and analyses that are available?

Were there any circumstances that increased or reduced the risk of the injury occurring? That might include:

• Patient factors (which may include depending on the context such factors as age, smoking status, BMI, other health conditions);
• Circumstances of treatment (urgency, available facilities);

• What happened during treatment – what was found during surgery (eg deteriorated arteries that were not visible pre-surgery).

Have client factors increased or decreased the identified risks of the treatment? If so, by how much?

Was the risk identified before treatment and what was the scope of consent prior to treatment? This may provide evidence to help clarify how significant the risk was believed to be before treatment began, but treatment providers will obtain consent for many unlikely possibilities and things may change in the course of treatment. The question is the objective likelihood of the outcome, not whether it was identified.

Considering all the above factors, was the nature and the severity of the injury within the normal range of outcomes for the treatment provided to this patient?

9.0 Links to legislation

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

Treatment Injury Exclusions from Cover Policy v9.0

Summary

Objective
Use this guidance to help you determine cover for a treatment injury claim.

Background
Treatment injuries are excluded from cover if:

• they are solely attributable to a resource allocation decision
• the treatment simply did not achieve the desired result.

See also Cover criteria for treatment injury.

Owner

Expert

Policy

1.0 Solely attributable to a resource allocation decision

a We decline cover when an injury is solely attributable to a resource allocation decision. A resource allocation decision:

• relates to which services to make available to a population or group, not just an individual

• may be an implicit decision, eg not seeking additional funding for a type of treatment

• is not part of the treatment received from an individual provider; it sits outside the specific treatment.

NOTE **Example**
The emergency department at a rural hospital has closed. A patient is unaware of this and turns up for treatment for chest pains. By the time the patient has found the after hours General Practitioner (GP) clinic and been transferred to the proper facility, they've suffered a heart attack. The heart attack is not a treatment injury

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2.0 The treatment simply did not achieve the desired result

a The fact that the treatment simply did not achieve the desired result does not, of itself, constitute a treatment injury.

If the only reason for the treatment injury claim is that the client is dissatisfied with the outcome of the treatment, we do not accept the claim.

NOTE **Example**
Mr J's arthritis meant that he required a hip replacement. The hip replacement and subsequent healing was, in the opinion of the surgeon, unremarkable. Mr J expected he would regain the ability to resume tramping and climbing over fences. He did not regain the level of mobility he desired and lodged a claim because the surgery did not achieve the desired result. The claim was declined. It was not a treatment injury as achieving 100% range of movement was the client's desired result, but not meeting a desired result does not constitute a treatment injury

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REFERENCE

Scenarios for treatment injury

Introduction

Scenarios for treatment injury.

Allergic reaction –underlying health condition

Scenario

Mr James is a 44 year-old man who develops acute appendicitis. Following assessment at his local Accident and Emergency department, Mr James is admitted and scheduled for an urgent appendicectomy. All standard preoperative checks and consents are obtained.

During surgery, a standard anaesthetic mix is administered but Mr James reacts to the mix and sustains a stroke during the surgery. Mr James now has left-sided hemi-paresis.

Mr James had an unknown allergy to the particular anaesthetic. Had this allergy been known, a different anaesthetic mix would have been administered.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury was the stroke resulting in left sided hemi-paresis
Did the personal injury occur in the context of treatment?	Yes. The personal injury occurred while Mr James was receiving treatment for appendicitis. The treatment was performed by Registered Health Professionals
Was the personal injury caused by treatment?	Yes. The personal injury was caused by the administration of a particular anaesthetic mix, to which Mr James was allergic
Was the personal injury a necessary part of, or ordinary consequence of, the treatment required?	No. The treatment Mr James required was an appendicectomy and, in view of all the circumstances, Mr James required a different anaesthetic mix (which was available) and therefore a stroke is not a necessary part of, or ordinary consequence of, the treatment
Do any of the other exclusionary criteria apply?	No
Is cover available?	Yes

Cover questions	Answers
What is the personal injury for which cover is being provided?	The left side hemi-paresis

Key points

Comparing the relevant circumstances of a claim with other ‘like’ cases will assist in establishing whether or not the personal injury was an ‘ordinary consequence of the treatment’. But where, because of a circumstance that was unknown at the time of the treatment, the claimant did not receive the treatment required, another approach is needed.

Legislation

Section 32(1)(c) requires ACC to determine whether the personal injury was a necessary part of, or ordinary consequence of the treatment, taking into account all of the circumstances of the treatment.

If the personal injury was a necessary part or ordinary consequence of the treatment, cover is not available.

Policy

ACC policy is that the treatment, in this context, is the treatment the claimant required at the time of their presentation.

If the claimant did not receive the treatment he or she required, the personal injury cannot be either a necessary part of, or ordinary consequence of, the treatment.

In the case above, it is clear that Mr James did not receive the treatment he required, given his underlying allergy to the particular anaesthetic mix. The treatment Mr James required was another anaesthetic mix, which was available at the time of the treatment.

Therefore the subsequent personal injury cannot be a necessary part of, or ordinary consequence of, the treatment. Mr James’s claim is not excluded from cover under this provision.

Did Mr James’s underlying health condition wholly or substantially cause the personal injury?

Legislation

Subsection 32(2) excludes certain types of personal injuries from cover.

(a) personal injury that is wholly or substantially caused by a person’s underlying health condition

Policy

An underlying health condition is the general state of health of the person. In the case of Mr James, this includes his allergy to a particular anaesthetic as well as his appendicitis.

When considering whether the personal injury was substantially caused by a person’s underlying health condition, substantially means a marginal departure from wholly.

In the case of Mr James, the treatment Mr James received (the particular anaesthetic mix) was a significant causal factor in the personal injury occurring. Therefore, Mr James’ allergy cannot be said to have wholly or substantially caused the personal injury.

Mr James' claim for cover is not excluded from cover under this provision.\

Erb's Palsy – not an ordinary consequence

Scenario

Baby J sustains Erb's palsy during her delivery. She is a large baby with a birth weight of 5kg. Her delivery is prolonged, with labour commencing 48 hours before delivery.

