Clinical Services

Operational Guidelines

Effective 1 July 2023

This is a living document and will be updated as required – the latest version is available on ACC's Website.

Summary of changes 1 July 2023

Clause	Overview of Change
(Page 5) Useful Contact Information	Updated with current contact phone and email details
3. Who can hold this contract	Wording update
6. General Assessments	○ Wording update ○ Addition of DNA information
6.3. Telehealth Assessments	Wording update to align with ACC Telehealth Guide
6.6. Neurophysiological Assessments	References to 'Neurologist' replaced with 'Internal Medical Specialist'
8. Surgical treatment pathway	○ Clarification on what is required in the ARTP ○ Addition to the approval process ○ Wording update to non-contracted surgery
9. Medical Case Reviews and Medical Single Discipline Assessments	Reordered and wording updated Addition of provider search tool details
10. Procedures and non-surgical pathways	Updated to include: ○ Flowchart for accreditation ○ Clarification on what is required in the CSARTP ○ Tables 4, 5 and 6 from the contract ○ New injection codes
12. Providing clinical notes	New clause inserted
Appendix I – FAQs	Removed and replaced in relevant sections of the operational guidelines
Appendix II – FAQs for MCRs	Removed and replaced in relevant sections of the operational guidelines
Appendix III – CSARTP	Removed, is available on ACC website
Appendix I – Summary of changes log	Place holder for history of changes to these guidelines

Contents

Useful Contact Information

Please see below contact details for several teams across ACC that can assist you with any queries you have while providing Clinical Services to ACC clients.

ACC's Provider Contact Centre	Ph: 0800 222 070	Email: providerhelp@acc.co.nz
ACC's Client/Patient Helpline	Ph: 0800 101 996	
Provider Registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Register with us as a health provider (acc.co.nz)	
ACC eBusiness	Ph: 0800 222 994, Option 1	Email: ebusinessinfo@acc.co.nz
Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team:	
	Ph: 0800 400 503	Email: health.procurement@acc.co.nz
Website	For more information about ACC, please visit: www.acc.co.nz	
Provider Updates	This monthly publication updates Suppliers, Providers and Vendors on what's happening across ACC's business. https://www.acc.co.nz/for-providers/provider-updates/	
Engagement and Performance Managers (EPMs)	EPMs can help you to provide the services outlined in your contract. Use this link to contact our provider relationship team if you're unsure who your EPM is.	
Elective Surgery Documentation	ARTPS4ESU@acc.co.nz	For email submissions of ARTP's (incl in-rooms CSARTPs)
	disopnotes@acc.co.nz	For operation notes and supporting documents
	ESCMednotes@acc.co.nz	For general med notes related to ARTP submissions
Surgery Assessment Team	This team can assist with more unusual queries that require attention/urgent escalation. Requests for adding cover for non-prior approval procedures should also be sent here. PLEASE NOTE: Don't use this for regular queries. Email: surgeryassessmenteam@acc.co.nz	
Clinical Notes	Healthlink (EDI: **ACCSPECR**) or clinical.notes@acc.co.nz	
Prior Approvals Team	Prior.approval@acc.co.nz	For submission of CSARTP's requesting prior approval

ACC's website can provide you with a lot of information, especially our "Health and Service Providers" section. Please visit www.acc.co.nz/for-providers.

1. About these guidelines

This is a guideline to assist the implementation of the Clinical Services Service Schedule (also referred to here as "the contract").

Read this guide in conjunction with the contract and the ACC Standard Terms and Conditions.

Services must comply with the Clinical Services Service Schedule. Where there are any inconsistencies between this document and the Service Schedule, the Service Schedule takes precedence.

ACC will tell you when a new version of this guide is available on the ACC website at www.acc.co.nz. These guidelines can also be found under "Contracts" in the Resources area of the ACC website.

2. Introduction

The purpose of Clinical Services is to fund:

- various services surrounding elective surgery, including non-surgical treatment if that is more appropriate.
- specialist physician services
- various medical assessments in relation to determining diagnosis, causation, and/or treatment and rehabilitation recommendations.
- procedures that can be completed in specialists' rooms.

The Clinical Services Contract works in conjunction with the Elective Surgery Contract to enable first specialist assessment, anaesthetic pre-operative assessment, and further assessments in preparation for surgery.

To ensure that all specialists are aware of the process for funding assessments, the services are clearly outlined in this document. ACC supports best practice for the assessment of all clients.

Note: The price for each clinical service is the total amount chargeable and no additional amount may be charged to ACC or the client (no co-payments).

