Vocational Medical Services
Guidelines for Providers
Updated December 2017
**Useful contacts and telephone numbers**

Your role in undertaking Vocational Medical Services on ACC’s behalf is likely to involve contact with a number of our teams. Here are their contact details.

<table>
<thead>
<tr>
<th><strong>ACC Provider Helpline</strong></th>
<th>Ph: 0800 222 070</th>
<th>Email: <a href="mailto:providerhelp@acc.co.nz">providerhelp@acc.co.nz</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACC Client/Patient Helpline</strong></td>
<td>Ph: 0800 101 996</td>
<td></td>
</tr>
<tr>
<td><strong>Provider registration</strong></td>
<td>Ph: 04 560 5211</td>
<td>Email: <a href="mailto:registrations@acc.co.nz">registrations@acc.co.nz</a></td>
</tr>
<tr>
<td></td>
<td>Fax: 04 560 5213</td>
<td>Post: ACC, PO Box 30 823, Lower Hutt 5040</td>
</tr>
<tr>
<td><strong>ACC eBusiness</strong></td>
<td>Ph: 0800 222 994, option 1</td>
<td>Email: <a href="mailto:ebusinessinfo@acc.co.nz">ebusinessinfo@acc.co.nz</a></td>
</tr>
<tr>
<td><strong>Health Procurement</strong></td>
<td>If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:health.procurement@acc.co.nz">health.procurement@acc.co.nz</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ph: 0800 400 503</td>
<td></td>
</tr>
<tr>
<td><strong>Supplier managers</strong></td>
<td>Supplier managers can help you to provide the services outlined in your contract. Contact the Provider Helpline for details of the supplier manager in your region.</td>
<td></td>
</tr>
<tr>
<td><strong>ACC website</strong></td>
<td>For more information about ACC, please visit: <a href="http://www.acc.co.nz">www.acc.co.nz</a></td>
<td></td>
</tr>
</tbody>
</table>
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1 Introduction

Welcome to the Vocational Medical Services Operational Guidelines. When undertaking the Vocational Medical Services (VMS) on behalf of ACC you are performing a valuable clinical advisory and legislative role. This role is important as you identify appropriate treatment and rehabilitation which will guide us to support our client in achieving maximum independence with their injury recovery.

This document has been written to assist you with:

- understanding the standards and requirements for undertaking each of the different components of VMS
- ensuring that there is consistency in completing assessments and writing reports
- information that provides context for VMS and how these services relate to providing rehabilitation for our clients.

These operational guidelines should be read in conjunction with the Standard Terms and Conditions and Service Schedule for Vocational Medical Services (‘your contract’). Your medical assessments must comply with the contract. Where there are any inconsistencies between the operational guidelines and the contract, the contract will take precedence.

We’ll update these guidelines when required - emailing each new version to you once it’s made available on the ACC website at www.acc.co.nz.

2 The service philosophy of Vocational Medical Services

Vocational Medical Services are designed to support ACC’s vocational rehabilitation philosophy. The philosophy of the Vocational Medical Services is:

1. **Support and advice through the rehabilitation process**: using clinical experts to offer support and advice at the right time through the rehabilitation process to ensure a safe and timely return to work.

2. **Provide flexibility**: by providing tailored support and advice to clients.

3. **Be responsive**: providing services in a timely manner throughout the client’s rehabilitation journey.

4. **Encourage team work**: by actively fostering good working relationships between health professionals – making sure the client experiences a single clear direction in their rehabilitation.

5. **Promote openness and transparency**: by ensuring the purpose, processes, and possible outcomes of the VMS are communicated and delivered in an open and transparent way to clients.

3 ACC’s obligations under the Accident Compensation Act 2001 (AC Act 2001)

The AC Act 2001 describes ACC’s responsibilities with regards to who can receive vocational rehabilitation following personal injury and what the extent of this rehabilitation should be. Vocational rehabilitation aims to return the client:

- in the first instance to their previous employment - maintain employment
- or the closest possible equivalent – obtain employment
or prepare the client for employment that matches their experience and training before injury as closely as possible - regain employment or acquire Vocational Independence.

The Individual Rehabilitation Plan (IRP)

The IRP is required by the AC Act 2001. It is used to document the agreed and planned activities that have been negotiated in partnership between the client and ACC. It’s signed by both the client and ACC and is binding.

It’s an integral part of the client’s vocational rehabilitation and vocational independence process. It’s a record of the vocational rehabilitation plan agreed and completed, and is one of the documents required to be provided and considered when you complete an Initial Medical Assessment (IMA) and a Vocational Independence Medical Assessment (VIMA).

In regard to the vocational independence process, the IRP should document:

- a clear rehabilitation outcome
- the work types identified as medically sustainable or likely to be sustainable
- all agreed medical rehabilitation recommendations from the IMA, or other medical reports
- all vocational rehabilitation recommended from the Initial Occupational Assessment (IOA) or other vocational assessments to overcome barriers to any work type/s
- the rehabilitation activities that have been completed or there is a clear statement why these have not been completed.

The IRP document is updated throughout a client’s rehabilitation. All rehabilitation activities on the IRP should be complete before the client is assessed for a VIMA.

If, during the course of vocational rehabilitation it appears the client will be unable to return to their previous employment, ACC is required to provide appropriate assessments to determine the client’s vocational rehabilitation needs.

An objective of the IRP process is to ensure that comprehensive vocational rehabilitation has been provided.

Vocational Rehabilitation and Vocational Independence

Following completion of the rehabilitation recommendations arising from the Initial Medical Assessment, ACC is able to assess whether the client is ‘Vocationally Independent’ as described in Sections 107 to 113 of the AC Act 2001. See Appendix I for links to the AC Act 2001.

Vocational Independence is defined in the AC Act (section 6(1)) as the claimant’s capacity, as determined under section 107, to engage in work –

(a) for which he or she is suited by reason of experience, education, or training, or any combination of those things; and
(b) for 30 hours or more per week.

Under section 107, part of the determination of a client’s vocational independence is an assessment by: a suitably qualified medical practitioner of the client’s capacity to work for 30 hours or more per week in one or more of the types of work identified in the Vocational Independence Occupational Assessment.
The table below shows the order the assessments are undertaken and their purpose. Vocational Medical Services are highlighted in **bold**:

<table>
<thead>
<tr>
<th>Order</th>
<th>Assessment</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Initial Occupational Assessment (IOA)</strong></td>
<td>This assessment identifies the types of work that may be appropriate for the client because of their previous work experience, training and education.</td>
</tr>
</tbody>
</table>
| 2     | **Initial Medical Assessment (IMA)**         | An assessment to determine whether the types of work identified in the IOA are, or are likely to be, medically sustainable for the client.  
If work types are not currently sustainable, please provide rehabilitation suggestions for making them medically sustainable. If the work types are currently medically sustainable without the need for rehabilitation, then you should indicate this. |
| 3     | **Vocational Independence Occupational Assessment (VIOA)** | To consider the progress and outcomes of the vocational rehabilitation under the individual rehabilitation plan; and whether the types of work identified in the initial assessment or any new jobs are suitable for the client. |
| 4     | **Vocational Independence Medical Assessment (VIMA)** | The purpose of the VIMA is to provide an opinion as to whether, having regard to the client’s personal injury, the client’s rehabilitation is complete and has the capacity to undertake any type of work identified in the occupational assessment, and reflected in the client’s individual rehabilitation plan. |
4 Service outcomes of Vocational Medical Services

The diagram below shows what as a supplier of VMS you will provide for everyone involved in the client’s vocational rehabilitation:

- **GP**
  - Provide expert guidance on safe return to work practices
  - Provide confidence in a safe recovery process for their patient
  - Assist with the management of their patient

- **Employer**
  - Improve staff retention and productivity
  - Provide expert guidance on safe return to work practices
  - Encourage ‘Better at Work’ culture

- **Client**
  - Provide expert guidance and reassurance on return to work practices
  - Improve the likelihood that the client will retain their job
  - Encourage participation in ‘Better at Work’ culture

- **ACC**
  - Provide expert rehabilitation for ACC clients
  - Advance the client’s rehabilitation in the workplace, where appropriate
  - Improve rehabilitation rates for clients

- **VRS Provider**
  - Provide expert guidance on safe return to work practices
  - Ensure timely completion of Vocational Rehabilitation Service programmes


Accident Compensation Corporation
5 Overview of the services

Vocational Medical Assistance (VMA)

A referral for a VMA will be initiated when expert advice is required to assist with problem solving such as how to address barriers to rehabilitation. It’s designed to provide flexible, responsive, advice tailored to each client’s needs. This service should be delivered promptly.

There are two components to Vocational Medical Assistance: Liaison Services and Case Conferencing.

Five sessions are pre-approved. Any additional sessions will need a purchase order from a case owner.

When the service is used

Liaison

Liaison support is a flexible service aimed at providing responsive problem solving or advice. It can be provided by a medical assessor that may or may not have examined the client. Either by phone or email by:

- answering questions of a general nature asked by a GP, VRS provider or case owner on a medical condition or injury - and how it relates to the functional requirements of a particular occupation for a client
- working with a GP, VRS provider or case owner to discuss or get clarification on aspects or questions from an assessment report that the provider has completed (VRR, IMA, VIMA) note that this does not include discussions with a case owner in regards to completeness or quality issues of a recently submitted report
- answering questions by a GP, VRS provider or case owner on the need for, or appropriateness of, a specific rehabilitation intervention for a client.

A liaison session may include multiple correspondences related to a single request.

In addition to providing the advice, you’ll need to collect information to be able to invoice for the liaison service. The conversations need to be documented, and linked to an approved ACC claim eligible to receive vocational rehabilitation for the invoice to be paid. This could be via an email follow-up. A record of the conversation then needs to be sent to the client’s case owner. Refer to section 10 on reporting and section 13 on invoicing for more information.

Case conference

Case conferencing is another flexible service aimed at all the relevant people involved in the client’s vocational rehabilitation. It enables everyone to gain a shared understanding of the best way to support the client’s rehabilitation programme.

You must have assessed the client previously - either for a Vocational Rehabilitation Review (VRR), IMA, or VIMA if Vocational Independence has not been achieved, before a case conference takes place.

Some examples of situations where case conferences can be used are:

- to address concerns or issues that might prevent the successful completion of a Vocational Rehabilitation Service (VRS), Pain Management Services, or other rehabilitation programme, for example, where concerns about symptoms prevents participation
- where vocational rehabilitation has stalled and a discussion with the team may clarify any misunderstanding about the client’s current level of fitness and help to regain traction on the
programme and build confidence

- post IMA or VIMA engagement with the client where there is disagreement or clarification required by the client or their treatment providers on the report
- post VIMA where a client is able to work fewer than 30 hours per week and it would be useful to provide advice about occupational options
- follow-up meeting with a client, case owner, VRS provider, and employer where the medical assessor participating in the case conference has previously provided a VRR or IMA that recommended a VRS programme.
- To discuss what the next steps are for clients not able to achieve Vocational Independence.

**When a client will be referred to you and by who**

A referral for VMA may be initiated when a Vocational Rehabilitation Services (VRS) provider, case owner or GP is seeking rehabilitation advice for their client. For example, it may be to discuss barriers which seem to be affecting a client’s rehabilitation and may be causing delays in them returning to work and/or independence.

**Liaison service:**

- These types of referrals should be straightforward and not require an in-depth assessment. Referral can be direct from the client’s GP, VRS provider, or case owner.
- When accepting a liaison referral, the medical assessor should ask if the referrer has previously sought advice from another medical assessor. This is important to ensure there is continuity of advice for the client.
- Depending upon the request, the medical assessor may suggest that the referrer go back to the previous medical assessor - if this is more appropriate than referring to a second medical assessor.

**Case conference:**

- Referral for case conference can also be initiated by the client’s GP, VRS provider, or case owner. Remember, you can only accept a case conference referral if you have assessed the client previously for a VRR or an IMA.
- These referrals should also be straightforward. For example a case conference may be needed when there’s a difference in opinion within the client’s rehabilitation team and clarification for all is required.
Summary of the referral process for the Vocational Medical Assistance services:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Service component</th>
<th>Referral scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Case conference</td>
<td>GP indicates on eACC18 that additional support needed and the client’s case owner makes the arrangements. Alternatively, phone call or email received from GP requesting case conference support. You contact the client’s case owner to facilitate the case conference arrangements. The case owner contacts the client’s VRS provider (if applicable), and the client, to arrange the appointment details.</td>
</tr>
<tr>
<td>Liaison</td>
<td></td>
<td>The GP contacts you by email or phone. Confirm with the GP that the client has an accepted ACC claim and is eligible to receive vocational rehabilitation from ACC. If it’s unclear whether this is the case, contact ACC to confirm before providing the service.</td>
</tr>
<tr>
<td>VRS provider</td>
<td>Case conference</td>
<td>The VRS provider contacts you to arrange an appointment for a case conference and coordinates the arrangements with ACC, the client, and their GP (if applicable).</td>
</tr>
<tr>
<td>Liaison</td>
<td></td>
<td>The same process applies as when a GP contacts you for liaison.</td>
</tr>
<tr>
<td>Case owner</td>
<td>Case conference</td>
<td>Referral sent directly to you. The case owner will coordinate the arrangements for the case conference.</td>
</tr>
<tr>
<td>Liaison</td>
<td></td>
<td>The case owner contacts you by email or phone. They give you the claim number for you to invoice against and send to ACC.</td>
</tr>
</tbody>
</table>

6 Vocational Rehabilitation Review (VRR)

The VRR is an assessment and report which can be used to assist people returning to work following an injury.