During her delivery by an obstetrician, Baby J's neck is stretched which results in neuropraxia. The upper part of the brachial plexis is involved (C5&C6). After gentle physical therapy, Baby J regains full function of her arm when she is four months old.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury was the neuropraxia (neck stretch)
Did the personal injury occur in the context of treatment?	Yes. The personal injury occurred while Baby J was being delivered. The delivery occurred in a hospital and was performed by a registered health professional (obstetrician)
Was the personal injury caused by treatment?	Yes. The personal injury was caused by the method of delivery

Cover questions	Answers
Was the personal injury a necessary part of, or ordinary consequence, of the treatment required?	No. The treatment required was the delivery of Baby J. During birth, a brachial plexis injury is neither a necessary part of, nor an ordinary consequence of, the birthing process Clinical advice received confirmed that a brachial plexis injury is not an ordinary consequence when comparing Baby J's circumstances with other like cases. When taking onto account the large birth weight, the incidence of injury with this circumstance is 5% (E. Baxley, 2004)
Do any of the other exclusionary provisions apply?	No
Is cover available?	Yes
What is the personal injury for which cover is being provided?	The neuropraxia

Key points

This example demonstrates how comparing the claim against like cases can assist in determining whether or not the personal injury was an ordinary consequence of the treatment.

Ordinary consequences of the treatment (with reference to the body of knowledge of the health profession to which the treating registered health professional (RHP) belongs) are those that are:

- within the expected treatment process and expected recovery times, meaning

- regular, usual, in the ordinary course of events, an established type of consequence, or commonplace (including usual variations)

given all of the circumstances of the treatment.

When determining whether or not the personal injury was an ordinary consequence of the treatment compare the consequence of that person's treatment with the treatment consequences for people in similar relevant (material) circumstances. This means people with similar underlying health conditions undergoing similar treatment in similar treatment circumstances.

In the case of Baby J, the material circumstance was the large birth weight.

The circumstances of this claim are compared with other like cases (other deliveries that involve large babies).

When comparing 'like with like', clinical advisors consult the body of knowledge of the treatment provider's profession. In this case, it is established that the incidence of brachial plexis, even when the baby is large, is quite low. Therefore the personal injury cannot be said to be an 'ordinary consequence' of the treatment Baby J required.

Cover for the personal injury is therefore available.

Fatigue following appendicectomy –no personal injury

Scenario

Mr Smith undergoes an appendicectomy. The procedure is uneventful and the post-surgery healing is unremarkable. While Mr Smith experiences tenderness and abdominal discomfort for six weeks following the surgery, this is also unremarkable.

Two months after the surgery, Mr Smith complains of ongoing fatigue. His GP completes a number of tests to attempt to diagnose the cause of the fatigue, but all tests come up negative.

Four months following surgery, Mr Smith lodges a claim for a treatment injury, describing the personal injury as fatigue. Mr Smith also seeks entitlement to weekly compensation stating that he feels unable to return to employment as a retail manager.

Cover questions	Answers
Was there a personal injury?	No. Fatigue, or a generalised malaise, may be symptomatic of an underlying health condition but, for the purposes of cover, fatigue is not a personal injury
Did the personal injury occur in the context of treatment?	Not applicable. No personal injury could be identified
Was the personal injury caused by treatment?	Not applicable
Was the personal injury a necessary part of, or ordinary consequence, of the treatment required?	Not applicable
Do any of the other exclusionary criteria apply?	Not applicable

Cover questions	Answers
Is cover available?	No
What is the personal injury for which cover is being provided?	Not applicable

Key points

To receive cover under treatment injury provisions, a personal injury must have occurred. Personal injury is defined in section 26 of the Accident Compensation Act 2001 as:

a) the death of a person; or

b) physical injuries suffered by a person, for example, a strain or a sprain; or

c) mental injury suffered by a person because of physical injuries suffered by the person; or

d) mental injury suffered by a person in the circumstances described in section 21; or

e) damage (other than wear or tear) to dentures or prosthesis that replace a part of the human body.

In the case described above there is no personal injury, therefore cover is declined.

Hypothermia – ‘at the direction of an RHP’ and ordinary consequence of the treatment

Scenario

Ms K is a 67 year-old woman who suffers severe hypothermia on a tramping trip. Following her rescue she is transported via ambulance to the local hospital. En-route, Ms K goes into cardiac arrest. No defibrillator is used, given her severely hypothermic condition. Instead CPR is commenced. The ambulance officer communicates with the local Accident and Emergency department, where the registrar advises to continue CPR.

While continuing chest compressions, the ambulance officer hears ‘graunching’ sounds, indicating that several ribs have cracked as a result of the CPR.

Ms K fully recovers from both hypothermia and cardiac arrest although she experiences several months of pain as her ribs heal. Ms K lodges a treatment injury claim and seeks entitlement to home help while she recovers.

Ms K has had a history of osteoporosis prior to her treatment injury.

Cover questions	Answers
Was there a personal injury?	Yes. The ACC2152 noted that x-rays confirmed cracked ribs
Did the personal injury occur in the context of treatment?	Yes. The personal injury occurred while CPR (the treatment) was being given. The treatment was at the direction of the local Accident and Emergency registrar
Was the personal injury caused by treatment?	Yes. The cracked ribs were clearly caused by the CPR

Cover questions	Answers
Was the personal injury a necessary part of, or ordinary consequence, of the treatment required?	Necessary, no. Damage to ribs, while not unusual, is not an essential or intrinsic part of CPR. Ordinary consequence, yes. When comparing this claim with other like cases (urgency, use of CPR, underlying health condition including osteoporosis), cracked ribs are an ordinary consequence of the treatment.
Do any of the other exclusions apply?	No
Is cover available?	No
What is the personal injury for which cover is being provided?	Not applicable

Key points

At the direction of a registered health professional (RHP)

Legislation

Section 32(1) prescribes what personal injuries constitute a Treatment Injury. This includes the following:

(1) Treatment Injury means a personal injury that is-

(a) suffered by a person –

I. seeking treatment from 1 or more registered health professionals; or

II. receiving treatment from, or at the direction of, 1 or more registered health professionals; or

III. referred to in subsection (7) (infection provision)…

Registered Health Professional (RHP)

(a) means a chiropractor, clinical dental technician, dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, nurse practitioner, occupational therapist, optometrist, pharmacist, physiotherapist, or podiatrist; and

(b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when acting in accordance with any conditions of such interim certificate.