3. Who can hold this contract

The contract can be held by a suitable corporate entity such as a hospital, a group of specialists or an individual. If an individual holds the contract, they are expected to have access to:

- a nursing team led by registered nurses, and
- a sufficient range of diagnostic and assessment services, and
- staffing arrangements for a multi-disciplinary approach.

The contract holder must notify ACC of the individuals who will be Named Providers providing service under the contract. A Named Provider must be:

- Medical Practitioner registered under the Medical Council of NZ and holds a vocation scope of practice in one of the listed areas at Clause 6.1 (a) of the contract, or
- Dental Practitioner registered under the Dental Council of NZ and holds a vocational scope of practice in:
    - Oral Surgery
    - Oral and maxillofacial surgery

A specialist can be named on more than one Clinical Services contract, e.g. if they work in both public and private hospitals. The supplier is responsible for managing the contract and disseminating information to the named providers.

The Clinical Services contract covers specialist assessment in the vocational scopes as defined in the contract. Service must not be provided at a higher level of expertise than needed. While this applies to all services and is aimed at promoting appropriate delegation of tasks within the wider health care team, it is particularly important if multiple providers work within the same premises.

4. Referral Process

Clients can be referred into this service by:

- vocationally registered medical specialists
- general practitioners
- any other treatment provider as defined in the Accident Compensation Act 2001 (e.g. physiotherapists)
- ACC

Note: Medical Case Reviews and Medical Single Discipline Assessments can **only** be requested by ACC.

Referrals to a medical specialist under this contract from a primary care setting (integrated family health centre, medical centre or urgent care clinic) should only be made if the injury requires assessment or treatment that is within the scope of practice of the specialist and outside the scope of practice of the primary care provider.

Referrals for assessment and/or treatment will contain the following:

- client name
- ACC claim number
- date of injury
- initial injury diagnosis
- list of any previous known treatment and/or tests on this claim, and
- the rationale for requesting the specialist's opinion.

If the referral does not meet these criteria the Supplier can decline the request.

5. Clinical Services Contract and the Elective Surgery Contract

The Clinical Services Contract works in conjunction with the Elective Surgery Contract to enable first specialist assessment, anaesthetic pre-operative assessment, further assessments in preparation for surgery, completion of ARTP and so on.

In addition, the Clinical Service Contract provides a mechanism for funding non-surgical interventions or certain 'in-rooms' procedures.

6. General Assessments

General assessments are carried out by Named Providers as the treating specialist. Where in opinion of the treating specialist the client's personal injury was not caused by accident, the Supplier should communicate this with both the client and ACC. It is ACC's expectation that this occurs where the clinical picture is clear.

In some instances, clients can be seen for more than one claim on the same day. There can be a consultation billed for each claim provided they each have separate referral letters, appointment slots and reporting.

Note: Our payments system will hold any invoices for more than one consultation per day, this information will be checked before payment is released.

Note: The supplier may not charge ACC if a client fails to attend an appointment. The only exception is the CSN1 (Did not attend) fee payable when a client fails to attend a scheduled appointment for a MCR without giving two working days notice.

6.1. Initial assessments

This is the first specialist assessment (FSA) for a client. Specialists will ensure that the initial assessment occurs within a clinically appropriate timeframe following receipt of referral. If the specialist cannot meet this timeframe, the Client should be

advised to discuss options with the referrer, unless ACC and the supplier agree a different timeframe.

Initial assessments may include the provision of any/all of the following:

- taking of medical history relevant to the injury or injuries
- examination of the presenting injury condition(s)
- diagnosis of the presenting injury or injuries
- review of and/or amendment to any existing diagnosis
- arranging access to, and the provision of, any necessary radiological investigation, including High Tech Imaging
- interpretation of diagnostic films/reports
- performing any necessary and appropriate procedure(s)
- prescription of any necessary pharmaceuticals
- liaison with other health and support services
- education about caring for the injury and expectations of recovery
- provision of injury prevention advice to minimise the risk of re-injury or complications
- referral to an appropriate Registered Health Professional for any further treatment required, including referral for orthotics
- completion of the necessary assessment report and treatment plan.

An initial assessment can either be Simple or Complex depending on clinical best practice and client complexity.

- **CS100** - Simple initial assessment is expected to take up to 45 minutes
- **CS200** - Complex initial assessment is expected to take over 45 minutes. The increased time is justified in the clinical notes. The increased time will be justified in the clinical notes.

Note: Initial assessments can only be claimed once per **claim**.

What should a treatment plan include?

- identification of causation (especially whether or not caused by an accident)
- identification of further diagnostic procedures if causation or the characteristics of the injury require further investigation
- expected duration for Clinical Services assessment and/or treatment
- anticipated treatment
- any referrals required
- the client's capacity for return to normal function and/or employment.