Although the benefit of this service is to enable early intervention, the VRR can be done at any point in the client’s vocational rehabilitation and up until they begin the Vocational Independence Assessments. The VRR can be used to assist a client’s rehabilitation where medical aspects of ‘Fitness for Work’ are unclear and/or rehabilitation has stalled and to clarify a diagnosis.

Support during vocational rehabilitation

The VRR service is designed to be a solution to a situation where:

- momentum and confidence in the rehabilitation process has been lost
- medical leadership is required to restore a team approach
- a clearly defined medical opinion on fitness for work is required.

It’s intended that the VRR service complements the work of any Vocational Rehabilitation Service (VRS) being delivered concurrently. The VRR could take place alongside either a Stay at Work or a Work Readiness VRS programme.
The Stay at Work service aims to return a client back to their pre-injury employment. The Work Readiness service aims to support a client into new employment in a role that has been assessed as being medically safe and sustainable for that client to undertake. An example of when the VRR could be used for these services is:

- during a Stay at Work service there may be a difference in opinion between the VRS provider and GP about the proposed return to work plan and clarification from someone with occupational expertise is required, or
- during a Work Readiness service the client is experiencing an increase in their pain levels and a medical assessment is required to determine if a work trial is safe to continue.

A case owner will refer for a standard VRR or a complex VRR.

The criteria for a complex VRR is as follows:

- A client whose case relates to a Serious Injury; or
- who have a covered Sensitive Claim; or
- covered injury is a moderate to severe traumatic brain injury; or
- claim older than 6 months at the time of referral; or
- unable to return to their pre-injury role.

To ensure the service is readily available and easy for case owners and GPs to access, it’s designed to be a fairly brief clinical assessment with a rapid turn-around time. This is a deliberate feature that should ensure that case owners, VRS providers, and GPs refer cases at the right time in the clients rehabilitation.

The service is not designed for clients with complex diagnostic issues. However, the history and examination is aimed at providing information on the diagnosis and the bio-psychosocial model will help to inform the assessment and recommendations.

**Certification**

A key aspect of the service is to accurately describe the client’s fitness for work. Part of a VRR may be for assessing a client’s suitability for a return to work programme. This could include providing medical certification that identifies restrictions, and details on fitness for work so that the client can safely undertake the programme. Certification following a VRR would only happen where the client doesn’t have a current certifying provider.
Who refers a client to you for a VRR

The table below indicates the different ways that a referral for a VRR may be made to you:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Referral scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>Indicates the need for assistance in the form of a VRR on the eACC18 medical certificate to ACC.</td>
</tr>
<tr>
<td></td>
<td>Case owner arranges a referral to you and keeps the GP informed of arrangements</td>
</tr>
<tr>
<td></td>
<td>The case owner contacts the client’s VRS provider (if applicable) and the client to arrange appointment details.</td>
</tr>
<tr>
<td>or</td>
<td>The GP contacts you directly for Vocational Medical Assistance.</td>
</tr>
<tr>
<td></td>
<td>You determine that an assessment is required, so contact case owner and discuss the need for a VRR. If a VRR is agreed upon, the case owner completes the referral form and sends this to you with any other additional supporting information required.</td>
</tr>
<tr>
<td></td>
<td>The case owner contacts the VRS provider and the client to arrange the appointment details.</td>
</tr>
<tr>
<td>VRS provider</td>
<td>Referral sent directly to you.</td>
</tr>
<tr>
<td></td>
<td>Invoice sent to ACC following the delivery of the service.</td>
</tr>
<tr>
<td></td>
<td>The VRS provider is responsible for contacting the case owner and client’s GP to let them know a referral to an assessment has been made.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> the VRS provider can ask for three VRRs before needing to seeking approval from ACC.</td>
</tr>
<tr>
<td>Case owner</td>
<td>Referral sent directly to you with the client’s consent and relevant supporting information.</td>
</tr>
<tr>
<td></td>
<td>If the client is receiving a VRS programme then it’s the case owner’s responsibility to contact the VRS provider – and GP - to let them know the assessment is taking place.</td>
</tr>
</tbody>
</table>
7 Initial Medical Assessment (IMA)

The purpose of the IMA is to identify whether the types of work identified in the Initial Occupational Assessment (IOA) are, or are likely to be, medically sustainable for the client. The IMA forms part of the vocational rehabilitation process and happens after an IOA. The referral will always come to you through a case owner.

These assessments should comment on any factors which could affect the client’s ability to engage in each of the identified work types. The work types able to be considered are those identified in the IOA.

If work types are not currently sustainable then you should provide reasoned rehabilitation suggestions that would lead to these work types becoming medically sustainable. If the work types are currently medically sustainable without the need for rehabilitation, then you should indicate this.

Any recommendations from your assessment on further medical treatment, rehabilitation or other options should be clearly outlined in your report.

If a client has had a VRR before their IMA then the preference, where possible, is for the same assessor to undertake the IMA because:

- you’ve already been able to establish rapport with the client
- you have the benefit of having assessed the client previously, so have knowledge of the client’s personal injury history and the rehabilitation challenges they’re dealing with.
8 Section 103 Assessment and Reports – Returning to pre-injury employment

A case owner may request your opinion and recommendations to determine the client’s ability to return to their pre-injury employment. This may occur at any time during a client’s rehabilitation.

This question is addressed in the AC Act 2001 under Section 103.

This request asks you to consider the question of whether the client is unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury.

ACC requests that you consider whether the client has sufficiently recovered from their injury to be able to substantially engage in their pre injury employment.

This is a very specific consideration that relates to the work the client did at the time of their injury and their ability to perform that work. In this context, the definition of ‘substantially engage’ is usually taken to mean all of the essential tasks of the role and most of the day-to-day tasks.

Please see Appendix II which provides reporting guidelines

Where there are other non-injury related factors that are considered the primary reason for the client not being able to return to work this should be indicated when writing the report. Refer to section 10, considerations during the assessment, for guidance.

Examples:

- a fire officer won’t be able to substantially engage with their role if they’re unable to physically function to a high level while wearing oxygen breathing apparatus
- a factory worker will be able to substantially engage with their role if they’re able to undertake all tasks except the annual tank cleaning operation, which is not standard for all workers at the site, but they’ve done this for the past five years
- a case manager with a moderate Traumatic Brain Injury won’t be able to substantially engage their role if they’re unable to manage high level cognitive tasks including listening, multi-tasking and managing a noisy environment.

If the client’s specific pre-injury role isn’t sustainable given their current restrictions, we may ask you to consider their fitness for work for that ‘type’ of employment, as opposed to the exact role. Again, you need a very good understanding of the client’s restrictions and a clear description of the more generic role in question.

Example - A baker had a specific pre-injury role working with wood fired ovens in a restaurant. After a shoulder injury, the baker could not load the wood fired oven. After rehabilitation their shoulder was strong enough for the general work type of a baker using a commercial baking oven, with loaded trays and manually preparing loaves. That is, they have fitness for work for a generic baker’s role but not for the specific task of using a wood fired oven of his pre-injury role.

When this service would be used

This service may be requested at any stage during a client’s rehabilitation to determine whether they may be able to return to their pre-injury role.
9  **Section 103 Assessment following an IMA**

There may be occasions when a case owner requests a s103 assessment following an IMA. Best practice in the first instance would be to refer for a s103 assessment and report. However there are occasions when it is appropriate for the s103 questions to be requested by the case owner following an IMA.

If an IMA assessment has been completed in the past month and you completed the IMA and are in agreement, a referral for the s103 questions will be sent directly to you without an appointment being made for the client. The case owner will notify the client of this as you will need to contact the client for a consultation by phone in order to complete the assessment (i.e. to discuss the client's ability to engage in their pre-injury role)

The case owner will send a referral with the questions and the purchase order will include the VMS01 code but also a code for vocational medical assistance liaison (VMA01) as there will be a requirement for you to contact the client to ensure the s103 questions have been covered.

*This question is addressed in the AC Act 2001 under Section 103.*

This request asks you to consider the question of whether the client is unable, because of his or her personal injury, to engage in employment in which he or she was employed when he or she suffered the personal injury.

ACC requests that you consider whether the client has sufficiently recovered from their injury to be able to substantially engage in their pre injury employment.

This is a very specific consideration that relates to the work the client did at the time of their injury and their ability to perform that work. In this context, the definition of ‘substantially engage’ is usually taken to mean all of the essential tasks of the role and most of the day-to-day tasks.
10 Section 105 Assessment and reports – capacity for employment by reason of experience, education or training

Section 105 is a specific assessment that relates to the client engaging in work for which the client has experience, education, or training or any combination of those things. The report addresses whether the client sufficiently recovered from their injury to be able to perform the requirements of any jobs identified to a satisfactory standard for not less than 30 hours per week.

This assessment may be carried out for a client who is not currently employed however they are entitled to weekly compensation, for example due to Loss of Potential Earnings (mainly clients injured before turning 18 while still students). These clients may go through Vocational Independence but ACC is also able to determine if they are able to work in terms of section 105.

These assessments are by case owner request, and often occur after an IOA.

These assessments should comment on any factors which could affect the client’s ability to engage in each of the identified work types. The work types are those identified in the IOA and you will need to comment on all jobs provided as to whether the client is fit or unfit for a role.

If the client is currently unable to engage in any of the work types then you should provide reasoned rehabilitation suggestions that would lead to the claimant being able to engage in these work types.

If the claimant is able to engage in the work types without the need for rehabilitation, then you should indicate this.

Where there are other non-injury related factors that are considered the primary reason for the client not being able to engage in work this should be indicated when writing the report. Refer to section considerations during the assessment, for guidance.

Keep in mind that a section 105 assessment is a capacity test (similar to a VIMA) and not a report suggesting rehabilitation options and which work types may be sustainable in the future (unless the claimant is not fit for the work types).

The function of an initial medical assessment is to make vocational rehabilitation suggestions and to determine which work types are, or are likely to be medically sustainable.

When this service would be used

This service may be requested if a client was not working at the time of their injury but qualifies for weekly compensation under the Loss of Potential Earnings provisions, ACC can request a s105 assessment to see if the client is able to work in any capacity.

Example

A client was injured as a child but has since been to university, completed a commerce degree and worked for three years before becoming incapacitated by their injury.

This sort of client could theoretically be assessed as being able to engage in a number of clerical and administrative work types based on their tertiary training and work experience.

Please see Appendix II which provides reporting guidelines
11 Vocational Independence Medical Assessment (VIMA)

The VIMA is an assessment and report used to determine:
- whether a client’s vocational rehabilitation is complete and
- that the client is vocationally independent – the client has the ability to return to work suitable to their experience for 30 hours per week.

ACC has a responsibility to ensure that all identified and required treatment and rehabilitation is complete before requiring the client to undergo vocational independence assessments.

It may be evident from the information provided that a client has not been compliant or participated fully in their rehabilitation or that the outcome of rehabilitation has not been totally successful.

However, the VIMA assessor needs to determine if the rehabilitation has been undertaken as much as possible and the client has been given every opportunity to participate in the process and the treatment or rehabilitation provided has made identified work types medically sustainable. If it is noted that the client participation has been less than ideal with recommended rehabilitation, the assessor should enquire as to the reason/reasons for that from the client.

If during an assessment, it is found that previously recommended treatments or rehabilitation have not been provided, the assessor must note these omissions and also note whether this interferes with a determination of the work capacity in respect of any of the job types.

It’s preferable you don’t undertake a VIMA if you have previously undertaken any vocational medical assessment for the client, for example IMA/VRR as this may create a perceived conflict of interest which may compromise the integrity of the assessment process.

The service is the final assessment in the Vocational Independence process. A referral for a VIMA will always come to you through a case owner.
12 Providing Vocational Medical Services

Your role

Clinical leadership
For this service to be effective, we depend on everyone involved working in partnership. Your clinical leadership of each case is critical. It ensures the client and others supporting them (such as the GP, ACC, Employer, VRS provider) have a shared understanding of what’s required of them to contribute to the client’s rehabilitation.

Developing and maintaining networks and good working relationships are an important element to the success of the VMS and we encourage you to work as part of the rehabilitation team. Encourage others in the team to make a contribution. Your role as a leader does not diminish or change the role of others. It provides the expertise required for the team.

The importance of establishing a client-centred approach to maximise participation and satisfaction
One of the key aims of the VMS is to ensure clients feel comfortable with the assessment process. Having an environment which promotes trust and empathy is important in fostering open communication and a good relationship.

The client has a right to express their opinion and be part of the discussion around any findings and recommendations. It’s important that the client is invited to comment on and discuss any issues they have concerning their injury, any occupations or alternative duties that you may suggest, and understand any recommendations made. Ensure the client understands that any decisions made as a result of this service are made by ACC. Decisions are based on a number of factors, and not made by you as the assessor.