Policy

Treatment received at the direction of a RHP includes treatment received from a non-RHP on the specific instructions of a RHP, or otherwise under a RHP's supervision or guidance.

Treatment is under a RHP's supervision or guidance where:

- It forms part of the treatment plan set by a RHP and supports the ongoing treatment provided by the RHP.
- The RHP retains responsibility for the specific intervention and the patient.
- The specific intervention is within the RHP's scope of practice.
- The RHP exercises, or is required to be available to exercise, clinical judgement that essentially shapes the specific intervention by the non-RHP, including the way it is administered.

In the case described above, the ambulance officer (a non-RHP) was given specific instruction to continue CPR by the Accident and Emergency registrar (a RHP). Therefore the treatment was at the direction of a RHP.

Was the personal injury an ordinary consequence?

When considering whether or not the personal injury was an ordinary consequence of the treatment, comparison is made between the consequences of that person's (Ms K) treatment with the treatment consequences for people in similar relevant (material) circumstances. This means people with similar underlying health conditions undergoing similar treatment in similar treatment circumstances.

In Ms K's case, this meant comparing the personal injury with the treatment consequences of people with osteoporosis who required pulmonary resuscitation while hypertensive.

'Ordinary' defined

An ordinary consequence of the treatment (with reference to the body of knowledge of the treating registered health profession) is one that is:

(i) within the expected treatment process and expected recovery times, meaning

(ii) regular, usual, in the ordinary course of events, an established type of consequence, or commonplace (including usual variations)

given all of the circumstances of the treatment.

In the case described above, if the clinical advice is that cracked ribs are an ordinary consequence of the treatment Ms K required (having regard to her underlying health condition which included osteoporosis) then the claim may be declined on this basis.

Lupus–no personal injury

Scenario

Mrs Smith is advised by her GP that she has lupus. [Systemic Lupus Erythematosus (S.L.E. or lupus) is a chronic autoimmune disease that causes inflammation of various parts of the body. The skin, joints, kidneys and blood cells are especially involved.] The treatment decision was to monitor the condition.

Her GP also informs Mrs Smith that she was incorrectly advised three months ago that a previous blood test contained no signs of active lupus. The blood test did in fact indicate active lupus.

Mrs Smith lodges a treatment injury claim on the basis of the GP's failure to diagnose her condition three months ago.

Cover questions	Answers
Was there a personal injury?	No. The three months delay in the diagnosis did not result in a personal injury There is no discrete personal injury as a result of the delayed diagnosis
Did the personal injury occur in the context of treatment?	Not applicable
Was the personal injury caused by treatment?	Not applicable
Was the personal injury a necessary part of, or ordinary consequence of, the treatment required?	Not applicable
Do any of the other exclusionary criteria apply?	Not applicable

Cover questions	Answers
Is cover available?	No
What is the personal injury for which cover is being provided?	Not applicable

Key points

To receive cover under treatment injury provisions, there must be a personal injury. Personal injury is defined in section 26 of the Accident Compensation Act 2001 as

a) the death of a person; or

b) physical injuries suffered by a person, for example, a strain or a sprain; or

c) mental injury suffered by a person because of physical injuries suffered by the person; or

d) mental injury suffered by a person in the circumstances described in section 21; or

e) damage (other than wear or tear) to dentures or prosthesis that replace a part of the human body.

Policy

A fundamental requirement for cover is that there must be a personal injury identified. Where there is no personal injury, there can be no cover.

Role of Health and Disability Commissioner

There can be an alleged medical error without a personal injury occurring. ACC is required to advise claimants of the role of the Health and Disability Commissioner (HDC). Information about the HDC is sent with letters to claimants. It is the claimant's decision whether or not to raise an issue with the HDC.

Massage therapist –context of treatment

Scenario

Mr Jake visits a massage therapist to seek treatment for the tension and immobility in his neck and right shoulder. Mr Jake does not advise the massage therapist that he has fractured his shoulder two months prior to the visit.

Following the massage, Mr Jake experiences intense pain in his right shoulder. He goes to the emergency centre and an x-ray confirms that his shoulder has re-fractured.

Mr Jake lodges a treatment injury claim.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury was the re-fracture of the right shoulder

Cover questions	Answers
Did the personal injury occur in the context of treatment?	No. The claimant must have been seeking or receiving treatment from, or at the direction of, one or more Registered Health Professionals A massage therapist is not a Registered Health Professional and therefore the personal injury did not occur in the context of treatment
Was the injury caused by treatment?	Not applicable
Was the personal injury either a necessary part, or ordinary consequence, of the treatment required?	Not applicable
Do any of the other exclusions apply?	Not applicable
Is cover available?	Not for treatment injury, but could still be considered a PICBA
What is the personal injury for which cover is being provided?	Re-fracture of the right shoulder

Key points

Legislation

Section 32(1) prescribes what personal injuries constitute a treatment injury. This includes the following:

(1) Treatment Injury means a personal injury that is -

(a) suffered by a person –

(i) seeking treatment from 1 or more registered health professionals; or

(ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or

(iii) referred to in subsection (7) (infection provision)...