Note: Initial assessments do **not** include assessments by an Anaesthetist (See Anaesthetist Specific Assessments).

6.2. Subsequent assessments

Subsequent assessments are used for assessments or consultations where specialists discuss the results of tests or interventions with the client and explore the resulting treatment and rehabilitation options. It is also used to provide necessary on-going management and/or conservative treatment, or if the client has not reached the outcomes predicted in the initial ARTP and needs a subsequent assessment or consultation.

A subsequent assessment can either be Simple or Complex depending on clinical best practice and client complexity.

- **CS61** - Simple subsequent assessment is expected to take up to 30 minutes.
- **CS62** - Complex subsequent assessment is expected to take over 30 minutes. The increased time will be justified in the clinical notes.

Note: A subsequent assessment may take place on the same day as the initial assessment if an intervening event (such as imaging) has occurred to justify it.

Note: The national average of assessments completed is two per claim. In exceptional circumstances where a client requires more than 20 subsequent assessments, approval from ACC is required. This can be obtained by submitting a CSARTP which includes appropriate rationale and treatment plan for the ongoing assessments. A purchase order will then be provided. If you have any queries, please contact your local Engagement and Performance Manager.

6.3. Telehealth Assessments

Consultations may be undertaken by electronic means (Telehealth) in accordance with the "ACC Telehealth Guide".

A Telehealth consultation replaces an in-person consultation. This means that providers should not hold a Telehealth consultation and then require an in-person consultation to undertake a physical examination as part of the initial consultation. Clinical appropriateness (including the potential need for a physical examination) needs to be determined to ensure that a Telehealth consultation is appropriate. Telehealth assessments should be billed under specific Telehealth codes (i.e. CS1T, CS2T, CS61T, CS62T).

6.4. Second opinion assessments

A second opinion assessment is done when a second opinion is needed from an anaesthetist or other specialist while a client is being assessed or diagnosed, and/or having their ongoing care options considered. A second opinion may be requested regardless of whether the initial assessment recommended surgical or non-surgical care. All vocational scopes of practice can refer for second opinions.

A second opinion assessment can be either Simple or Complex depending on clinical best practice and client complexity.

- **CS400** - Simple second opinion assessment is expected to take up to 45 minutes
- **CS900** - Complex second opinion assessment is expected to take over 45 minutes. The increased time will be justified in the clinical notes.

Second opinion assessments may include the provision of any/all of the following:

- taking of medical history relevant to the injury or injuries
- examination of the presenting injury condition(s)
- diagnosis of the presenting injury or injuries
- review of and amendment to any existing diagnosis
- arranging access to, and the provision of, any necessary radiological investigation, including High Tech Imaging
- interpretation of diagnostic films/reports
- performing any necessary and appropriate procedure(s)
- prescription of any necessary pharmaceuticals
- liaison with other health and support services
- education about caring for the injury and expectations of recovery
- provision of injury prevention advice to minimise the risk of re-injury or complications
- referral to an appropriate Registered Health Professional for any further treatment required, including referral for orthotics
- completion of the necessary assessment report and treatment plan.

Payments for second opinion assessments

This type of assessment will be paid under:

- this agreement if the second specialist is a named specialist, or
- the appropriate regulations if the second specialist is not named in any current Clinical Services contract with ACC.

Overall responsibility for Clinical Services ARTP in the event of second opinions

The initial specialist remains responsible for providing the Clinical Services Assessment Report and Treatment plan (CSARTP) to ACC, and for including in it any recommendation made by the second specialist.

6.5. Reassessment after 12 Months – CS500

Reassessments are used for subsequent simple or complex assessments by the provider who carried out the initial assessment. The client must have been discharged from the care of the provider and a new referral is required before a reassessment can occur.

Note: Reassessments cannot occur within 12 months of the initial assessment.

Note: This is not a pre-organised assessment by the named provider who carried out the initial assessment.

Reassessments are distinguished from the CS61 and CS62 codes so that ACC can identify and report on lingering injuries.

6.6. Neurophysiological assessments

These assessments are performed by Internal Medical Specialists and consist of the initial consultation and a simple and complex follow up consultation.

- **CS83** – Neurophysiological consultation – this includes the administration of the initial nerve conduction study.
- **CS84** – Simple Neurophysiological consultation – this includes checking for muscle innervation or repeating a section of the nerve conduction study.
- **CS85** – Complex Neurophysiological consultation – this is equivalent to an initial study and is expected to take over 45 minutes.

Note: Nerve conduction studies can be administered by a neurophysiologist commissioned by the Internal Medicine Specialist.