A client also has responsibilities to participate and co-operate in their own rehabilitation. They have responsibilities to notify their case owner or yourself if they are unable to keep their appointment, or where there are unexpected changes in their circumstances. They’re obliged to participate appropriately in any assessment or case conference.

Any unwillingness to participate during an assessment as part of these services or vocational rehabilitation is a flag that should be included in the rehabilitation recommendations.

Self care – look after yourself
ACC acknowledges that undertaking this work on behalf of ACC can be stressful, especially when dealing with conflict or challenging clients. It’s important that you take steps to look after yourself and have the support frameworks in place to help you manage stress and avoid burnout. Guidance and advice on looking after yourself can be found at the Medical Council of New Zealand and Medical Protection Society websites.

Your responsibilities: privacy and storage of client health information
You are bound by the Health Information Privacy Code 1994 in regard to collecting and storing health information. This means that:

- Health information may only be gathered for the purpose for which it is required and must be as accurate as possible.
- The client must be informed about why the information is being asked for and give their consent for this information to be gathered.
- The client has the right to see their information and correct any information which is incorrect.
- Care must be taken with the storage of this information and there are limits on the
disclosure of this information.

- The client’s permission must be obtained for any disclosure of the information gathered.

**Practical meaning of the code:**

- Check you’ve been sent the right information.
- Store information responsibly. For example, personal client information shouldn’t be left unattended in your car or unsecured at your personal residence.
- Use secure email for correspondence that includes personal client health information. Secure email is an email account with password and security features that only you and authorised people can access.
- Remember not to discuss health issues with the employer. The employer needs to know about time frames and fitness for work, supports and accommodation. It’s not necessary for the employer to have personal health information.
- Further information and advice on ACC’s requirements for provider storage of personal and health information can be found on our website: [http://www.acc.co.nz/about-acc/procurement/WPC133871](http://www.acc.co.nz/about-acc/procurement/WPC133871).

**Client eligibility**

**Check the client is eligible for the service**

When you receive a referral for a VMA or VRR from a GP or VRS provider, check the client does not need prior approval from ACC before you give the advice or arrange the appointment. The number of services that a client can have before ACC prior approval is required is shown in the table below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of services before prior approval required</th>
</tr>
</thead>
<tbody>
<tr>
<td>VMA01 Liaison</td>
<td>A total of five combined for a single client (ie on the sixth service prior approval required)</td>
</tr>
<tr>
<td>VMA02 Case Conference</td>
<td></td>
</tr>
<tr>
<td>VMR01 Vocational Rehabilitation Review</td>
<td>Three (ie prior approval required for the fourth service)</td>
</tr>
</tbody>
</table>

Make sure you keep a record of how many services you have provided for the clients you provide advice or assessments to as part of your own clinical practice. If you think advice about a client has been given by another provider, and you’re unsure how many services the client has already had, ask the VRS provider or GP who made the referral. If they don’t know contact the ACC case owner.

It is important that the client eligibility is clarified before giving your advice because ACC may not be able to pay for services provided over the service limits that don’t have prior approval.

**Preparing for the assessment**

**Check you’ve been sent the right information**

Following receipt of a referral for a VRR, s103 assessment, s105 assessment, IMA or VIMA, you should:
• ensure that you've been provided with sufficient relevant information from the referrer to conduct the assessment
• allow sufficient time to review the information prior to the appointment to become familiar with the information and the client’s condition and to determine if further information is required
• familiarity with the client and their situation will also help establish a good relationship.

Make sure you’ve received:
• details of the client’s normal work requirements
• confirmation of the client’s consent to the collection and release of information necessary for the provision of VMS
• the type and number of treatments or other rehabilitation interventions to date, or planned
• current assistance being provided to the client (for example, home help, transport)
• any information relevant to the client’s function (for example, current daily activities)
• any known barriers or obstacles to a successful return to work or work readiness
• specific note of any known threatening or challenging behaviour that ACC has observed the client exhibit.

Forms specific to VIMA:
• ACC192 file Vocational Independence Assessment – List of referral documents for medical assessor
• ACC193 Vocational Independence Assessment - Client questionnaire
• ACC194 Vocational Independence Assessment - General Practitioner’s questionnaire
• ACC195 Vocational Independence Assessment - Occupational Assessment
• ACC196 Vocational Independence Assessment - Job details sheets.

If you consider more information is required to complete the assessment, please ask the case owner before undertaking the assessment.

If it’s noted during the assessment that there’s information missing, you should request this information and complete your report once you have all information you need. If relevant, discuss any new or changed recommendations with the client.

Multiple support people
To complete a good assessment, the client should feel comfortable and relaxed. This may be helped with the support of a friend or relative.

The client has the right to bring a support person/s (friends, family members / whanau, or other representatives) with them for support, provided that the safety of all involved can be assured and the effectiveness of the assessment is preserved. Clients do not have to explain or justify why they want a support person and it may involve more than one person.

However, if you are not comfortable with the situation and consider that you cannot undertake the assessment (eg, a support person/s becomes disruptive and/or obstructs the assessment process) this should be discussed with the client. If you cannot resolve the issues you may need to terminate the assessment and contact the client’s case owner.

Clients that require an interpreter
ACC has a responsibility to ensure that any interpreting needs of the client have been identified prior to the assessment. If the client needs an interpreter, a professional interpreter will be provided to ensure the VMS is conducted in a way that is confidential, effective, and ensures the
client is fully aware of what’s being asked of them. Family members acting as interpreters are not appropriate in this setting, although they are welcome to attend as a support person.

The cost of the interpreter service is met by ACC. Payment is conditional on ACC’s prior approval being given that an interpreter is needed, cost effective and appropriate.

**Clients who may pose a security or safety risk**

There are specific internal ACC criteria and processes for identifying and managing situations and behaviour that is considered a risk. If a client has been identified as posing a risk, the case owner should have provided any information in regard to:

- any threatening or challenging behaviour that has been observed and / or
- any diagnosed mental condition the client has which is likely to leave them susceptible to becoming aggressive or violent.

If you think the client may be a safety risk, talk to us about having a security guard present and we can discuss and arrange someone prior to the assessment if it’s agreed. We’ll notify the client that a security guard will be present.

Consider whether the presence of an advocate or support person may also lessen the incidence of challenging behaviour.

Your safety is a priority and any assessment should be terminated if the client, their advocate or support persons make you to feel threatened or unsafe in any way.

Please report any threatening behaviour:

- to the case owner and
- to the police, if you feel that is warranted in the circumstance.

**Assessor chaperones**

There’s no ACC policy for assessors to use chaperones. This should fall within your normal practice consideration and professional behaviours. You should be familiar with the usual indications for chaperones and how this interacts with your professional style. If you consider a chaperone is necessary, it’s not advisable for a family member to fill this role. This avoids any misinterpretation of specific examinations.

Advice on the use of chaperones can be found on the MCNZ website:


**Considerations specific to Sexual Abuse and Mental Injury**

Comprehensive best practice guidelines for providers of services to people who have experienced sexual abuse can be found on acc.co.nz by searching for ACC4451 Sexual abuse and mental injury practice guidelines for Aotearoa NZ. It is an expectation that providers that deliver Vocational Medical Services to clients who have experienced sexual abuse will incorporate the principles and best practice guidelines outlined in the document into their assessment.

**Recording assessments**

Clients occasionally ask to tape audio or video record the assessment. We don’t consider recording is necessary for the completion of a good quality assessment. Although recording could take place if you agree to it, you are under no obligation to agree. Recording cannot take place without your (written) permission.
Consider requests carefully. Consider how this might be undertaken, how it might affect the assessment, what benefits there might be, and what risks there are of the misuse of the recording. Come to a conclusion about whether you would support any recording. Document the result of your discussion with the client.

We need to see that there were attempts to negotiate agreement about the recording request, or to otherwise meet the client’s wish for a record of what was said at the interview or assessment.

**Stopping the Assessment**

If for some reason, such your safety or an inability to obtain a history or undertake a physical assessment, you consider that the assessment may not be able to continue, discuss the situation with the client and try and resolve the situation. Another reason for stopping the assessment is when a client withdraws their consent to continue with the assessment.

If despite discussion you are unable to reach a resolution and feel that the assessment should not or cannot continue, you should explain this to the client and terminate the assessment. Notify the client’s case owner as soon as possible and fully document the reasons for the termination of the assessment in your report.

**Considerations during the assessment**

When seeing a client for a VRR, section 103 assessment, section105 assessment, IMA or VIMA your assessment should include:

- a review of the relevant documentation included with the referral
- a relevant medical history obtained from the client
- a relevant examination of the client
- a diagnosis (and or differential diagnosis) of the client’s presenting injury/injuries and other relevant medical conditions.
- summary of any factors affecting recovery, such as pain, mood problems and fatigue
- determination of medical fitness for work including restrictions and accommodation as appropriate relating to the injury and/or other conditions
  - face to face discussion with the client covers these points:
    - explanation of the current condition, injury recovery process and fitness for work
    - advice on the next rehabilitation steps
    - confirmation of client consent to contact treatment providers and employers or any other treatment or service providers (where applicable for a complex assessment).

More specific information on some of how to address some of these factors is outlined below.

**Diagnosis**

The basis for good rehabilitation and treatment is accurate diagnosis/es. You need to critically review the information provided. Use your own examination and observations when confirming or determining the diagnosis to both avoid predetermining the diagnosis (‘confirmation bias’). Make recommendations based on your own diagnosis/es.

If you conclude that the diagnosis is incorrect or is not clear or there are additional diagnoses that have not been considered, you need to indicate this in the diagnosis section of your report.

Any change to the initial diagnosis needs to be clearly outlined as a difference. If not it may affect the basic premise of the assessment.
Non-injury related factors
ACC must consider non-injury related factors, and the effect this has on a client’s ability to work when making decisions on their rehabilitation. Non-injury factors will, from time to time, influence the client’s ability to work, and must be taken into account.

Injury and non-injury factors should be clearly differentiated in both the body of the report and for all identified work types – sustainable and unsustainable. Assessors should provide a clear opinion with rationale, in regard to the impact of injury and non-injury factors on the client’s ability to undertake each work type.

Restrictions and limitations
One of the most important components of the VRR, s103, s105 and IMA reports is the identification of and summary of the client’s restrictions and limitations. Your diagnosis and analysis of details in the history and examination will allow you to form a medical picture of the client’s current function. Turn your attention, with this function in mind, to tasks and environments which the client should avoid or limit. Contrast this with the tasks and functions mentioned on the relevant work type details sheet.

Restrictions and limitations refer to prescribed measures relating to both the individual and/or others that serve to manage risks. They describe what the patient should not do, even if they are willing and able to do so.

These concern:
- safety of the person preventing the injury from getting worse. This may relate to tasks or the environment in which tasks are undertaken
- the safety of others
- what the client is physically and mentally/cognitively able to do.

Appropriate restrictions should be recommended in order to
- prevent injury recurrence
- prevent injury aggravation; and
- support healing.

Example - Mr Brown injured his shoulder and has undergone rotator cuff repair. He has made an excellent recovery and is keen to get back to work but still has some loss of ROM and some pain on reaching above his head. You are undertaking an IMA. One of the identified tasks entails reaching above his head. You recommend that this activity be avoided for the next two months while he is completing his post-operative physiotherapy programme.

For others, restrictions serve to protect co-workers or members of the public.
Limitations refer to what the client is simply unable to do i.e. existing constraints upon their physical or mental capacity to perform required tasks.

The assessment of limitations needs to be based on objective findings considering physical, cognitive, social interaction and endurance/tolerance factors where relevant.

Example - Mr White sustained a mild traumatic brain injury and has made a good recovery. However, he still has some fatigue issues, for which he is receiving rehabilitation. As one of the identified work types is truck driver, you recommend this is not suitable at the moment due to the fatigue. Mr White could be assessed in the future, following further progress and completion of the appropriate rehabilitation.

Incapacity
The term incapacity is specific to the client’s pre-injury occupation and their inability to perform their pre-injury employment and hours worked. If a client is found to have incapacity, they are no longer able to engage in their pre-injury employment.

It should be noted that IMA assessments cannot be used for determining incapacity for current employment or for determining Vocational Independence. This is because the purpose of the IMA is to assess vocational rehabilitation needs and not incapacity.

Medical sustainability
When determining whether job types are sustainable, you will need to appreciate the concept of medical sustainability. Medically sustainable is the term used in the IMA (Section 89). This concept does not have work hours attached to it but it is interpreted by the Act (and in practice) as meaning 30 hours per week within a reasonable period of the assessment.

‘Capacity to undertake work’
This is the term used in regard to the VIMA (section 108). ‘Capacity to undertake’ means work must be physically and cognitively sustainable for at least 30 hours per week in a work type for which the person has been assessed as having the necessary education, training and experience. You should make express reference to 30 hours for each identified job type in the assessment of vocational independence (VIMA).