When amended, Registered Health Professional is defined in section 6(1) of the AC Act (with amendments pursuant to the Health Practitioners Competence Assurance Act 2003) as:

Registered Health Professional—

a) means a chiropractor, clinical dental technician, dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, occupational therapist, optometrist, pharmacist, physiotherapist, or podiatrist; and

b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when acting in accordance with any conditions of such interim certificate; and

c) includes a member of any occupational group included in the definition of registered health professional by regulations made under section 322

The definition is effective until the Regulations come into effect (on a date appointed by the Governor-General by Order in Council), as specified in the IPRC Amendment (No 2) Act 2005.

Policy

It is ACC's policy that treatment received at the direction of a RHP includes treatment received from a non-RHP on the specific instructions of a RHP, or otherwise under a RHP's supervision or guidance.

Treatment is under a RHP's supervision or guidance where:

- It forms part of the treatment plan set by a RHP and supports the ongoing treatment provided by the RHP.
- The RHP retains responsibility for the specific intervention and the patient.
- The specific intervention is within the RHP's scope of practice.
- The RHP exercises, or is required to be available to exercise, clinical judgement that essentially shapes the specific intervention by the non-RHP, including the way it is administered.

Legislation and policy applied to the case

In the case described above, the massage therapist is not a Registered Health Professional, nor was he acting at the direction of a RHP. Mr Jake's personal injury, therefore, cannot be considered a treatment injury.

Mr Jake did, however, sustain a personal injury which is covered under the PICBA provisions of the AC Act as there was clearly a physical injury caused by force or resistance.

Mr Jake's claim would be accepted under PICBA provisions.

Delay in diagnosing lung cancer

Scenario

Mr. R arrived at the hospital emergency department with acute abdominal pain. An emergency department physician saw him and ordered a number of investigations including a chest x-ray.

Mr. R was admitted under the surgical team for probable cholecystitis, and subsequently had an uncomplicated laparoscopic cholecystectomy. Neither the emergency physician nor the surgical team viewed the chest x-ray or the radiologist’s report, which noted an ill-defined mass in the right lung, and recommended further investigation.

Mr R made an uneventful recovery, and was discharged. He wasn’t seen until two years later, when he went to his GP with weight loss, cough, and shortness of breath. His GP ordered an urgent chest x-ray which showed a large mass in the right lung, later diagnosed as an extensive metastatic adenocarcinoma.

A treatment injury claim was lodged for a delay in diagnosis. ACC sought external clinical advice from an emergency physician who concluded that:

- progression of the cancer had resulted from treatment
- the physician who ordered the original chest x-ray had a responsibility to ensure it was followed up
- Mr R lost the opportunity for earlier investigation and intervention.

ACC also sought oncology external advice, which concluded that:

- if the cancer was diagnosed at the time of the original x-ray then it would have most likely been a stage 1A disease, with a good long-term prognosis
- as a result of the delay, the cancer progressed to stage 3B, with a poor prognosis.

Cover questions	Answers
Has there been a failure to provide treatment or a delay in providing treatment?	Yes, there was a failure to follow-up the chest x-ray repo Clinical advice concluded that this resulted in a lost opportunity for earlier investigation and intervention.

Cover questions	Answers
Is there a personal injury over and above the natural consequences of the underlying condition for which treatment was sought?	Yes, the lung adenocarcinoma progressed from stage 1/ (primary tumour only, with a diameter of 3cm or smalle stage 3B (large tumour with extension to adjacent struc and significant spread to lymph nodes).
Had the condition been diagnosed or treatment been received earlier, would the personal injury have been prevented or lessened?	Yes, oncology advice concluded that if the cancer was diagnosed at the time of the original x-ray it would hav likely been a stage 1A disease with a good long-term prognosis, and that as a result of the delay the cancer progressed to stage 3B with a poor prognosis.
Did the personal injury occur in the context of treatment?	Yes, it occurred during Mr R's treatment at the emerger department and admission to hospital
Was the personal injury a necessary part of the treatment required?	Not applicable
Was the personal injury an ordinary consequence of the treatment required?	Not applicable
Do any of the other exclusionary provisions apply	No
Is cover available	Yes
What is the personal injury for which cover is being provided?	Progression of lung cancer from stage 1A to stage 3B

Delay in diagnosing haemochromatosis with progression of disease resulting in bilateral ankle cartilage damage

Scenario

Mr B consulted his GP, complaining of bilateral ankle pain starting in 1982 and he was seen by his GP a number of times for this pain. Following referral to a specialist a working diagnosis of osteoarthrosis was made and Mr B was appropriately treated for this diagnosis.

In 2004 Mr B underwent blood screening at which time ferritin levels formed part of that screening

Note:

In 2004 blood screens commonly included checks for ferritin but this was not the case in 1982.

Mr B's blood results indicated an abnormal level of iron and after further investigations he was identified as having hereditary haemachromatosis (HH). If left uncontrolled for long periods of time HH is known to cause damage to joints.

Mr B lodged a treatment injury claim for delay in diagnosis of haemochromatosis resulting in progression of disease and ankle cartilage damage.

Advice from a peer external clinical advisor was obtained. Dr A commented:

"Ankle and other joint pains are very common presentations in general practice. In the vast majority of cases the diagnosis is 'osteoarthrosis' or 'osteoarthritis'. It is not usual in general practice to seek a systemic illness as a cause of ankle pain unless there are other pointers to there being a systemic disease.

"The general practitioner did refer Mr B to a specialist early in the course of his problem and the specialist did not consider other investigations to be warranted.

"I therefore conclude that on balance, the general practitioner had taken the usual management steps for this problem and there were no other earlier indicators for the condition that was later diagnosed."