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

Procedure	Code	Definition	Treatment Provider
Simple Assessment (Initial)	CS100	Simple Assessment (Initial) – per consultation	Specialist
Simple Assessment (Initial) – Telehealth	CS1T	Simple Assessment (Initial) Telehealth – per consultation	Specialist
Complex Assessment (Initial)	CS200	Complex Assessment (Initial) – per consultation	Specialist
Complex Assessment (Initial) – Telehealth	CS2T	Complex Assessment (Initial) Telehealth – per consultation	Specialist
Second Opinion Assessment (Simple)	CS400	Second Opinion Assessment (Simple) – per consultation	Specialists Anaesthetist
Reassessment	CS500	Reassessment – per consultation	Specialist (same specialist who provided initial assessment)
Subsequent Assessment (Simple)	CS61	Subsequent Assessment (Simple) – per consultation	Specialist
Subsequent Assessment (Simple) – Telehealth	CS61T	Subsequent Assessment (Simple) Telehealth – per consultation	Specialist
Subsequent Assessment (Complex)	CS62	Subsequent Assessment (Complex) – per consultation	Specialist

Procedure	Code	Definition	Treatment Provider
Subsequent Assessment (Complex) – Telehealth	CS62T	Subsequent Assessment (Complex) Telehealth – per consultation	Specialist
Neurophysiological consultation	CS83	Neurophysiological consultation - Neurophysiological study and consultation	Internal Medicine Specialist Neurosurgeon (testing may be administered by a neurophysiologist commissioned by an Internal Medicine Specialist or Neurosurgeon)
Simple Neurophysiological Follow up	CS84	Simple Neurophysiological Follow up and consultation	Internal Medicine Specialist Neurosurgeon
Complex Neurophysiological Follow up	CS85	Complex Neurophysiological Follow up and consultation	Internal Medicine Specialist Neurosurgeon
Second Opinion Assessment (Complex)	CS900	Second Opinion Assessment (Complex) – per consultation	Specialist Anaesthetist

7. Anaesthetist Specific Assessments

These assessments are for clients for whom Elective Surgery have already been approved by ACC (or clients proceeding to elective surgery under the non-prior approval criteria). If a surgical application has not been approved before these assessments are performed, ACC will normally decline payment. The depth of assessment required is determined by the anaesthetist on a case by case, risk-assessed basis, commencing with a review of an anaesthetic pre-assessment form possibly escalated for review by a suitably skilled delegated clinical staff member such as a nurse.

Where surgery is recommended, the provider ensures that clients complete an anaesthetic pre-assessment form as soon as possible for attachment to the surgical ARTP. This is to ensure that it is reviewed by the anaesthetist involved or by the lead provider's preoperative service working in conjunction with the anaesthetists. This will allow them to respond to the information in the form to optimise surgical outcomes and avoid cancellations of surgeries due to unidentified client complexities.

ACC does not specify the form to be used but expects any such form would meet the standards of the various professional and clinical bodies involved.

Where the provider and their Elective Surgery Lead Supplier already have a process in place which allows client's risk to be identified and managed early, this process can remain as is, but it is the responsibility of the clinical services provider to determine that an alternative arrangement to that described above is satisfactory in managing anaesthetic risk. An ARTP will not be held up in the absence of an attached anaesthetic pre-assessment form.

Any client who is classified as an ASA 3 or greater, no matter what procedure they are having, should be formally assessed by an anaesthetist.

7.1. Pre-operative anaesthetic assessments

This initial assessment may be by telehealth where clinically appropriate. If necessary, this is followed up with an in-person consultation and must be done before the day of admission. We accept that geographical and client convenience considerations may encourage wider use of modern technology, but the anaesthetist is accountable for the quality of the assessment regardless of the means employed to conduct it.

A Pre-operative anaesthetic assessment can be either Simple or a Complex depending on clinical best practice and client complexity.

- **CS250** - Simple pre-operative anaesthetic assessments is expected to take up to 45 minutes
- **CS260** - Complex pre-operative anaesthetic assessments is expected to take over 45 minutes. The increased time will be justified in the clinical notes.

These assessments will typically be undertaken for clients:

- whose co-morbidities are likely to pose anaesthetic risk
- requiring non-core complex/unpredictable procedures if the client is expected to need High Dependency Unit/Intensive Care Unit care post-surgery
- who have been identified with significant anxiety about anaesthesia
- with a known prior history of complex anaesthetic needs
- with a personal injury of unusual complexity
- requiring more complex level of investigation

It is up to the anaesthetist to determine the assessment level required, based on length of assessment as informed by client and surgical risk factors. After this assessment, the anaesthetist must inform the Lead Supplier and surgeon of the perioperative plan and post-operative plan.