Taking into account fatigue conditions, pain, and mood or anxiety symptoms
The majority of clients you assess will have experienced symptoms of fatigue, pain and mood or anxiety following their personal injury. Your patients could either have experienced or be experiencing one or a combination of these symptoms. These symptoms are often major contributing factor(s) of a client’s incapacity for work. Therefore, it is important that careful consideration is given to these symptoms when you undertake a VIMA assessment and determine how they affect the client’s ability to work 30 hours a week or more. See sections 15, 16 and 17 for more details on how to address pain, fatigue, and depression and anxiety in your assessment.

Example - Miss Smith had an MVA and sustained a spinal cord injury resulting in paraplegia at T12 level. One of the identified work types is a role that involves kneeling, bending and lifting objects above shoulder height. Due to her injury, Miss Smith would be unable to complete these specific work tasks.
Workplace modifications and task modifications (accommodations)

Sometimes specific changes in the way or place where the client is required to undertake a task may allow return to work. This might include equipment, hours of work, and exposures to certain environments.

Provide examples of identifying where accommodations, treatment or rehabilitation may make the work type sustainable now or in the future. The client’s VRS provider (where relevant) can support any recommendations made through the appropriate VRS programme.

Availability of employment is not relevant to medical sustainability

Whether or not the client can obtain specific employment is not relevant when determining whether or not work types are medically sustainable. This is part of the underlying principle that the assessment of medical sustainability relates to a generic work type, rather than a specific employer or a specific job. This applies to the IMA and VIMA.

Assessing function using collateral information

It's important that you use all of the information at your disposal to inform the assessment of whether a client's ability to perform their work role is sustainable.

There are a number of assessments or interventions that the client may have had that will be of assistance when assessing the client's pain, mood and fatigue. Their participation in everyday activities of daily living help build a bigger picture of their abilities, particularly in regard to their potential for return to work.

These may include reports from rehabilitation services provided to the client including pain management and vocational reports. A Functional Capacity Evaluation (FCE) is often used to assist in the assessment of fitness for work. However, generally, FCE is not a test that can be regarded as a purely objective measure of physical function. The results are impacted by behavioural factors including pain factors. Therefore, a FCE must be seen as another assessment of physical function, and another source of functional information, but not one that can stand alone. The results are also not valid within the context of chronic pain.

When getting information on function you may sometimes be required to use other supporting information, to make an assessment of the client’s functional abilities.

You can use a number of methods - structured questionnaires to support the validity of your opinions or targeted questions about the non-occupational activities or history such as:

- how the client occupies their typical day and the activities they undertake during their waking hours
- key areas of interest - what motivates and grabs their attention
- how the client looks after their own needs (preparing meals, hygiene etc)
- how the client sustains or tolerates a specific function eg sitting, standing, walking driving, lifting and how often they undertake those activities
- the effect of medication on these activities
- how the client copes with important events (funeral/tangi; social occasions; travelling to meet case manager etc).

You should ask the client about detail from their day to day lives. For example: how they interact with interests; hobbies; pets; sport; activities of daily living; shopping; who is at home; responsibilities for children and other dependents; time with friends/family and whanau; social clubs; volunteer work; domestic chores such as cleaning, cooking, and gardening.
Both abilities and limitations should be explored, as well as attitudes and any inconsistencies. The degree of consistency around reported functioning should also be explored by referring to other sources and cross-referencing these with the client.

If clients are not forthcoming on functional matters then you should make specific note of that in the report.

**Completeness of rehabilitation and the VIMA**

ACC has a responsibility to ensure that all identified and required treatment and rehabilitation is complete before requiring the client to undergo vocational independence assessments – VIOA and VIMA. Any specific treatment that has been recommended, agreed upon and documented on the Individual Rehabilitation Plan (IRP) as part of the vocational rehabilitation and independence process must have been completed prior to the vocational independence assessment.

It may be clear from the information provided that a client has not been compliant or participated fully in their rehabilitation or that the outcome of rehabilitation has not been totally successful.

However, the VIMA assessor needs to determine if the rehabilitation has been addressed sufficiently, ie. undertaken as much as possible. The client must also:

- be given every opportunity to participate in the process
- the treatment or rehabilitation provided should have made identified work types medically sustainable
- if it’s noted that the client participation has been less than ideal with recommended rehabilitation, the medical assessor should ask the client why.

If during an assessment, it is found that previously recommended treatments or rehabilitation have not been provided, the medical assessor must make a note of that and whether this interferes with a determination of the work capacity in respect of any job types. If all the vocational rehabilitation that was identified on the IRP has not been completed then this is a fundamental flaw in the Vocational Independence process.

**Ongoing or future treatment and vocational independence**

A client may require ongoing medical treatment for an injury from time to time to help maintain their level of function. This should not affect the status of the client from reaching a stage where they can be assessed for vocational independence, provided that any rehabilitation required has been agreed to and completed. For example, a client may require some pain psychological treatment from time to time when dealing with pain to help them manage.

You should be provided with information about the client’s ongoing need for any treatment and take those matters into account when determining if there is still an injury-related barrier returning to partial or full employment.

Any prospect for possible treatment some time in the future should not put a stop to assessing for vocational independence. For example, metal-ware may need to be surgically removed or a knee replacement required sometime in the future, but those procedures are not intended at the time of the assessment.

However, any specific treatment that has been recommended, agreed upon and documented in the Individual Rehabilitation Plan (IRP) as part of the vocational rehabilitation and independence process must be completed prior to the vocational independence assessment.
Computer literacy, literacy and numeracy
The occupational assessment has to say whether computer literacy, literacy and numeracy have been addressed. There should be documented evidence that this is the case. If you have concerns that these areas haven’t been addressed adequately let the case owner know.

What to do with client files following an assessment
After completing an assessment it’s important that you dispose of the client records or files securely. A secure document destruction service should be used. If you do not have access to this service you may return the files to your nearest ACC office for disposal at your cost.

Identifying urgent medical attention required during the assessment as a non-treating practitioner
If during the assessment you are made aware of a condition that requires either urgent medical attention or contact with the client’s normal treating practitioner, you should act accordingly. For example:

- arrange for immediate hospital assessment or treatment - urgent consultation with the client’s normal practitioner and ensure the client has transport there
- inform the client of any urgent findings, your proposed response and get their consent for this.

The Medical Council of New Zealand has information regarding this – it’s on the MCNZ website – www.mcnz.org.nz - A doctor’s duty to help in a medical emergency.

13 Pain, pain disorders and the ability to work
Intrusive or disabling pain is experienced by 20 per cent of the general population. Pain can be a persisting injury that affects an ACC client daily, often years after the original accident event. Despite experiencing pain, most people manage a range of activities and, with optimal management, will also manage participation in the workplace.

As a medical assessor, you need an excellent understanding of pain modulation. This will help you characterise the client’s pain, recommend rehabilitation, restrictions, and limitations and ultimately work fitness.

Considering pain as a phenomenon of neurological disturbance helps to group pain experiences into types. The International Association for the Study of Pain (IASP) has further developed criteria for pain conditions and this helps with applying medications, therapies and prognosis. The Neuro Orthopaedic Institute (NOI) has on-line resources and offers courses on pain management. We recommend you familiarise yourself with the standard literature and keep up to date with multimodal approaches to pain management.

Anxiety may aggravate symptoms
Many clients coming to the assessment will be anxious about how they will cope with the more formal structure of the workplace. Their anxiety can aggravate the experience of symptoms and has been shown to affect self-reported symptoms during an assessment. Therefore your diligent assessment of the client’s ability to work in the context of pain as a discrete symptom, will reassure ACC and the client that your conclusions are robust and reliable.

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1 World Health Organization supports global effort to relieve chronic pain. Geneva 11 October 2004
2 http://www.iasp-pain.org – IASP taxonomy
Key points when undertaking a medical assessment

Pain is an important symptom to consider when carrying out a medical assessment in that:

- the diagnosis may require clarification as pain may not have been well characterised
- pain management may not yet be optimal
- moderate - severe pain limits an individual’s tolerance of tasks
- pain may impact on concentration and mobility making some work tasks more risky

To adequately assess a client with pain ensure you:

- Take a good pain history which includes a bio-psychosocial approach
- Specifically identify the client’s personal psychological/behavioural response to pain
- Describe the character of the pain and where possible the diagnosis
- Identify what modalities have been used for pain management.

For IMA

- Identify and recommend any important and necessary investigations, treatments and appropriate modalities for further management

For VIMA

- Comment on the client’s response to and your assessment of the efficacy and appropriateness of the pain management. Pain must be dealt with in the body of the report and also specifically as it relates to each work type.

History

As you take a history of pain experience and pain management, consider the points above. If pain management has not been successful, consider the reasons and what this means for current fitness for work.

A client with pain will usually have participated in a range of pain management, yet pain management may still need ongoing regular review in much the same way as Chronic Obstructive Pulmonary Disease or Rheumatoid Arthritis.

Consider whether the client has had opportunities to use helpful modalities and how they have responded. Discuss the role of future pain management or medication reviews.

Characterise the pain

Talk to the client about their pain and examine them. Using this information plus the findings of previous investigations characterise the pain they are experiencing and its physical and psychological make-up.

The way in which the client describes their experiences of pain is an important clue to the factors modifying the pain. The experience of pain is the end point of a complex neural interchange. Neural tissue is immensely plastic and responsive to a range of modifying factors including the influence of thoughts and emotions. Central and spinal cord changes dramatically affect the experience. This helps explain the limited effect of a purely nociceptive approach to pain management and the demonstrable aggravation of pain related disability with well-studied psychological responses such as ‘grief’, ‘fear avoidance’ and ‘catastrophising’.

Has pain been well managed?

Just as the characterisation of pain benefits from a holistic approach, the management of pain requires attention to multiple modalities.

Modern pain management encompasses the following approaches:

- calming the emotional reactivity and fear response to pain - mindfulness/
relaxation/Cognitive Behavioural Therapy (CBT)

- sleep habit recovery
- treating the nociceptive aggravation –
  - specific injection
  - regular pain medication
  - guarded use of opiates
- targeted approaches for neuropathic pain and Complex Regional Pain Syndrome (CRPS) - tricyclic antidepressants (TCAs), neuroleptics, serotonin and norepinephrine reuptake inhibitors (SNRIs)
- increasing physical activity/balance.
- normalising, maintaining and enhancing social activity

Because most people naturally respond to severe pain with aversion and retreating, it can take considerable coaching to get multimodal support accepted and underway. Risk factors for poor outcomes of pain disorders include poor social supports, negative personal thought patterns, high emotional reactivity and low resilience. If pain has become too dominant, we can expect some negative emotional reactions, loss of fitness and subtle changes in mood to emerge during the injury recovery.

Therapies need to be well coordinated and persistent. Return to work participation is part of the multimodal approach, but often requires some type of workplace accommodation and lots of support.

**Limitations and effect of pain on concentration, coordination stamina and tolerance**

Pain and pain medication can affect clients' concentration, memory, stamina, coordination and confidence to engage. Fear of further harm, aggravation of pain and common psychological responses to pain such as catastrophising may lead to self-imposed limitations around activity and shortening of tolerance. Some of these consequences increase short term with a change in daily routine but resolve with adaptation to a new environment. In general, structured daily routines and pacing of activities are helpful for pain management.

**Analysis**

Pain can cause the loss of coordination, concentration and cognitive sharpness. Lack of adequate sleep, sedating medications can aggravate these functional deficits. After your interview and examination, consider any discrete restrictions from a safety point of view. Neuropsychological testing may be required in rare cases where safety critical roles are identified and you consider function to be impaired.

In all assessments, it's important to analyse the current effect of pain on the client's physical, social, cognitive activities. Your analysis will take into account the client's self-reported limitations, current activity levels, evidence from work trials, physical activity programmes and medication. It will also take into account your understanding of potential for specific activities to cause harm to this client, the likelihood of positive adaptation to a work environment, along with the positive effects of routine, activity and socialisation of the work environment.

**Key points**

- Show your analysis
- Identify any restrictions or limitations that are required due to the client’s pain
- Ensure any work tasks that are likely to be more dangerous to the worker /other workers or the public, due to the client’s pain, have been clearly described in the report
- Ensure your analysis includes how you expect the client to adapt to the working environment
- Make sure your conclusions are supported by evidence gathered in the assessment process.
14 Fatigue and fatigability

We will all get tired, but after an injury or illness, clients may be worried about how they will manage when fatigue is part of their everyday experience. During the medical assessment, your attention to their levels of fatigue will reassure the client and us that the conclusions of the report are reliable and robust.

Fatigue is an important symptom of many medical, surgical and psychological conditions. Fatigue is also commonly linked to emotional strain in the context of personal or environmental stress in the absence of defined disease or illness. Fatigue is a common complaint given to GPs where initial steps are taken to characterise the symptom and make a differential diagnosis through the process of elimination.

Once medical or surgical conditions are identified and medical management is optimised, most people manage fatigue well with simple strategies and planning. However some clients will need support to reach this balance. It doesn’t necessarily mean that the client can’t work.

Key points when undertaking a medical assessment

It is important to clarify what a client is talking about when you discuss fatigue. Is it sleepiness? Is it a feeling of lethargy or exhaustion? Is it shortness of breath; panic, heart palpitations, trouble thinking or remembering or weakness in the legs or arms? Is it provoked by exercise or pain or does it happen regardless? Is it something that varies during the day or is it constant? Does the client feel better after a good sleep or just the same no matter what? How are they affected by emotional strain (such as coming for the assessment or going to a work trial?)