Cover questions	Answers
Has there been a failure to provide treatment or a delay in providing treatment (ie at the time of treatment should a different diagnosis reasonably have been made)?	No. Mr B's disease progressed under the care of his GP. Clinical advice received during investigation of the claim noted the adequacy of the general practice management that in their peer opinion there was no delay. The external clinical advisor considere the client's presentation, and the clinical knowledge at the time o treatment, to determine whether a different diagnosis or treatme path should reasonably have been given at an earlier point in tim
Is there a personal injury over and above the natural consequences of the underlying condition for which treatment was sought?	No, the cause and of Mr B's ankle cartilage problem was his underlying health condition.
Had the condition been diagnosed or treatment been received earlier, would the personal injury have been prevented or lessened (ie could the earlier treatment or diagnosis have led to a different outcome by preventing the injury or lessening its progression)?	Not applicable. Peer clinical advice states that as there were no earlier indicators for the client's ultimate diagnosis, a different diagnosis could not reasonably have been made, and a different treatment path could not reasonably have been undertaken at an earlier point in time.
Did the personal injury occur in the context of treatment?	Yes. The personal injury occurred while Mr B was receiving treatment from a Registered Health Professional.

Cover questions	Answers
Was the personal injury a necessary part of the treatment required?	Not applicable
Was the personal injury an ordinary consequence, of the treatment required?	Not applicable
Do any of the other exclusionary provisions apply?	Not applicable
Is cover available?	No
What is the personal injury for which cover is being provided?	There is no cover provided The personal injury is due to Mr B's underlying health condition. I is therefore excluded from cover.

Peritonitis–unreasonably withholding or delaying consent

Scenario

Dr Jones is called out to visit Mr M who is suffering acute abdominal pain.

Dr Jones diagnoses peritonitis and advises Mr M that he should be admitted to hospital immediately. Mr M refuses.

The GP repeatedly advises both Mr M and his wife that admission is imperative. The gravity of his condition is explained, as well as the potential outcome of refusing admission. Despite this repeated advice, Mr M continues to refuse admission.

Dr Jones makes notes of the conversation, prescribes pain relief and plans to visit Mr M in the morning.

Mr M dies during the night. Mr M's daughter subsequently lodges a treatment injury claim.

Cover questions	Answers
Was there a personal injury?	Yes. Mr M's death is the personal injury being claimed for cover
Did the personal injury occur in the context of treatment?	Yes. The personal injury occurred while under the care of Mr M's GP
Was the personal injury caused by treatment?	Yes. Treatment includes obtaining or failing to obtain the person's consent
Was the personal injury a necessary part, or ordinary consequence, of the treatment required?	No. Mr M required admission to treat peritonitis. Death is not a necessary part, or ordinary consequence, of the treatment Mr M required
Do any of the other exclusionary criteria apply?	Yes. Personal injuries that are the result of a person unreasonably withholding or delaying their consent to undergo treatment are excluded from cover.
Is cover available?	No
What is the personal injury for which cover is being provided?	Not applicable

Key points

Definition of treatment

The definition of treatment includes obtaining or failing to obtain the person's consent (section 33).

Exclusions

Section 32(2) specifically excludes certain types of personal injuries from cover. Subsection 32(2)(d) excludes a personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

In the case of Mr M, he made an informed decision not to consent to the treatment required to treat his condition. The claim for cover is declined on this basis.

IVinfection – minor injury given cover

Scenario

Mrs Jones is an 80-year-old woman with dementia who is admitted to a medical ward of the local public hospital due to dehydration and anorexia.

Her dehydration is treated with IV fluids. Mrs Jones develops a minor staphylococcal infection at the IV site. She sustains localised redness and swelling at the IV site which quickly resolves.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury was the staphylococcal infection and subsequent redness and swelling to her arm
Did the personal injury occur in the context of treatment?	Yes. The infection occurred while she was undergoing treatment for dehydration

Cover questions	Answers
Was the personal injury caused by treatment?	Yes. The infection was caused by exposure to an infection at the IV site
Was the personal injury a necessary part of, or ordinary consequence, of the treatment required?	Necessary, no. An infection is not an essential or intrinsic part of administering IV fluids Ordinary consequence, no. An infection is not an ordinary consequence of the IV dehydration therapy Mrs Jones required to treat her dehydration
Do any of the other exclusionary provisions apply?	No
Is cover available?	Yes
What is the personal injury for which cover is being provided?	Staphylococcal infection

Key points

Minor personal injuries may be accepted

Unlike the medical misadventure provisions of the AC Act 2001, there are no severity thresholds with the treatment injury provisions. Cover does not depend on the injury being severe. Minor personal injuries can be accepted for cover in the same way moderate and serious injuries may be covered.

Underlying health condition

ACC policy is that a person's underlying health condition is their general state of health. The above case illustrates that claimants may present at the time of treatment with a number of underlying health conditions.

Mrs Jones' underlying health conditions at the time of the treatment were dementia, dehydration and anorexia. Not all of the underlying health conditions were relevant to the injury, however.

Relevant vs irrelevant circumstances

It is important to distinguish the relevant and irrelevant circumstances of the treatment. When determining cover, the relevant circumstances are those which had a material impact on the personal injury.

In the case described above, the relevant underlying health condition (as a circumstance) was her dehydration (the condition being treated). The claimant's dementia and anorexia were not material circumstances of the personal injury.

Underlying health conditions vs personal characteristics

It is also important that personal characteristics such as the claimant's age, gender or ethnicity are not considered 'underlying health conditions'. While a claimant's underlying health condition, such as dementia, may be influenced by a person's age, the person's age is not an underlying health condition in itself.

Melanoma–defining the personal injury covered

Scenario

Mr Harris' GP repeatedly fails to detect a malignant melanoma. He asks his GP three times over a three-year period to check the spot. His GP considers the spot benign and therefore considers a biopsy unnecessary.

No referral is made to a specialist for further investigation.

Becoming increasingly concerned, Mr Harris decides to have a spot check done at another clinic. He is immediately referred to a specialist who diagnoses a malignant melanoma.