It is important that the Lead Supplier is notified of the anaesthetic plan (especially for any unusual cases) as they are responsible for the Elective Surgery contract and are therefore responsible for ensuring the necessary resources are made available based on the findings of the assessment. For example, arranging extra staff, additional services (such as HDU care), special equipment and applying for extra funding via non-core process. It is the responsibility of the anaesthetist to notify the Lead Supplier under the Elective Surgery contract of significant patient co-morbidities.

7.2. Pre-operative anaesthetic teleheatlh consultation - CS70

This consultation is a phone call to a client to serve as an initial or informational form of consultation in order to:

- clarify answers on the anaesthetic pre-assessment form,
- discuss the perioperative plan
- to relieve anxiety.

This is not a consultation in the sense applying above to the CS250 or CS260 codes. Following the initial discussion, it may be necessary to arrange a further assessment using the CS250 or CS260 codes, including by telehealth. The purpose of CS70 is to improve the service to clients as it is time and cost efficient and screen those clients who might require more in-depth assessments.

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

Procedure	Code	Definition	Treatment Provider
Simple Pre-operative Anaesthetic Assessment (Initial)	CS250	Simple Pre-operative Anaesthetic Assessment (Initial) (preoperatively only)	Anaesthetist
Complex Pre-operative Anaesthetic	CS260	Complex Pre-operative Anaesthetic Assessment –(Initial) -	Anaesthetist

Procedure	Code	Definition	Treatment Provider
Assessment –(Initial)		Per consultation (preoperatively only)	
Anaesthetic telehealth consultation	CS70	Anaesthetic telehealth consultation (pre-operatively only)	Anaesthetist

8. Surgical treatment pathway

Where a client has been assessed to require surgical treatment a Surgical Assessment Report and Treatment plan (ARTP) must be completed to obtain prior approval from ACC for the proposed surgical procedure (unless the procedure meets the criteria for non-prior approval). The ARTP must also include any clinic based pre-operative procedures which will be required as part of the procedure.

Note: If the procedure is on the non-prior approval list and meets the criteria, an ARTP is not required.

8.1. Completing a Surgical Assessment Report and Treatment Plan (ARTP)

The Surgical ARTP is the only version that will be accepted and can be downloaded:
https://www.acc.co.nz/assets/provider/7c34d75ff5/artp-template.doc

The Surgical ARTP must include:

- Current diagnosis
- Specialist clinical opinion on the link between diagnosis, mechanism of injury and treatment required (causal link)
- Prognosis and expectations for recovery
- Any supports required
- Supporting documentation e.g. referral, clinical notes, radiology reports

Complete the ARTP with as much detail as possible. At times, more information may be requested and will need to be provided in order for ACC to make a thorough assessment of the request. This will add delays to the approval process. The more we receive with the initial ARTP, the faster decisions are likely to be made.

The named provider on this contract is responsible for:

- drafting the ARTP
- selecting an Elective Surgical contract holder to act as the lead supplier
- submitting the draft ARTP to the lead supplier for review and submission to ACC.

The selected lead supplier for the Elective Services contract has overall responsibility for the surgical ARTP and is responsible for:

- reviewing and completing the draft ARTP in conjunction with the Clinical Services named provider to the standard required
- submitting the completed ARTP electronically to ACC Treatment and Support Team via ARTPS4ESU@acc.co.nz.

Note: The time involved in preparing the ARTP is not separately chargeable.

8.2. The approval process

The ACC Treatment and Support Team will prioritise consideration of ARTPs based on the priority category selected on the ARTP. It is the responsibility of the Elective Surgery Lead Supplier, with the advice of the named provider, to assign a priority category to an ARTP. Clinical priorities must match those provided in the elective surgery operational guidelines.

8.3. Informing the Client of their choice

The Client is entitled to make an informed decision regarding the choice of treatment. To do that they must be party to a discussion on options available to them and have all the information available.

Contracted Surgery

In most cases, a request for surgery arising from a Clinical Services consultation will occur under the Elective Surgery contract. This contract purchases a package of care from a Lead Supplier (usually the hospital where the surgery occurs) to deliver all perioperative services and post-discharge care for a period of six weeks.

Non-Contracted Surgery

Where a client choses treatment with a provider who either does not hold the Elective Surgery Contract or is not a Named Provider with an Elective Surgery contract holder, treatment may proceed under Cost of Treatment Regulations (CoTR). An ARTP and ACC prior approval will still be required, but the published prices in the Elective Surgery contract will not necessarily apply. Further, the ARTP from the provider under CoTR will need to specify how peri- and post-operative care will be provided.

Use the same ARTP and contact details as for contracted surgery but specify in the ARTP that this will be performed under CoTR with detailed costings. ACC will usually fund 60% of the price for the surgery listed in the Elective Surgery contract (noting that these prices includes a full package of care from admission to discharge + 6 weeks). For Non-Core surgery we will consider the costings and the extent of care before reaching an appropriate agreement with you.