Identifying fatigue is important in the medical assessment in that:

- The diagnosis may require clarification
- Fatigue management may not yet be optimal
- Fatigue limits an individual’s tolerance of tasks
- Fatigue can make some work tasks more risky.

To adequately assess a client with fatigue

- Take a really good history: Fatigue means different things to different people
- Clarify the cause of fatigue
- Find out what makes it better and worse.

For IMA/VIMA

- Describe the character of the fatigue and likely diagnosis
- Give some context to the stability of fatigue symptoms
- Comment on whether treatment of causal factors and management of fatigue have been implemented and with what success
- Comment on the role of medications used for the fatigue and whether this is optimal
- For the IMA describe appropriate rehabilitation/ treatment/therapies to manage fatigue, including self-management
- Identify any important and necessary investigations.

Clarify the cause of fatigue

In your assessment, where you gain a history of fatigue, ensure the history and review of medical notes explores the character of the fatigue and the contributing factors. In the context of injury related disability, clinicians need to keep an open mind as to the cause of fatigue while assessing the effect of the symptom on the client’s ability to sustain work.
## Causes of fatigue

<table>
<thead>
<tr>
<th>Causes of Fatigue</th>
<th>Fatigue due to brain injury</th>
<th>Fatigue due to sleep disorders</th>
<th>Fatigue accompanying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical /surgical</td>
<td>For example: rheumatological, cancer, liver and renal conditions, thyroid disorders, respiratory disease, cardiovascular disease, blood disorders, diabetes and other endocrine disorders, neurological disorders, neurological injury, GI disorders via malabsorption or anorexia</td>
<td>Going to sleep at the same time each night, exposure to natural light early in the morning, avoid alcohol and caffeine, light, cooked meal only in evening, exercise regularly before 5pm, use body relaxation through day or just at night, address OSA, no power naps</td>
<td>Sleep hygiene as above, exercise as therapy (three times a day light –</td>
</tr>
<tr>
<td>Sleep disorders</td>
<td>Primary sleep disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secondary sleep disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. mechanical: obstructive sleep apnoea (OSA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. other: alcohol, caffeine, eating habits, medications, exercise habits, obesity, pain, young wakeful children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td>anxiety, grief, worry, depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>pain medication, some blood pressure and antidepressant medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue states without progressive disease</td>
<td>sensitivity to fatigue: chronic fatigue syndrome, post viral fatigue syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary fatigue states due to physiological change</td>
<td>Pregnancy, lactation, post extreme exercise, post surgical/post anaesthetic intervention; post emotionally charged event</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Has fatigue been well managed?

Medical assessors will need to be familiar with the management of conditions manifesting with fatigue and be able to comment on the potential for further improvement and self-management. To do this the history will need to include self-management and habits.

<table>
<thead>
<tr>
<th>Type of fatigue</th>
<th>Improved by</th>
<th>Aggravated by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue due to brain injury</td>
<td>Maintaining good regular exercise; avoid having to attend to different sensory inputs at the same time, avoid noise/complex visual input, plan cognitive tasks for morning, ‘power naps’; structured and ‘contained’ social interaction</td>
<td>Multiple simultaneous stimuli, noise, complex visual input, concentrating on social interaction, tasks involving cognitive as well as verbal and social cue processing, untreated mood disorder, some medication</td>
</tr>
<tr>
<td>Fatigue due to sleep disorders</td>
<td>Going to sleep at the same time each night, exposure to natural light early in the morning, avoid alcohol and caffeine, light, cooked meal only in evening, exercise regularly before 5pm, use body relaxation through day or just at night, address OSA, no power naps</td>
<td>Shift work, night work, erratic hours of activity and sleep, consumption of heavy meal, alcohol within four hours of bed time, caffeine at any time in the day, day time dozing, some medication, anxiety /worry, watching TV or using computers or phones in late evening</td>
</tr>
<tr>
<td>Fatigue accompanying</td>
<td>Sleep hygiene as above, exercise as therapy (three times a day light –</td>
<td>Erratic sleep/activity cycles, lack of routine, some medications, low physical</td>
</tr>
</tbody>
</table>
What effect does fatigue have on the client’s stamina and tolerance?

If the client’s fatigue is well managed, the next consideration is what limitations should be placed on his/her activity to make sure participation in employment or rehabilitation is as sustainable as possible. Here, evidence of daily activity, tolerance for travel, social activities and home responsibilities are useful benchmarks for current state.

Work tasks require attention, focus and perseverance at variable levels depending on the work. When considering whether the client has any limitations, take into account the sustainability over a working week. Working days should not completely exhaust clients. Generally speaking, the output on a working day should not exceed 70% of the total daily capacity for activity and effort.

Performance of some specific cognitive activities may drop off over a day or over the week. Investigations such as neuropsychological assessment in clients with neurological injury may further demonstrate appropriate accommodations or limitations.

Clients with stable conditions may still be regarded as unsuitable for shift work, extended hours or evening work in order to minimise the disruption to the management of fatigue.

Clients who have not been working will experience more fatigue starting a new role. However, once they are familiar with their surroundings, the increase in daily activity and engagement with others may actually reduce troublesome symptoms of fatigue. When conducting your assessment take into account all the information and show how you have reached conclusions about sustainability.

Analysis

Fatigue is a risk factor for accident events and injury in the work place; so many safety critical work roles require screening for fatigue as part of the pre-employment. Doctors practicing in the field of Occupational Medicine are very familiar with assessing fitness for work in jobs requiring concentration, coordination and stamina. You will need to consider how this client’s limitations measure up against certain work types with regard to the responsibilities and what would happen if they were to lose concentration or attention due to fatigue.

Key points

To adequately assess a client with fatigue ensure you:

- Take a good history, enquire about signs and symptoms of mood and anxiety disorders
• Explore protective and aggravating factors
• Show methodical consideration of how the condition affects or does not affect fitness for work
• Are any restrictions or workplace accommodations required because of the fatigue?
• Are any work tasks likely to be more dangerous to the client/others because of the fatigue?
• How would you expect the client to adapt to the working environment?
• What information supports your conclusions?

15 Depression, anxiety and the ability to work

Injury, pain and challenging lifestyle changes associated with an injury can be difficult. This, coupled with the level of mood and anxiety disorders in the general population, means that many clients coming to you for an IMA or VIMA assessment have some symptoms of mood dis-regulation if not mood disorder.

The New Zealand Mental Health Survey, ⁴ undertaken between 2003 and 2004 was a nationally representative face-to-face household survey of nearly 13,000 New Zealanders (aged 16 years and over). It found that mental disorders are common in New Zealand, with 40% of respondents reporting that they had experienced a disorder at some time in their lives.⁵

Usually, significant psychological disorders will have been identified and treatment commenced. It is more rare for clients to not have disclosed their psychological distress to any therapist or medical practitioner prior to the assessment. It is important that the assessment remains an opportunity for enquiry into mood and analysis of work implications of psychological symptoms and signs.

Although many people with psychological disorders present with physical complaints, the majority will tell you about psychological problems if asked directly. A nonjudgmental manner and assurance of confidentiality will increase the likelihood of disclosure.⁶

In general, participation in work and the routine of the workplace are highly protective against episodic deterioration in mood. Importantly mood and anxiety disorders do not mean that a client can’t work, and, once treatment or therapy is instigated, work forms part of a therapeutic structure. However excessive work hours or work strain, unpredictability and hostile work relationships can be detrimental for vulnerable mental health consumers.

As a medical assessor, you need to have a good understanding of factors affecting mood/anxiety and be familiar with common psychiatric presentations, the significance of symptoms and likely prognosis.

16 Key points when undertaking a medical assessment

History

Always check for psychological symptoms as part of a general functional enquiry. If there is low mood, anxiety/worry, panic attacks, disturbed sleep, intrusive distressing thoughts, physical

---

agitation symptoms, ensure the interview history adequately looks into the symptoms and functional problems.

Has the condition been well managed?

Often therapy and/or medication will have been started. You will need to comment on the effectiveness and appropriateness of treatment. This means you do need to have a good knowledge of common treatment regimens. For further information on managing of depression in adults see the New Zealand Guidelines Group publication - Identification of Common Mental Disorders and Management of Depression in Primary Care Chapter 6.

The IMA asks for recommendations for further rehabilitation. Sometimes a mood disorder/anxiety disorder will be a covered condition and treatment managed under the claim. Other times the GP will be managing therapy and medication. Your recommendations will support the integration of treatment with other strands of rehabilitation and approach to vocational rehabilitation.

In the VIMA you are asked whether treatment for the covered conditions has been addressed. If there is outstanding treatment required for a mood or anxiety disorder, comment on how this affects the ability to assess fitness for work.

Analysis

Mood and anxiety disorders may affect memory, concentration, and a range of cognitive functions, social interaction and capacity for self-management. Whilst therapeutic interventions usually result in improved function, the question at the time of assessment is what restrictions exist on that day due to the condition(s). Sometimes, neuropsychological testing may be appropriate and if recorded may give an insight into the cognitive impairment.

The purpose of both IMA and VIMA assessments is centred around fitness for work. Your analysis needs to determine what limitations apply because of a psychological disorder and what effect the condition and associated medication have on the client’s concentration, coordination, stamina and tolerance.

The report must show a logical progression from symptoms, signs, corroborative medical material through to diagnosis, analysis of restrictions and then recommendations.

Key points

- Show your analysis
- Where significant psychological dysfunction is evident, it is necessary to spell out the very specific restrictions which apply. This may range from excluding shift work to reducing exposure to high stress customer-facing roles
- Are any work tasks likely to be more dangerous to the client/others because of the client’s depression or anxiety?
- Safety critical roles screen for mood and anxiety disorders as these disorders reduce decision making ability, cognitive functions and response. Where these symptoms are identified and the client’s role will be affected, it is important to comment on any restrictions which apply.

17 Reporting

VMA Reporting

Liaison

After completing the request for advice, send an email to the case owner stating:

1. the name and claim number of the client that the query related to
2. the name, role and organisation of the person that contacted you (not needed if requested by case owner)
3. a brief summary of what was discussed.
As this service is responsive, we’d like you to endeavour to send your advice to everyone within two business days of the liaison. As is usual clinical practice, you need to keep your records on each case.

Case conference

For case conferencing either the VRS provider or the case owner will take a record of the case conference. Keep your own records on each case, noting the request and the date of interaction, what information you were given, the issues, advice you gave, and relevant comments made by other parties.

VRR Reporting

The report will include:

- diagnostic issues
- multiple medical problems
- other potential or current barriers to rehabilitation
- relevant issues from the records you read.

This information doesn’t need to be exhaustive but important factors must be well recorded, especially where they could influence your assessment of fitness for work.

If there is a need for further investigation or the pursuit of a more specific diagnosis to either aid injury management, rehabilitation or assist in determination of fitness for work, set these out specifically. The purpose of the assessment and report is to identify what is necessary for rehabilitation and return to work. If it is your advice that a differential diagnosis needs to be followed up, then include this in your recommendations. If the diagnosis seems different from that in the clinical record, state your findings in detail and your diagnosis.

Your assessment of the client’s injury will generate some suggestions for rehabilitation which may have been refined after your conversation with the client’s treating clinicians.

Communication tasks for the VRR

Communication with the GP, employer, and VRS provider is essential to the VRR service. It’s important to share information that supports the client’s rehabilitation. This communication should take place within two working days of completing the assessment. It’s important that you let the client know at the assessment that you will be calling these people and get their consent to do so. If the client doesn’t give their consent contact their ACC case owner.

With this emphasis on communication, the service is expected to build relationships between VRR medical assessors, local GPs, VRS providers, and employers.

**Note:** for invoicing purposes it’s important to take note of the time it has taken to complete the necessary communications.

Calling the GP

Contact the GP to discuss the client’s diagnosis or injury management issues, your recommendations and any additional information or concerns from the GP. It’s a good time to discuss your recommendations around fitness for work. If the GP supports your recommendations, recovery is likely to be enhanced.

This is an important opportunity for the GP to voice any concerns and let you know if there are any other barriers that should be considered.
Calling the employer
You will call the employer or designated line manager and provide very clear guidance on activity and timeframes including review timelines.

Remember, the employer will not be receiving any clinical information - they just need to know about time frames and fitness for work, supports and accommodation. When you make the call, remember to convey and discuss restrictions, activities, and accommodation but not injury management or diagnosis.

It's also an opportunity for the employer to convey any concerns, doubts, and features of the workplace which need consideration, for example, safety, environmental features. It's also an opportunity to check how much of the time the employee is working alone/how many hours they're using any machinery.

This is an excellent time to discuss strategies for return to work and to find out what supports are going to be necessary.

Calling the Vocational Rehabilitation Services provider
If the client is already receiving a VRS programme then it's likely they've had a Stay at Work provider working alongside them. If so, you'll often be asked to discuss your recommendations with this provider which may include an allied health clinician. VRS providers are very good at taking calls and responding promptly.