The treatment Mr Harris subsequently requires is more extensive than would have been the case had the cancer been detected when Mr Harris first presented to his GP.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury is the deterioration of Mr Harris' underlying health condition. Note: The personal injury is not the malignant melanoma as first presented at the time of treatment. This is the underlying health condition. The personal injury is the spread of the condition which would not have occurred had Mr Harris received the treatment he required (the biopsy)
Did the personal injury occur in the context of treatment?	Yes. The deterioration arose following treatment (which included the failure to diagnose)
Was the personal injury caused by treatment?	Yes. The personal injury was caused by the treatment (failure to provide treatment in a timely manner)

Cover questions	Answers
Was the personal injury a necessary part of, or ordinary consequence of, the treatment required?	No. The deterioration of Mr Harris's underlying health condition was neither a necessary part of, nor an ordinary consequence of, the treatment Mr Harris required. Clinical advice confirmed the above. The advisors considered the nature of the melanoma and the significance of the period between Mr Harris' first consultation with his GP and the date in which the correct diagnosis was made.
Do any of the other exclusionary criteria apply?	No
Is cover available?	Yes
What is the personal injury for which cover is being provided?	The deterioration of the melanoma. Claimant requires more invasive surgery than would have been required if diagnosis had been made in a timely manner

Key points

Personal injury

When determining cover, the first step is to establish that a personal injury occurred. In this case, the personal injury is the deterioration of Mr Harris' underlying health condition due to the failure to diagnose.

The final step when determining cover is confirming the actual personal injury from which any entitlements will derive. This is critical. It is important that the cover decision clearly conveys what is being covered.

While the claimant may have ongoing needs that derive from the original underlying health condition being treated, ACC's responsibility (in terms of entitlements) is limited to the claimant's needs which arise from the specific treatment injury.

In the case of Mr Harris, cover is provided for the deterioration of the melanoma, which requires more invasive surgery than would have been the case had the diagnosis been made in a timely manner. Cover is not provided for the melanoma (the underlying health condition).

Clinical advice

At times, differentiating between the underlying health condition and the personal injury will be difficult. Clinical advice may be required to assist ACC in determining the scope of the personal injury to be covered. This step however is critical as ACC is only responsible for entitlements that derive from the personal injury itself.

It is important that the personal injury being covered is clearly outlined in the cover decision letter.

Bladder perforation–confirming the personal injury being covered

Scenario

Mr Henry undergoes lower abdominal surgery, during which his bladder is accidentally perforated, resulting in a 2cm wound. He requires catheterisation for two days following surgery.

The perforation requires no intervention and healing occurs within 48 hours.

Mr Henry lodges a treatment injury claim and seeks a range of entitlements including funding for incontinence pads. Mr Henry considers his incontinence to be the result of the bladder perforation.

After receiving clinical advice, ACC considers the cause of Mr Henry's urinary incontinence to be attributable to his underlying health condition, rather than the bladder perforation.

Cover questions	Answers
Was there a personal injury?	Yes. The personal injury was the 2cm bladder perforation
Did the personal injury occur in the context of treatment?	Yes. The perforation occurred while Mr Henry was undergoing lower abdominal surgery
Was the personal injury caused by treatment?	Yes. The perforation was caused by an accidental incision to the bladder
Was the personal injury a necessary part of, or ordinary consequence of, the treatment required?	The perforation of Mr Henry's bladder was neither a necessary part of, nor an ordinary consequence of, the treatment Mr Henry required
Do any other exclusionary provisions apply?	No
Is cover available?	Yes
What is the personal injury for which cover is being provided?	The 2cm bladder perforation

Key points

Cover is available

Mr Henry has a covered personal injury. All criteria are met. There was a personal injury, it occurred within the context of treatment, and the personal injury is not excluded from the treatment injury provisions.

Entitlements are limited to the personal injury

The final step when determining cover is defining the actual personal injury that is the subject of cover. It is essential that the exact nature of the personal injury being covered is conveyed to the claimant. All decisions concerning entitlements then derive from the covered personal injury.

In the case of Mr Henry, he claimed a number of entitlements including the funding of incontinence pads. This request for entitlement would be declined on the basis that the claimant's need did not derive from the personal injury (the bladder perforation). The personal injury resolved within 48 hours of the accident.

Fatality–injury severity not indicator of the complexity of claim

Scenario

Mr Harvey is a 45-year-old man who develops pneumonia and seeks treatment at a local accident and emergency department.

Given his presentation and the advanced nature of the illness, Mr Harvey is admitted to a medical ward of the hospital. Part of the treatment required is the insertion of an intercostal catheter drain to relieve fluid from around his lungs. The

procedure is performed by a house surgeon under the direction of a registrar.

During the procedure the hepatic veins and inferior vena cava are severed, resulting in haemorrhage and hypovolemic shock.

Despite every effort by the treating physicians, the haemorrhage and shock are not reversed. Mr Harvey dies.

Cover questions	Answers
Was there a personal injury?	Yes. The hepatic veins and inferior vena cava were severed, resulting in death
Did the personal injury occur in the context of treatment?	Yes. The death occurred in a hospital while receiving treatment from registered health professionals
Was the personal injury caused by treatment?	Yes. The death was caused by the hepatic veins and inferior vena cava being severed during treatment for pneumonia
Was the personal injury a necessary part, or ordinary consequence, of the treatment required?	Necessary, no. The severing of the hepatic veins and inferior vena cava are not essential or intrinsic components of treating pneumonia by inserting an intercostal catheter Ordinary consequence, no. The personal injury was not an ordinary consequence of the treatment Mr Harvey required
Do any of the other exclusions apply?	No

Cover questions	Answers
Is cover available?	Yes
What is the personal injury for which cover is being provided?	Death

Key points

Straightforward claims for cover

This example illustrates that the severity of the injury is not necessarily an indicator of the complexity of determining cover.

In the case above, a decision to provide cover can be made immediately based on the information received from the ACC45 and the ACC2152.

While an autopsy report would confirm the cause of the injury, where the cause is clear, a cover decision can be made immediately.

Harm reporting

Where the personal injury is death, this is a sentinel event. It is important that sentinel events are identified so that the Review Team in the Treatment Injury Centre is alerted for reporting purposes.

Additional Clinical Questions Guidance: Failure within the provision of treatment.