When ACC receives a request for non-contracted surgery, under the AC Act, ACC is responsible for informing the client that diagnosis and treatment can be undertaken by a contracted provider at no cost to them.

This information is given directly to the client in the decision letter 'ELE21 Surgery approved letter'. The client must sign the ACC7421 Elective Surgery Option Choice form and give this to their specialist or send it to ACC before they have their surgery. The signed form demonstrates an understanding and consideration of all the options available.

For information on ACC's liability to contribute see also: Regulation 18 of the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

8.4. Anaesthetic consultation on admission

This consultation is not paid for under the Clinical Services contract. It is included as part of the package of care for the approved surgery under the Elective Surgery Services contract.

As indicated above, the Anaesthetic Pre-Assessment Form should have been completed by the client at the earliest opportunity and made available to the anaesthetists as soon as possible. Elective Surgery Lead Suppliers should take responsibility for triaging these forms as they are presented and escalating to the anaesthetist according to agreed protocols, but we expect all clinicians to play their part in ensuring a smooth pathway to surgery, including ensuring anaesthetic pre-assessment is undertaken in a timely manner.

Note: Under this Clinical Services Contract, if the client has co-morbidities the provider needs to ensure they are assessed by a vocationally registered anaesthetist (preferably the anaesthetist who will attend the surgery) – see Pre-operative anaesthetic assessments. If the co-morbidities are identified as needing services outside the normal scope for this type of surgery, the provider should complete the relevant surgical ARTP section for a Non-Core Procedure, and forward it to the Surgical Lead Supplier for review and dispatch to ACC.

Example – An anaesthetic assessment under the Clinical Services Contract identifies that a client needs intensive monitoring, HDU, or ICU. The anaesthetist and referrer should identify a surgical Lead Supplier who has the resources to treat this patient safely. The draft ARTP referred to that Lead Supplier will reflect the anaesthetist's assessment, so the Lead Supplier can undertake an accurate costing of any legitimate non-core items required.

9. Medical Case Reviews and Medical Single Discipline Assessments

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

ACC uses a 'Provider Search Tool' to locate contracted specialists within regions and specialities for referrals. Our teams will usually send availability requests to the nominated contact for the contract holder prior to sending referrals. If you wish to have your contact details updated, please email elective.services@acc.co.nz

Note: Referrals for Medical Case Reviews and Medical Single Discipline Assessments may only be made by ACC. ACC will not pay for services where Clients self-refer or are referred other than by a treatment provider as set out under Clause 4.2 within the Service Schedule.

9.1. Declining a referral

The provider may decline a referral if:

- they cannot meet timeframes as set out under Clause 7.1 within the Service Schedule
- they do not have an appropriate medical specialist available in relation to the injury
- they consider that the referral is more appropriately managed under the Vocational Medical Services contract because:
  - it includes consideration of a client's employment as a major factor of the assessments;
  - an assessment by an occupational medicine specialist of work restrictions, limitations, fitness for work, the ability to engage in employment or the ability to participate in vocational rehabilitation is required.

The provider must notify ACC if the referral is declined.

9.2. Medical Case Reviews

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

- **CSM1 –** A Standard Medical Case Review is expected to take up to 3.5 hours.
- **CSM2** – A Complex Medical Case Review is expected to take more than 3.5 hours and less than 7.5 hours, as the Client's injury is of unusual complexity or there are co-morbidities that appear to be affecting the Client's recovery from injury; or the MCR will be undertaken in two parts whilst results of investigations are obtained.

Exceptional Medical Case Reviews

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

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

9.3. Medical Single Discipline Assessments

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

- **CSA1 –** A Standard Medical SDA is expected to take up to 2.5 hours.
- **CSA2 –** A Complex Medical SDA is expected to take more than 2.5 hours and less than 4.5 hours, as the Client's injury

is of unusual complexity or there are co-morbidities that appear to be affecting the Client's recovery from injury; or the Medical SDA will be undertaken in two parts whilst results of investigations are obtained.