Calling other treatment providers
The case owner may ask you to contact other treatment providers. Typically, these clinicians will be actively involved with the client, such as a surgeon, physiotherapist or perhaps psychologist.

This is an opportunity to build support for safe activity in the context of return to work. As with the GP, you are contacting the clinicians to understand their concerns and present your assessment of fitness for work. Some clinicians will be very interested in accommodations including the pace of return to work, specific activities, restrictions and exposures.

The conversation should allow you to pick up on any information not obvious in reports and get support for your suggested plan and recommendations.

Contacting the case owner
A phone call or email to the case owner concludes your communication tasks. If there are any recommendations that you're making in the report that can be implemented immediately, let the case owner know. Specify a good time when the case owner could call you.

Record the result of your conversations
Because the service is aimed at communicating about fitness for work, we need to see what you discussed with the GP, employer and other clinicians. It's important these notes are a full record of the conversation. Especially if there are:

- any concerns, areas of agreement or additional information that emerged
- a plan which you and the practitioner or employer agreed.

This record will assist all of those people involved in the client's rehabilitation. Different views will alert the case owner to the need for a highly supervised return to work programme when appropriate, with emphasis on communication between parties.

Recommendations for review
Taking timelines into account you will have formed a good idea of when the client should have a medical review. If there's disagreement about rehabilitation or the injury condition / employment situation could change, consider recommending a VRR medical assessor reassess things. It's
important to keep things moving towards full return to work. You can recommend this to the case owner but you must receive a further referral before you arrange to see the client again.

**S103 and S105 reports**  
There are headings provided in Appendix II.

**IMA reports**  
There are headings provided in Appendix II - IMA Report Headings and Content Guidelines. IMA reports must be completed using these headings

**Note:** The Initial Medical Assessor considers whether the types of work identified in the Initial Occupational Assessment are or are likely to be medically sustainable for the client. You don’t need to identify additional roles for the client. If you need to talk to someone about the work types contained in an Initial Occupational Assessment contact the client’s case owner to discuss.

Once the IMA report has been submitted to ACC, the case owner may make further requests for clarification of the report before it’s accepted. Once complete, the case owner will distribute copies of the report to the client and their General Practitioner.

**VIMA reports**  
The VIMA report must be completed using the headings as detailed in the service specifications and outlined below. See Appendix II - VIMA Report Headings and Content Guidelines.

**Note:** The VIMA Medical Assessor considers whether the types of work identified in the Occupational Assessment are medically sustainable for the client for 30 hours or more a week. As with the IMA, you don’t need to identify additional roles for the client. If you need to talk to someone about the work types contained in a Vocational Independence Occupational Assessment contact client’s case owner to discuss.

Once the VIMA report has been submitted to ACC, the case owner may make further requests for clarification of the report before it is accepted. Once complete, copies of the report will then be distributed by ACC to the client and their General Practitioner.

**Types of work and work type details sheets for IMA and VIMA**

‘*Types of work*’ means occupational categories of work that include a set of job functions requiring the performance of a common set of tasks and can include several jobs. It refers to a broad group of jobs and roles that have a common set of work tasks and functions.

These work types are detailed under the Occupational Assessor in the IOA and VIOA report. The details of the work types are outlined in Work Type Detail Sheets. The IOA and/or VIOA report must be provided to the IMA and VIMA assessors by the client’s case owner with the IMA/VIMA referral.

**Work type detail sheets**

The work type detail sheets used by occupational assessors were developed by occupational assessors and are based on the occupational classification system - Australian and New Zealand Standard Classification of Occupations, 2006 and reviewed in 2014.

The sheets refer to types of work available in the current New Zealand labour market and describe information relevant for each work type, including:

- work tasks
- work environment
Vocational Medical Services – Guidelines for Providers
Updated December 2017

- the physical and cognitive demands of the role
- the entry level requirements of the role
- specific further comments about the work type where relevant.

Occupational Assessors may choose to use these sheets or to develop their own for types of work they consider.

The work type detail sheets can be accessed through the following major occupational groups:

- Managers
- Professionals
- Technicians and Trades Workers
- Community and Personal Service Workers
- Clerical and Administrative Workers
- Sales Workers
- Machinery Operators and Drivers
- Labourers

ACC has a link on its website for details and examples of work type detail sheets. Refer to: http://www.acc.co.nz/for-providers/work-type-detail-sheets/index.htm.

18 Reassessment: VRR, IMA and VIMA

Follow-up assessment or review subsequent to a VRR, IMA or VIMA may be undertaken upon referral from a case owner. The criteria, timeframes and conditions for reassessments are the same as for the initial assessment. The reassessment codes are only applicable where you are the practitioner that completed the initial assessment. You can use the code where that initial assessment took place within three months without completing another full assessment. If the timeframe is shorter than the original assessment, and where it’s improbable that any meaningful progress has been made (because very little rehabilitation has actually taken place), Vocational Medical Assistance (whether case conference or liaison) may be more appropriate.

Reassessment may be helpful where:

- a significant development has occurred since the original assessment, such as a new injury
- faster than expected progress in rehabilitation has occurred
- a client had a VRR before a return to work programme commenced, and the client is having some difficulty with the return to work programme recently commenced. The VRS provider thinks a significant investigation is warranted which requires something more than a case conference or liaison.

19 Assessment, booking, accomodation and travel

Booking assessments

For VRR, IMA and VIMA

The provider is responsible for the administration and booking of VMS assessments unless an alternative arrangement has been reached with ACC. The assessment must be provided in clinic rooms or a facility that meets the same standards as clinic room.

For VMA

For case conference, the VRS supplier or case owner will facilitate the booking and appointment time. The location of the case conference is flexible and will be determined by what’s most
appropriate in the circumstances and who is involved in the case conference. Some examples of appropriate locations are:

- a meeting room at the client's place of employment
- the GP rooms
- VRS provider's office
- an ACC office
- by teleconference if appropriate.

Avoiding clients not attending/missing appointments

When clients miss their appointments it can cause lost time and effort to everyone. Some helpful steps to try and avoid client’s missing their appointments are:

- send an appointment letter to the client that clearly indicates the appointment date, time and directions to the assessment rooms
- call the client the day before the appointment to ensure they are coming and have the correct details, or
- send a text message reminder to the client.

Non-attendance fee

There are two circumstances where you can invoice ACC for a client non-attendance fee:

1) if the client does not attend their appointment
2) if the client arrives at their appointment too late and it's not possible to complete the assessment in the allotted time.

Reasonable steps should be taken to ensure that the appointment runs on time. If a client does not attend or is too late for their appointment to continue advise their ACC case owner.

Accommodation

ACC will pay actual and reasonable accommodation costs when:

- prior approval is gained from an case owner and receipts provided
- a case owner requests that you travel outside your home/practice region (somewhere that is not where you live or usually practice) and you need overnight accommodation.
- a meal allowance when you are staying overnight.

Note: ACC does not reimburse for alcohol, including mini-bar expenses.

Travel

ACC will sometimes ask you to travel to areas outside your normal area of practice. When invoicing us include your receipts for your actual costs incurred. Remember that if you see more than one client on your travels that the total cost is divided among the total number of clients that you see.

Remote access fee

This fee is payable where we request the assessor to conduct a clinic in an area outside that which is not the assessor’s usual area of residence or practice. As a result they’re required to hire rooms for the specific purpose of providing Services.
Unfilled block bookings

Where a provider travels to an area outside their usual service area at the request of ACC to conduct a block booking (defined as a day of more than two appointments) and where one of these appointments is not filled, ACC will pay the amount specified in the service schedule. This does not apply where an appointment is made but the client does not attend the appointment, in which case a non-attendance fee is chargeable.

Invoicing

Electronic billing

Our method of invoicing for this service is electronic billing which makes the process faster, easier, and more efficient. For more information on working electronically with ACC, see For Providers/Set up and work with ACC/Work online with ACC. There are a number of ways electronic invoicing can be done. The eBusiness team will help to determine which method is best for you. Their contact details are:

- telephone 0800 222 994 (option 1)
- email ebusinessinfo@acc.co.nz

The Provider Helpline will answer queries relating to payment of invoices: Free phone 0800 222 070.

When do I submit an invoice

An invoice for the service can be submitted following completion of the service ie following the completion of the assessment(s), reports and any required communication and/or follow up.

You can invoice for several clients' assessments in one electronic invoice.

What you'll need to include in electronic invoices

- an invoice number
- the invoice date
- the relevant ACC purchase order number (not applicable for the first five VMA and first three VRR)
- the contract number
- the name and claim number of the client receiving the VMS
- the appropriate service codes
- the ACC provider number of the provider who delivered the service and
- the date on which the service was provided, being the date on which the client was examined.

How we pay you

Our payments are usually made on the 20th of the following month after receiving the invoice. We need the completed documentation and receipts (where applicable) before paying for the service invoiced.

The payment will be made to the supplier who holds the contract. If you are a VRR provider but you are not the supplier (ie the contract holder), you will need to make arrangements with the supplier about your payment.
20 Performance

Your performance delivering VMS will be measured against the two Key Performance Indicators listed in the Service Schedule. These are timely delivery of the service against the contractual timeframes and the quality of your reports you send through to us. Your local Supplier Manager will communicate with you about your performance against these measures on an ongoing basis as the need arises. We’ll also communicate with you more formally on a six monthly basis where we’ll send a report to you about how you’re performing against the measures. Other people that may be involved in these discussions with you are ACC Rehabilitation Advisors, Branch Medical Advisors or Regional Clinical Leads.

Timely delivery of services

Early intervention is a key principle that underpins successful vocational rehabilitation. Therefore, it is critical for successful vocational rehabilitation that the components of the service are delivered in a timely way.

ACC will use data from invoices submitted that includes the date the client was assessed or seen and match that with our own records from when the referral was made, to measure if services are being delivered within contractual timeframes. This information will be reported on every six months.

Report quality standards

The quality of a sample of your reports will be measured against a quality reporting tool. The specific questions that the tool asks and how they are scored are shown below:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Guidance</th>
</tr>
</thead>
</table>
| Administrative check  | Documentation of Assessors name, role and health qualifications/designation. Client’s correct details, claim number and dates (date of injury, appointment and report).  
Report completed within **8 working days of assessing client**.                                                                                       |
| History               | Summary of the claim information including injury details and management, past, medical, social and occupational history.  
Review and summary of necessary materials to provide an informed opinion including investigations and relevant reports.  
Notes the absence of information where applicable.                                                                                                          |
| Current situation     | Summary of the current situation, including symptoms, function, daily activities, and medications.  
Pain, psychological symptoms and fatigue are identified and explored further as appropriate.  
Discusses functional abilities and restrictions and limitations specific to work capacity.                                                               |
| Examination and Diagnosis | **Examination:**  
Examination findings recorded including general observations, injury specific assessment, and appropriate general health observations.  
Where relevant undertakes specific examination with respect to the demands of the various work types.                                              |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis:</strong>&lt;br&gt;Records diagnosis/es for the injury/injuries (including differential diagnosis supported by rationale).&lt;br&gt;Recommends further investigations if required.&lt;br&gt;List other medical and surgical conditions.</td>
<td></td>
</tr>
<tr>
<td><strong>IMAX</strong>&lt;br&gt;Recommendations for rehabilitation are clear, concise and actionable.&lt;br&gt;Recommendations are based on the information gathered throughout the full assessment and include reference to pain, psychological disorders and fatigue and any other barriers to rehabilitation as appropriate.&lt;br&gt;Recommendations are supported with assessors rationale.</td>
<td></td>
</tr>
<tr>
<td><strong>VIMA</strong>&lt;br&gt;Comments on completeness of rehabilitation (VIMA) as agreed upon and documented on the IRP&lt;br&gt;Comments are supported with assessors rationale.</td>
<td></td>
</tr>
<tr>
<td><strong>Conclusion</strong>&lt;br&gt;Provides an analysis with clear rationale of the claimant’s current work capability, and this is aligned with the client's functional ability for each of the generic work types and there is a rationale for every work type.&lt;br&gt;Includes claimant’s comments and ensures symptoms, medication, and geographical area have been considered in context of each job type&lt;br&gt;Non-injury related factors affecting work capability are considered and differentiated from injury related factors for all identified work types.&lt;br&gt;Demonstrates appropriate analysis and consideration of the available materials including relevant reports and investigations.</td>
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<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>CI – continuous improvement (exceeds)</td>
</tr>
<tr>
<td>3</td>
<td>FA – fully attained</td>
</tr>
<tr>
<td>2</td>
<td>PA – partially attained</td>
</tr>
<tr>
<td>1</td>
<td>UA – unattained</td>
</tr>
</tbody>
</table>
Appendix I

Relevant extracts from the Accident Compensation Act

Section 72 Responsibilities of claimant who receives entitlement

Section 75 Corporation to determine need for rehabilitation plan

Section 76 Provision of rehabilitation before and after rehabilitation plan agreed

Section 77 Assessment of needs and content of plan

Section 80 Purpose of vocational rehabilitation

Section 85 Corporation liable to provide vocational rehabilitation

Section 86 Matters to be considered in deciding whether to provide vocational rehabilitation

Section 87 Further matters to be considered in deciding whether to provide vocational rehabilitation

Section 88 Vocational rehabilitation may start or resume if circumstances change

Section 89 Assessment of claimant’s vocational rehabilitation needs

Section 93 Medical assessor

Section 94 Assessments when medical assessor unavailable

Section 95 Conduct of initial medical assessment

Section 96 Report on initial medical assessment

Section 103 Corporation to determine incapacity of claimant who, at time of personal injury, was earner or on unpaid parental leave

Section 104 Effect of determination under section 103 on entitlement to weekly compensation

Section 105 Corporation to determine incapacity of certain claimants who, at time of incapacity, had ceased to be in employment, were potential earners, or had purchased weekly compensation under section 223

Section 107 Corporation to determine vocational independence

Section 108 Assessment of claimant's vocational independence

Schedule 1 Clause 28 Conduct of medical assessment

Schedule 1 Clause 29 Report on medical assessment
Appendix II

Report Headings and Content Guidelines

IMA report headings

The IMA report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage comprehensive reports which provide quality, completeness and consistency. All sections should be covered in the report.