Purpose:

To provide additional guidance for Specialist Cover Assessors when asking clinical questions where there has been a treatment injury considered to be due to a failure within the provision of treatment.

This guidance will help Cover Assessors to format and ask effective clinical questions for internal and external clinical advisors[1].

Policy:

To determine cover for a personal injury due to failure to provide treatment, or failure to provide treatment in a timely manner, the injury must meet the following criteria[2]:

- there has been a failure to provide treatment or to provide treatment in a timely manner[3]
- there is a personal injury, over and above the natural consequences of the underlying condition for which the treatment was sought
- had the condition been diagnosed or treatment received earlier, the personal injury would have been prevented or lessened.

A treatment injury must be considered to have occurred due to a failure within the provision of treatment or delay in treatment if the treatment injury was caused by at least one of the following:

- *A system failure* – an event where there has been a systemic or process issue in the chain of events leading to the client's treatment injury
- *A medical equipment failure* – an event where an error has occurred due to equipment malfunctioning, being contaminated, being used incorrectly or was incorrect for the procedure, leading to a treatment injury claim
- *An administration failure* - an event where there has been a clerical error leading to the treatment injury claim. For example, typos or other errors in paperwork, referrals, or clinical records.
- *A communications failure* – an event where an error has occurred during the relaying of information by a registered health professional (such as staff handovers, poor communication with client), leading to a treatment injury claim.

Definition of failure – Risk of Harm[4]

Failure is an act or instance of failing or provide, to be unsuccessful or of a suboptimal quality; an insufficient quantity or quality.

Treatment injury failure can be described as the failure to provide treatment, or to provide treatment in a timely manner. This includes failing to obtain a person's informed consent for

[1] Also refer to Clinical Questions Guide: Treatment Injury Cover Assessment Centre June 2019.
[2] Refer to Promapp – Causal Link Policy
[3] AC Act, 2001: Section 33(1)(b), a failure to provide treatment, or to provide treatment in a timely manner.
[4] Legislation – AC Act 2001 Section 284: Reporting Risk of Harm to public. Applies from 1 July 2005.

treatment, the failure of any equipment, device or tool used as part of the treatment process, including the failure of an implant or prosthesis.

Failure is the departure from clinical standards, processes and practices that would usually be used to provide treatment that causes a personal injury that is not a necessary part or ordinary consequence of that treatment.

Failure can occur within any support systems, policies, and administrative systems that are used by registered health professionals to directly support the treatment provided to the patient.

Where it has been determined that the client has suffered a consequential injury[5] (e.g. gradual process, disease or infection due to a covered injury or due to treatment for a covered injury), the requirement that a personal injury is ***not a necessary part or ordinary consequence*** of the treatment has already been met.

When there is a confirmed failure identified during the claims' assessment, a judgement needs to be made as to whether there is a risk of harm to the public. We have a responsibility to report that risk, and any other relevant information, to the authority responsible for patient safety in relation to the treatment that caused the personal injury.

When to seek Clinical Advice – Internal and external advice

You can seek clinical advice when you need help to determine cover regarding a failure, standard of care, appropriateness of the chosen treatment pathway, identification of a physical injury, causation and determining what contribution patient specific factors (or underlying health conditions) had in the development of an injury.

You can request information and a report from the health professional involved about their treatment rationale to assist you in determining if there was a treatment injury caused by failure within the provision of treatment or delay in treatment. Or, you can request a Medical Case Review (MCR) to obtain an opinion from a non-treating practitioner or a second opinion from a suitably qualified assessor: Arrange Medical Case Review (MCR) Assessment | Nintex Promapp®

Internal advice can be gained from a variety of specialists and Advisors. To assist in making decisions by receiving internal specialist guidance from a number of different areas: Seek Internal Guidance | Nintex Promapp®

- Clinical Services
- Medical Advisors
- Technical Services
- Practice Mentors
- Payments
- Technical Overpayments
- Privacy

Medical Case Reviews (MCRs) and Medical Single Discipline Assessments (Medical SDAs) are initiated by ACC to seek an opinion from a non-treating medical specialist. These are used to determine

[5] Refer to Promapp – Consequential Injury Claims Policy

diagnosis, causation, and/or treatment and rehabilitation recommendations: Medical Case Review and Medical Single Discipline Assessment Service Page | Nintex Promapp®

When you determine that this specialist advice and opinion is needed, you can also seek external clinical advice (ECA) to provide an independent blind review of the clinical information. The ECA specialist will be within the relevant scope of practice and will base their findings, advice, and opinion on the information that you provide to them. External Clinical Advice is an opinion solely based on the paper file review from an independent provider. It helps to answer the questions on the standard of care (if relevant), physical injury, causation, background population risk (necessary part of treatment), ordinary consequence of treatment etc.

The ECA's role is to comment on clinical facts, accepted standard practice, whether a failure has occurred and likelihood of an injury occurring, taking into account the particular clients presenting and contributing factors. Refer to: Seek External Clinical Advice | Nintex Promapp®

Formatting Clinical Questions to establish 'failure' of the treatment:

1. Provide a summary of the clinical events that lead to the claim: The summary sets out, from your initial claim analysis, the context of where the alleged failure occurred and the resulting injury. This summary leads to the questions that you are needing to answer to make a cover decision and ascertain if there was a failure involved. What happened (the claimed injury)? Where did it happen (the anatomical location)? When did it happen (date of injury)? How did it happen (context: was the injury necessary or ordinary)? Why did it happen (the cause)? Who was involved (registered health professional)?
Example summary 1: The basis of this claim is the client has presented to their *[registered health provider]* on *[date]* with *[symptom(s)/concern]*, and *[treatment/referral]* was provided and *[outcome/diagnosis/injury]* occurred. We are seeking your opinion to establish whether there was a failure of the [treatment/equipment/tool/policies/practices/support systems] involved that resulted in the claimed injury. ***Example summary 2:*** The basis of this claim is the client has presented to their *[registered health provider]* on *[date]* with *[symptom(s)/concern]* and was provided with *[treatment/referral] for [disease/symptoms/other] by [registered health provider].* We are seeking your opinion to determine whether a the *[practitioner/provider]* involved provided the appropriate course of treatment given their clinical indications at the time. ***Example summary 3:*** The basis of this claim is the client has presented to their *[registered health provider]* on *[date]* with *[symptom(s)]*, but it was not until *[date]* that *[treatment/referral]* was provided and *[outcome/diagnosis/injury]* occurred. We are seeking your opinion to determine whether the *[practitioner/provider]* involved could and should have done something differently based on what was known at the time of consultation with *[the client's registered health provider]*.