Exceptional Medical Single Discipline Assessments

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

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

9.4. Reporting requirements for Medical Case Reviews and Medical Single Discipline Assessments

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

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

In addition, MCRs must include:

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

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

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

In addition, Medical SDA reports must include:

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

9.5. Timeframes for submitting MCR/Medical SDA report to ACC

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

9.6. Prioritising referrals

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

9.7. "Out of Town" Clinics

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

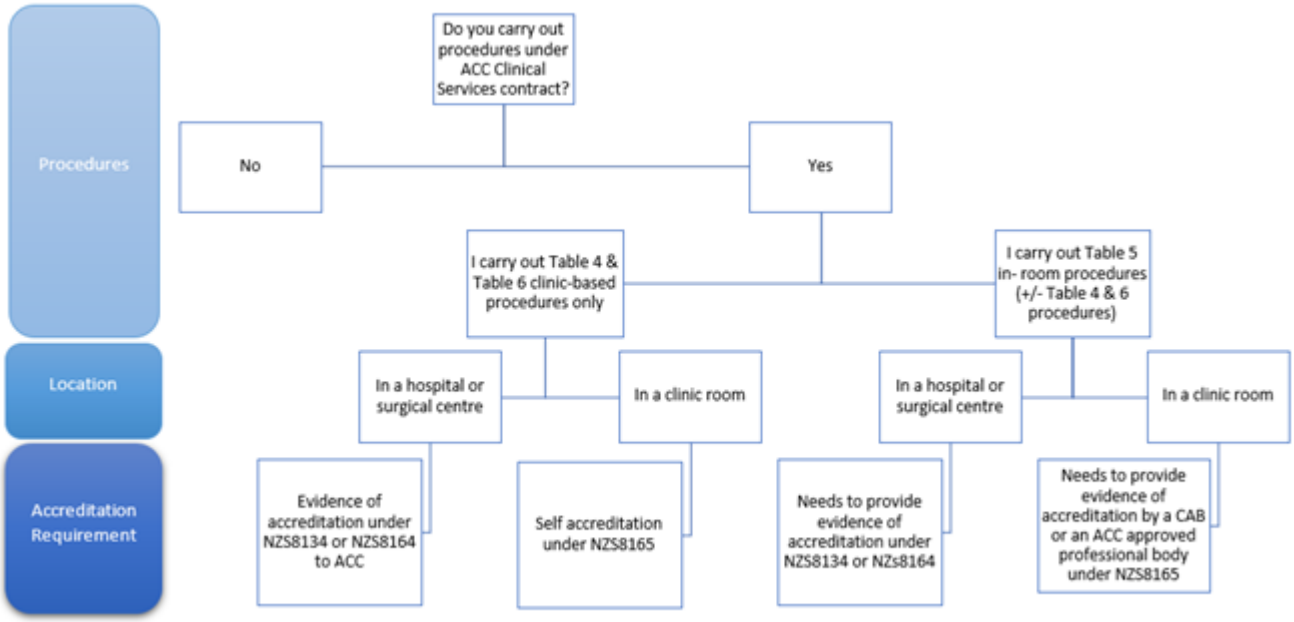
Table 3 – Medical Case Reviews and Medical Single Discipline Assessments

Procedure	Code	Definition	Treatment provider
Medical Case Review (Standard)	CSM1	Medical review to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Case Review (Complex)	CSM2	Medical review taking between 3.5 hours and 7.5 hours to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist
Medical Single Discipline Assessment (Standard)	CSA1	Medical assessment to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist
Medical Single Discipline Assessment (Complex)	CSA2	Medical assessment taking between 2.5 hours and 4.5 hours to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist

10. Procedures and Non-Surgical Pathways

The Clinical Services Contract has both Clinic-based and In-rooms procedures available as detailed in tables 4, 5 and 6. Procedures can only be performed by a named provider of the vocational type identified in the tables. Procedures must be performed at a location holding the appropriate accreditation.

Use this flowchart to determine what level of accreditation is required:



10.1. Clinic-based procedures

Clinic-based procedures are listed in Table 4 and Table 6 of the Clinical Services Contract.

- If performed in a hospital or surgical centre accreditation under NZS8134:2021 Ngā paerewa Health and Disability Services standard or NZS8164:2005 Standard for Day stay surgery and procedures must be evidenced.
- If performed in a clinic room self-audit under the NZS8165:2005 Rooms/Office based surgery and procedures standards must be evidenced.

Table 4 – Clinic Based Procedures

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Reduction of fractured nose	CST11	Closed reduction of displaced/fracture of nasal bones performed under local anaesthetic. This type of reduction will be performed for fractures of the nasal bones that are limited in size and complexity.	Otolaryngologist	• No prior approval required • Consultation included • Must not take place earlier than 7 days from the date of injury