It’s not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the ‘Additional Comments’ section.

Identification/assessment information

Appropriate identification of information including:
- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name; date of accident; date of birth; ACC Claim number; occupation at date of injury
- any support person present
- any other relevant information such as any information given to the client about the purpose of the assessment.

Documents reviewed

List the documents provided by ACC. Comment on whether any information is missing/required.

Introduction and Consent Statement

Indicate that there has been a discussion with the client and they are aware of the requirements of the assessment. The Introduction and Consent Statement is required to be completed in accordance with the guidance contained in the Medical Council of New Zealand statement - Non-treating Doctors Performing Medical Assessments of Patients for Third Parties.

History of the injury and its management

A clear background history must be documented with:
- presenting problem and contributing factors
- symptom onset and time course
- chronological record of events
- relevant dates specified.

Include details about the injury and management:
- how the injury was sustained
- the consequences of the injury
- previous assessments and investigations
- any medical or surgical treatment undertaken and response to treatment
- any self management techniques.
Information about current medical certification and any attempts at returning to work should be described.

Any relevant inconsistencies should be highlighted.

**Current situation/ functional enquiry**

The client’s current situation regarding their function needs should be explored and discussed, including:

- functional or cognitive limitations
- pain, site and radiation, character, severity, aggravating or relieving factors and associated symptoms
- focused general medical functional enquiry
- general symptoms (sleep, energy, mood) should be stated including their perception of what is wrong and their concerns
- their current abilities and participation in activities of daily living, household chores, family responsibilities, volunteer work, exercise, hobbies and sporting and social activities, including driving
- specifics in regard to what exactly the client does throughout a typical day
- The client’s goals for work and non-work activities should be discussed and noted.

**Note:** Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance. See relevant sections for more information.

**Past Medical/Surgical History**

The client’s past medical history must be outlined. The impact of any illness or injury should be outlined including:

- ongoing symptoms
- any disability and
- any adverse consequences of treatment.

**Medications**

List current medications including any noted side effects. Reference any significant trials of other medications and the outcome of these. Allergies should be noted.

**Personal and social history**

The client’s personal and social history must be noted including:

- smoking, alcohol and drug habits and history
- past participation in volunteer work, sports or hobbies
- areas of interest and motivation
- significant relationships, responsibilities and living arrangements
- any financial, social or domestic issues or concerns.

**Past occupational history**

A brief outline needs to be noted of the client’s past occupational history including:

- work types and periods of employment
- where appropriate, any exposure and the duration of this exposure to potentially hazardous
substances or situations.

**Most recent employment**

In regard to the most recent employment, information is required about:

- the job title, name of employer, period of employment and hours of work, tasks undertaken, additional responsibilities, travel requirements, work environment
- where appropriate, exposure and the duration of this exposure to potentially hazardous substances or situations
- comment on job satisfaction, work security, work performance, and relationship with manager and co-workers and any conflicts
- comment on presence or absence of ongoing communications with employer
- comment on whether or not the job is still available for the injured worker and in what form.

**Examination**

A focussed assessment should be undertaken in respect to the injury and any other medical conditions. This assessment should address the following:

- General observations such as:
  - your overall impressions
  - the person’s attitude, thought process, communication and participation in the assessment
  - any normal or abnormal behaviours or postures
  - any consistencies and inconsistencies.
- Specific observations such as:
  - height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
  - specific observations eg swelling, scars muscle wasting.
- Specific relevant injury examination should be included
  - regional examination eg back condition with lower limb neurology
  - organ system examination eg neurological.

More specific examinations should be undertaken, where relevant. These should take into consideration the injury and the demands of the various work types and the fitness to undertake that work including

- functional tests - range of movement, strength, nerve function, cognitive function, general vision and hearing
- general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting and carrying, reaching, climbing stairs, rising from sitting, dexterity.

**Diagnosis**

Provide a diagnosis/diagnoses for the injury/injuries (or failing that a differential diagnosis). List other medical and surgical conditions. Make recommendations for investigations if necessary (more appropriate for IMA).

**Barriers to rehabilitation For IMA**

Explore and list any other barriers to participation in rehabilitation such as:

- diagnostic difficulties
- access to work
- attitudes, beliefs and goals
- any noted cognitive and behavioural issues
- any work, social, cultural, family or other issues raised by the client.

**Recommendations for management and rehabilitation**

Clarification of diagnosis: If the diagnosis is in doubt, specify what steps need to be undertaken to clarify the diagnosis: appropriate investigations, specialist referral or opinion.

Clinical management/rehabilitation: provide recommendations with rationale and likely/expected outcomes including:
- the recommended modality/modalities
- frequency
- duration
- type of therapy/therapist.

Use a biopsychosocial and vocational framework. Consider all the barriers identified and the pre-injury job, and whether there are any options for accommodations or modifications in the workplace.

Include any client comment regarding recommendations.

**Current restrictions and limitations - if any**

List any current restrictions and limitations:
- What can/can’t the client do?
- What activities can/can’t they safety perform?
- What activities need to be avoided for the safety in the workplace for the client and others?
- What activities need a shortened exposure time to account for specific symptoms?

Describe any work schedule modifications, equipment or other accommodations that would make a difference to the client’s ability to engage with work activities.

**Note:** Restrictions and limitations need to be listed and clearly defined as they will be used to inform employers and others involved in any future vocational rehabilitation. This ensures that any proposed return to work or work trial is provided in a safe environment for the client.

**Determination of likely sustainability of work types, including client comments**

The assessor needs to make a determination of the likely medical sustainability of the work types by:
- having regard to the present consequences of the client’s personal injury
- having regard to any medical/surgical conditions not related to the injury and
- disregarding any non-medical issues such as lack of job opportunities, child care etc.

Each work type should be listed separately noting:
- work types medically sustainable now with rationale
- work types likely to be medically sustainable with rationale, including timeframes
- work types medically unsustainable indefinitely with rationale
- special attention should be placed on the pre-injury work type, abilities, restrictions, limitations and timeframes
- consistent and reasoned recommendations should be provided for all work types
- adhere to the work types as specified in the work detail sheets
- where present, the impact of pain, fatigue and mood needs to be specifically addressed for each work type
- tolerance for each work type must be discussed, including the viability for self-management practices in the workplace
- record client’s comments with respect to the work ability assessment for each work type and the assessor’s findings and proposed rehabilitation recommendations.

**Additional Comments**

Assessor to add any additional comments or relevant information.
VIMA report headings

The VIMA report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage comprehensive reports which provide quality, completeness and consistency. All sections should be covered in the report.

It’s not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the ‘Additional Comments’ section.

Identification/assessment information

Appropriate identification of information including:
- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name; date of accident; date of birth; ACC Claim number; occupation at date of injury
- any support person present
- any other relevant information such as any information given to the client about the purpose of the assessment.

Documents reviewed

List the documents provided by ACC. Comment on whether any information is missing/required.

Introduction and Consent Statement

Indicate that there has been a discussion with the client and they are aware of the requirements of the assessment. The Introduction and Consent Statement is required to be completed in accordance with the guidance contained in the Medical Council of New Zealand statement - Non-treating Doctors Performing Medical Assessments of Patients for Third Parties.

History of the injury and its management

A clear background history must be documented with:
- presenting problem and contributing factors
- symptom onset and time course
- chronological record of events
- relevant dates specified.

Include details about the injury and management:
- how the injury was sustained
- the consequences of the injury
- previous assessments and investigations
- any medical or surgical treatment undertaken and response to treatment
- any self management techniques.

Information about current medical certification and any attempts at returning to work should be described.
Any relevant inconsistencies should be highlighted.

**Current situation/ functional enquiry**

The client’s current situation regarding their function needs should be explored and discussed, including:

- functional or cognitive limitations
- pain, site and radiation, character, severity, aggravating or relieving factors and associated symptoms
- focused general medical functional enquiry
- general symptoms (sleep, energy, mood) should be stated including their perception of what is wrong and their concerns
- their current abilities and participation in activities of daily living, household chores, family responsibilities, volunteer work, exercise, hobbies and sporting and social activities, including driving
- specifics in regard to what exactly the client does throughout a typical day
- The client’s goals for work and non-work activities should be discussed and noted.

**Note:** Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance. See relevant sections for more information.

**Past Medical/Surgical History**

The client’s past medical history must be outlined. The impact of any illness or injury should be outlined including:

- ongoing symptoms
- any disability and
- any adverse consequences of treatment.

**Medications**

List current medications including any noted side effects. Reference any significant trials of other medications and the outcome of these. Allergies should be noted.

**Personal and social history**

The client’s personal and social history must be noted including:

- smoking, alcohol and drug habits and history
- past participation in volunteer work, sports or hobbies
- areas of interest and motivation
- significant relationships, responsibilities and living arrangements
- any financial, social or domestic issues or concerns.

**Past occupational history**

A brief outline needs to be noted of the client’s past occupational history including:

- work types and periods of employment
- where appropriate, any exposure and the duration of this exposure to potentially hazardous substances or situations.
**Most recent employment**

In regard to the most recent employment, information is required about:

- the job title, name of employer, period of employment and hours of work, tasks undertaken, additional responsibilities, travel requirements, work environment
- where appropriate, exposure and the duration of this exposure to potentially hazardous substances or situations
- comment on job satisfaction, work security, work performance, and relationship with manager and co-workers and any conflicts
- comment on presence or absence of ongoing communications with employer
- comment on whether or not the job is still available for the injured worker and in what form.

**Examination**

A focussed assessment should be undertaken in respect to the injury and any other medical conditions. This assessment should address the following:

- General observations such as:
  - your overall impressions
  - the person’s attitude, thought process, communication and participation in the assessment
  - any normal or abnormal behaviours or postures
  - any consistencies and inconsistencies.
- Specific observations such as:
  - height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
  - specific observations eg swelling, scars muscle wasting.
- Specific relevant injury examination should be included
  - regional examination eg back condition with lower limb neurology
  - organ system examination eg neurological.

More specific examinations should be undertaken, where relevant. These should take into consideration the injury and the demands of the various work types and the fitness to undertake that work including

- functional tests - range of movement, strength, nerve function, cognitive function, general vision and hearing
- general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting and carrying, reaching, climbing stairs, rising from sitting, dexterity.

**Diagnosis**

Provide a diagnosis/ diagnoses for the injury/ injuries (or failing that a differential diagnosis). List other medical and surgical conditions. Make recommendations for investigations if necessary (more appropriate for IMA).

**Current restrictions and limitations - if any**

List any current restrictions and limitations:

- What can/can’t the client do?
- What activities can/can’t they safety perform?
- What activities need to be avoided for the safety in the workplace for the client and others?
What activities need a shortened exposure time to account for specific symptoms?

Describe any work schedule modifications, equipment or other accommodations that would make a difference to the client’s ability to engage with work activities.

**Note:** Restrictions and limitations need to be listed and clearly defined as they will be used to inform employers and others involved in any future vocational rehabilitation. This ensures that any proposed return to work or work trial is provided in a safe environment for the client.

**Determination of likely sustainability of work types, including client comments**

The assessor needs to make a determination of the likely medical sustainability of the work types by:

- having regard to the present consequences of the client’s personal injury
- having regard to any medical/surgical conditions not related to the injury and
- disregarding any non-medical issues such as lack of job opportunities, child care etc.

Each work type should be listed separately noting:

- work types medically sustainable now with rationale
- work types likely to be medically sustainable with rationale, including timeframes
- work types medically unsustainable indefinitely with rationale
- special attention should be placed on the pre-injury work type, abilities, restrictions, limitations and timeframes
- consistent and reasoned recommendations should be provided for all work types
- adhere to the work types as specified in the work detail sheets
- where present, the impact of pain, fatigue and mood needs to be specifically addressed for each work type
- tolerance for each work type must be discussed, including the viability for self-management practices in the workplace
- record client’s comments with respect to the work ability assessment for each work type and the assessor’s findings and proposed rehabilitation recommendations.