Example summary 4: The basis of this claim is the client has presented to their *[registered health provider]* on *[date]* with *[symptom(s)/concern]*, but it was not until *[date]* that *[treatment/referral]* was provided and *[outcome/diagnosis/injury]* occurred. We are seeking your opinion to establish whether the treatment was provided in a timely manner.	
Failure to provide treatment, or to provide treatment in a timely manner:	**Example - Clinical Questions**
A treatment injury claim where the treatment is alleged to be about 'failure' is whether an alternative treatment that would have prevented the personal injury ***could and should*** have been given having regard to clinical indications at the time of the alleged failure.	In your opinion, could and should this patient have undergone [procedure/treatment] or have been referred to [provider] earlier? If so, what treatment pathway should this have been and why? Considering the clinical knowledge at the time of treatment, could or should [practitioner/provider] have taken an alternative course of action? Please explain your reasoning.
A ***departure from a standard*** is required to establish 'failure' of the treatment.	In reviewing the clinical findings and presentation of the patient on [date], did the [procedure/treatment] provided on [date] follow standard procedures for [professional body]? Please explain how the evidence supports your conclusion. In reviewing the clinical findings and presentation of the patient on [date], did the [registered health professional] on [date] follow standard procedures for [professional body] and ensure that the treatment was adequately explained and informed consent gained for that treatment? Please explain how the evidence supports your conclusion. Can you please describe how this patient's claimed injury occurred during [procedure/use of equipment/procedure]?
'Failure' cannot occur in circumstances where there are ***no clinical indications*** for a different treatment course.	Can the health professional involved please provide a report on their treatment rationale for [patient] in relation to their clinical presentation on [date]? Please also provide any other relevant comment or information about the treatment provided. In reviewing the clinical findings and presentation of the patient on [date], was the clinical description [clinical impression/diagnosis] and treatment provided reasonable and appropriate? Please explain why/why not. Based on the patient's presentation (including complexity of presentation and any co-morbidities

	present) and clinical knowledge at the time of treatment, should a different diagnosis reasonably have been made or should a different treatment path reasonably have been undertaken at an earlier point in time? Please explain why/why not.
An alternative course of treatment needs to have been available; if there was ***no alternative treatment available***, even if the treatment that was given was a 'failure', then there cannot be a personal injury caused by that 'failure'.	Considering the clinical knowledge at the time of the patient seeking treatment and considering the patient's clinical presentation, was there an alternative treatment available? Please describe how the evidence supports your conclusion. If an alternative treatment option was available to the patient at the time, would that alternative treatment lead to a different outcome for the patient? Please describe how the evidence supports your conclusion. If a different diagnosis/treatment path was indicated, and if it had been followed, on the balance of probabilities would this have lead to a different outcome? (i.e. whether it would have prevented the claimed injury or altered the progression of the injury). Please describe how the evidence supports your conclusion.
Importantly, if there is a 'failure' of the treatment then it must be found that a ***personal injury was caused by that 'failure'***. The personal injury might be distinctly separate from the health condition being treated, or the personal injury may be a progression of the health condition being treated, e.g. disease progression of cancer - over and above the underlying condition and its natural progression.	Can you please describe how this patient's [presenting condition e.g. cancer/disease] changed from [date] to [date]? If there was [presenting condition e.g. cancer/disease] progression, what was the impact of this delay on the patient's health status and did the treatment differ as a result? If so, please explain how and why. Has the delay in treatment likely to have resulted in disease progression and changed prognosis? If so, please explain how and why. Has the delay in treatment resulted in additional treatment, such as surgery, that may not have been required at the time? If so, please explain why.
Departure from clinical standards ('failure') is required to comply with the requirement that a personal injury is ***not a necessary part or ordinary consequence*** of the treatment.	Was the claimed injury a necessary or ordinary consequence of the [procedure/use of equipment/communication/system]? Please explain how the evidence supports your conclusion. In reviewing the clinical findings and presentation of the patient on [date], in your opinion was the

	patient's injury caused by the [equipment, device, tool] used as part of the treatment process? Please explain how the evidence supports your conclusion. In reviewing the clinical findings and presentation of the patient on [date], in your opinion was the patient's injury caused by a failure within the [policies, processes, administrative systems] used by [registered health provider] that directly supports the treatment provided to the patient on [date]? Please explain how the evidence supports your conclusion.
Hindsight – Do not apply hindsight: You must investigate what treatment was actually required, based on the client's presentation at the time rather than on what was subsequently proved to be the case with the benefit of hindsight.	Considering the clinical knowledge at the time of treatment, and without the benefit of hindsight, in your opinion what treatment was required? Considering the clinical knowledge at the time of treatment, and the presentation of the patient (without the benefit of hindsight), in your opinion would the [treatment/or lack of treatment] cause the claimed injury? Please explain how you reached your conclusion. If, in your opinion a different treatment method was provided], would that treatment have led to a different outcome for the patient? Please describe how the evidence supports your conclusion. Considering the clinical knowledge at the time of treatment, and the presentation of the patient (without the benefit of hindsight), in your opinion is there any doubt that [claimed injury] was caused by a failure? Please explain how you arrived at your conclusion. On the balance of probability and without the benefit of hindsight, had [delay/equipment/communication/system failure] not occurred, would there have been a different outcome for the patient? Please describe how the evidence supports your conclusion.