**Comments on completeness of rehabilitation and medical treatment**

Comment on whether recommended and agreed rehabilitation is ‘complete’ or not and what outcomes have been achieved. Give sufficient detail. In cases where rehabilitation has been provided but is incomplete or the outcome is less than expected, discuss whether there has been adequate opportunity for the client to engage with the rehabilitation and what is the significance of the outcome?

If further medical treatment is required or will be required in the future (for either injury or non-injury conditions), then provide recommendations for clinical management.

Include any client comment regarding recommendations.

**Specific determination of sustainability of work types including client comments**

When you are making your determination of the medical sustainability of the work types as well as considering all the factors listed under the relevant headings also consider the specific question for VIMA of:

- whether the work type is medically sustainable now **for 30 hours or more per week**
• conversely, whether the work type is medically unsustainable now for **30 hours or more per week**

*Additional Comments*

Assessor to add any additional comments or relevant information.
VRR report headings and content guidelines

**Identification/Assessment information**

Appropriate identification of information including:
- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name; date of accident; date of birth; ACC Claim number.
- any support person present
- any other relevant information.

**Documents reviewed**

List the documents provided by ACC. Comment on whether any information is missing/required.

**History of the injury/injuries and management**

A clear background history must be documented with:
- how the injury was sustained
- the consequences of the injury
- presenting problem and contributing factors
- chronological record of events with relevant dates specified
- review of relevant assessments and investigations
- treatment and rehabilitation undertaken and response to this

Information about current medical certification and any attempts at returning to work should be described.

Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance upon the client’s ability to undertake their job.

If you need further investigations to help with your conclusions please discuss this with the client and case manager. You may complete the assessment but delay releasing the final report until your investigation is complete.

**Examination**

A focussed assessment should be undertaken. Details of this assessment in respect to the injury and any other medical conditions should be recorded in this report including:

General observations such as:
- your overall impressions
- the person’s attitude, thought process, communication and participation in the assessment
- any normal or abnormal behaviours or postures
- any consistencies and inconsistencies.

Specific observations such as:
- height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
• other specific observations eg. swelling, scars muscle wasting
Specific relevant injury examination should be included
• regional examination eg. back condition with lower limb neurology
• organ system examination eg. neurological

Apply the findings of your physical examination specifically taking into consideration the injury and the demands of the pre-injury work types and the fitness to undertake that work including:
• functional tests - range of movement, strength, nerve function, cognitive function, general vision and hearing, etc.
• general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting and carrying, reaching, climbing stairs, rising from sitting, dexterity.

**Barriers to rehabilitation**

Explore and list any other barriers to participation in rehabilitation such as:
• diagnostic difficulties
• access to work
• attitudes, beliefs and goals
• any noted cognitive and behavioural issues
• any work, social, cultural, family or other issues raised by the client.

**Summary of the diagnosis**

Provide a diagnosis/diagnoses for the injury/injuries including other medical and surgical conditions.

**Employer communication**

*There needs to be a separate page at the back of the report which will be provided to the employer. This is to inform them as to the work tasks the client can manage, how these can be increased and over what time frame. Where possible an indication as to when the client is likely to be able to manage all tasks from their pre-injury role would be beneficial. This can be completed in table form or as a written paragraph and is to include any restrictions. The page is to be separate for ease of forwarding to the employer while maintaining the clients privacy.*
S.103 Report Headings and Content Guidelines

The S.103 report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage comprehensive reports which provide quality, completeness and consistency. All sections should be covered in the report.

The guidance provided is not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the ‘Additional Comments’ section.

Identification/Assessment information

Appropriate identification of information including:
- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name; date of accident; date of birth; ACC Claim number.
- any support person present
- any other relevant information.

Documents reviewed

List the documents provided by ACC. Comment on whether any information is missing/required.

History of the injury/injuries and management

A clear background history must be documented with:
- how the injury was sustained
- the consequences of the injury
- presenting problem and contributing factors
- chronological record of events with relevant dates specified
- review of relevant assessments and investigations
- treatment and rehabilitation undertaken and response to this

Information about current medical certification and any attempts at returning to work should be described.

Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance upon the client's ability to undertake their job.

If you need further investigations to help with your conclusions please discuss this with the client and case manager. You may complete the assessment but delay releasing the final report until your investigation is complete.

Examination

General observations such as:
- your overall impressions
- the person’s attitude, thought process, communication and participation in the assessment
• any normal or abnormal behaviours or postures
• any consistencies and inconsistencies.

Specific observations such as:
• height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
• other specific observations eg. swelling, scars muscle wasting

Specific relevant injury examination should be included
• regional examination eg. back condition with lower limb neurology
• organ system examination eg. neurological

Apply the findings of your physical examination specifically taking into consideration the injury and the demands of the pre-injury work types and the fitness to undertake that work including:
• functional tests - range of movement, strength, nerve function, cognitive function, general vision and hearing, etc.
• general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting and carrying, reaching, climbing stairs, rising from sitting, dexterity.

Summary of the diagnosis
Provide a diagnosis/diagnoses for the injury/injuries including other medical and surgical conditions.

Confirm the occupation and work tasks of the pre-injury role with the client

List the following information about the client’s pre-injury role:
• the job title, name of employer, period of employment and hours of work
• detailed description of tasks undertaken, additional responsibilities, travel requirements, work environment
• where appropriate, exposure and the duration of this exposure to potentially hazardous substances or situations
• comment on job satisfaction, work security, work performance, and relationship with manager and co-workers and any conflicts
• comment on presence or absence of continuing communications with employer
• comment on whether or not the job is still available for the injured worker and in what form.

If you do not have this information you can’t complete the report. Contact the client’s ACC case owner to get the information. Specify if you have gathered this information from a previous report and any discussion you have had with the client regarding this information.

Section 103 questions
Answer these Section 103 specific questions and any additional questions in the referral. Include clear rationale to support your answers.

1. Considering the client’s current injury and functional limitations, please outline:
   • what aspects of their specific pre-injury role can they not currently undertake safely?
• considering physical, cognitive and social tasks and exposures, what aspects of their specific pre-injury role can they mostly undertake safely?

2. Considering the current specific job requirements, can the client substantially engage in their pre-injury role? Engage means able to perform most, ie the majority of the works tasks and all essential work tasks of that job.

3. If the client cannot substantially engage in their pre-injury role, which essential requirements or key aspects of this role are they unable to perform? Please detail with possible timeframes for potential resumption of these functions.

4. If the client cannot substantially engage in their pre-injury role, to what extent do their current functional limitations relate to their injury? Please consider the impact and relative significance of other injury or non-injury incapacitating conditions.

5. If the client is unable to perform their pre-injury role, please discuss any current or possible future investigations, treatment or rehabilitation you would consider appropriate to help in restoring them to their pre-injury function and work role.

6. Considering the generic job description, can the client apply their current fitness for work safely to a more generic role of this type?

7. If the client cannot perform a more generic role, please discuss any current or possible future investigations, treatment or rehabilitation investigations you would consider appropriate to help in restoring them to the pre-injury function and generic role.
S.105 Report Headings and Content Guidelines

The S.105 report is to be completed with the headings outlined below. Additional information has been added beneath the headings to guide and encourage comprehensive reports which provide quality, completeness and consistency. All sections should be covered in the report.

The guidance provided is not intended to limit the provider from recording any relevant information which should still be included in the report in the most relevant section. If additional information does not appear appropriate in the sections outlined, please record in the ‘Additional Comments’ section.

Identification/Assessment information

Appropriate identification of information including:
- assessor details
- referrer details, and date
- assessment date and duration and location.
- report date
- client details – name; date of accident; date of birth; ACC Claim number.
- any support person present
- any other relevant information.

Documents reviewed

List the documents provided by ACC. Comment on whether any information is missing/required.

History of the injury/injuries and management

A clear background history must be documented with:
- presenting problem and contributing factors
- symptom onset and time course
- chronological record of events
- relevant dates specified.

Include details about the injury and management:
- how the injury was sustained
- the consequences of the injury
- previous assessments and investigations
- any medical or surgical treatment undertaken and response to treatment
- any self management techniques.

Information about current medical certification and any attempts at returning to work should be described.

Any relevant inconsistencies should be highlighted.

Current situation/ functional enquiry

The client’s current situation regarding their function needs should be explored and discussed, including:
- functional or cognitive limitations
- pain, site and radiation, character, severity, aggravating or relieving factors and associated symptoms
- focused general medical functional enquiry
- general symptoms (sleep, energy, mood) should be stated including their perception of what is wrong and their concerns
- their current abilities and participation in activities of daily living, household chores, family responsibilities, volunteer work, exercise, hobbies and sporting and social activities, including driving
- specifics in regard to what exactly the client does throughout a typical day
- The client’s goals for work and non-work activities should be discussed and noted.

**Note:** Where symptoms such as pain, fatigue or mood disorder are identified, these need to be specifically noted and explored in terms of their nature and significance. See relevant sections for more information.

**Past Medical/Surgical History**
The client’s past medical history must be outlined. The impact of any illness or injury should be outlined including:
- ongoing symptoms
- any disability and
- any adverse consequences of treatment.

**Medications**
List current medications including any noted side effects. Reference any significant trials of other medications and the outcome of these. Allergies should be noted.

**Personal and social history**
The client’s personal and social history must be noted including:
- smoking, alcohol and drug habits and history
- past participation in volunteer work, sports or hobbies
- areas of interest and motivation
- significant relationships, responsibilities and living arrangements
- any financial, social or domestic issues or concerns.

**Past occupational history**
A brief outline needs to be noted of the client’s past occupational history including:
- work types and periods of employment
- where appropriate, any exposure and the duration of this exposure to potentially hazardous substances or situations.

**Most recent employment**
In regard to the most recent employment, information is required about:
- the job title, name of employer, period of employment and hours of work, tasks undertaken, additional responsibilities, travel requirements, work environment
- where appropriate, exposure and the duration of this exposure to potentially hazardous substances or situations
- comment on job satisfaction, work security, work performance, and relationship with manager
and co-workers and any conflicts
- comment on presence or absence of ongoing communications with employer
- comment on whether or not the job is still available for the injured worker and in what form.

**Examination**
A focussed assessment should be undertaken in respect to the injury and any other medical conditions. This assessment should address the following:
- General observations such as:
  - your overall impressions
  - the person's attitude, thought process, communication and participation in the assessment
  - any normal or abnormal behaviours or postures
  - any consistencies and inconsistencies.
- Specific observations such as:
  - height, weight, hearing, vision and mobility, BMI, blood pressure and heart rate etc
  - specific observations eg swelling, scars muscle wasting.
- Specific relevant injury examination should be included
  - regional examination eg back condition with lower limb neurology
  - organ system examination eg neurological.

More specific examinations should be undertaken, where relevant. These should take into consideration the injury and the demands of the various work types and the fitness to undertake that work including
- functional tests - range of movement, strength, nerve function, cognitive function, general vision and hearing
- general capabilities and any restrictions or limitations should be noted or discussed, as relevant, such as walking, standing, sitting, kneeling, squatting, lifting and carrying, reaching, climbing stairs, rising from sitting, dexterity.

**Diagnosis**
Provide a diagnosis/ diagnoses for the injury/ injuries (or failing that a differential diagnosis). List other medical and surgical conditions.

**Current restrictions and limitations - if any**
List any current restrictions and limitations:
- What can/can't the client do?
- What activities can/can't they safety perform?
- What activities need to be avoided for the safety in the workplace for the client and others?
- What activities need a shortened exposure time to account for specific symptoms?

Describe any work schedule modifications, equipment or other accommodations that would make a difference to the client’s ability to engage with work activities.

**Note:** Restrictions and limitations need to be listed and clearly defined as they will be used to inform employers and others involved in any future vocational rehabilitation. This ensures that any proposed return to work or work trial is provided in a safe environment for the client.
Section 105 questions

Answer these Section 105 specific questions and any additional questions in the referral. Include clear rationale to support your answers

1. Please describe the client’s restrictions, limitations and fitness for work. Include comment on specific exposures, activities or tasks the client should avoid because of their injury related incapacity.

2. With regard to the client’s current fitness for work, is the client able to safely engage in each of the identified work types outlined in the IOA? Engage means able to perform most, ie the majority of the work tasks and all essential work tasks of that job. Relevant work types refers to work for which the client has been determined to have the necessary experience, education or training and are described in the accompanying occupational assessment. Please comment separately on each job type.

Determination as to whether the client has sufficiently recovered from their injury to be able to perform the requirements of any of the work types identified to a satisfactory standard for not less than 30 hours per week, including client comments

The assessor needs to make a determination of these work types by

- having regard to the present consequences of the client’s personal injury
- having regard to any medical/surgical conditions not related to the injury and
- disregarding any non-medical issues such as lack of job opportunities, child care etc.

Each work type should be listed separately noting

- work types that meet the requirements, with rationale
- work types that may meet requirements, including timeframes
- work types that do not meet requirements with rationale
- adhere to the work types as specified in the work detail sheets
- where present, the impact of pain, fatigue and mood needs to be specifically addressed for each work type
- tolerance for each work type must be discussed, including the viability for self-management practices in the workplace
- record client’s comments with respect to the work ability assessment for each work type and the assessor’s findings and proposed rehabilitation recommendations.

Additional Comments

Assessor to add any additional comments or relevant information.