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Flexi Cystoscopy	CST12	Flexi Cystoscopy	Urologist	• No prior approval required • Consultation included
Flexi Cystoscopy (with 300 units Botulinum Toxin)	CST14	Flexi Cystoscopy (with 300 units Botulinum Toxin.)	Urologist	• No prior approval required. • Consultation included • Includes 300 units of Botulinum Toxin
Urology Baskets	CSAB	Flexi Cystoscopy add on code for costs of urology baskets	Urologist	• No prior approval required • Can be invoiced in conjunction with Flexi Cystoscopy
Urology Dilators	CSAD	Flexi Cystoscopy add on code for costs of urology dilators	Urologist	• No prior approval required • Can be invoiced in conjunction with Flexi Cystoscopy
Urology Grasping and Biopsy Forceps	CSAG	Flexi Cystoscopy add on code for costs of urology grasping and biopsy forceps	Urologist	• No prior approval required • Can be invoiced in conjunction with Flexi Cystoscopy
Urology Guidewires	CSAW	Flexi Cystoscopy add on code for costs of urology guidewires	Urologist	• No prior approval required • Can be invoiced in conjunction with Flexi Cystoscopy
Supra Pubic Catheter Insertion	CST15	Supra Pubic Catheter Insertion	Urologist	• No prior approval required • Consultation included
Supra Pubic Catheter Change	CST16	Supra Pubic Catheter Change	Urologist	• No prior approval required • Consultation included
Removal of foreign bodies (not eye)	CST17	Removal of foreign bodies (not eye)	Orthopaedic Surgeon Plastic and Reconstructive Surgeon	• No prior approval required • Consultation included
Urodynamic Studies	CST18	Urodynamic Studies	Urologist	• No prior approval required • Consultation not included
Flow and residual test	CSD10	Test focused on the bladder's ability to empty steadily and completely	Urologist	• No prior approval • Additional to consultation
Removal foreign body – eye	CST41	Removal of foreign body from the eye	Ophthalmologist	• No prior approval required • Consultation included
YAG Laser Capsulotomy	CST42	YAG Laser Capsulotomy	Ophthalmologist	• No prior approval required • Consultation included
Removal of wire/screws	CST1	Removal of wire/screws	Orthopaedic Surgeon	• No prior approval required, but ACC must have funded the insertion of wire/screws • Consultation not included
Reapplication of plaster casts/ thermoplastic splints above knee	CST21	Reapplication of plaster casts/ thermoplastic splints above knee	Nurse under supervision of a specialist	• No prior approval required • Cannot be invoiced in conjunction with consultation cost if within 6-week post-operative period (otherwise consultation not included)

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Reapplication of plaster casts/ thermoplastic splints above elbow	CST22	Reapplication of plaster casts/ thermoplastic splints above elbow	Nurse under supervision of a specialist	• No prior approval required • Cannot be invoiced in conjunction with consultation cost if within 6-week post-operative period (otherwise consultation not included)
Reapplication of plaster casts/ thermoplastic splints below knee	CST31	Reapplication of plaster casts/ thermoplastic splints below knee	Nurse under supervision of a specialist	• No prior approval required • Cannot be invoiced in conjunction with consultation cost if within 6-week post-operative period (otherwise consultation not included)
Reapplication of plaster casts/ thermoplastic splints below elbow	CST32	Reapplication of plaster casts/ thermoplastic splints below elbow	Nurse under supervision of a specialist	• No prior approval required • Cannot be invoiced in conjunction with consultation cost if within 6-week post-operative period (otherwise consultation not included)
Optical Coherence Tomography (OCT) scan (unilateral and bilateral)	CSD40 and CSD41	Measurement of the thickness of the macula, the tissue make-up of the nerve fibre layer or to analyse individual layers of the retina. OCT is also used to analyse the optic nerve head in glaucoma	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included
Visual Field Test-unilateral (ophthalmology)	CSD42	Determining a patients peripheral vision (side) vision - one eye	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included
Visual Field Test-bilateral (ophthalmology)	CSD43	Determining a patients peripheral vision (side) vision - two eyes	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included
Orthoptic assessment (for a child or an adult)	CSD44 and CSD45	Assessment of the eye movements and binocular vision disorders	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included
Fluorescein angiography	CSD46	Test used to assess the health of certain blood vessels in the eye. In this test, fluorescein dye is injected into a vein in the arm and photographs are taken of the eye as the dye circulates.	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included
Corneal Topography	CSD47	Corneal topography	Ophthalmologist Medical Orthoptist	• No prior approval • Consultation not included

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Internal Examination for Maternal Birth Injury	CSD15	Internal examination to assess Maternal Birth Injury	Gynaecologist Obstetrician Urologist	• No prior approval • Consultation not included

Table 4 – Clinic Based Procedures (Injections)

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Non-guided injections (landmark)				
Initial non-guided injection: non-spinal	CSP30	Initial injection and/or aspiration, including the use of local anaesthetic and/or steroid into peripheral joint, bursa, or around peripheral nerve.	Orthopaedic Specialist Musculoskeletal Medicine Specialist Sports & Exercise Physician Anaesthetist Specialist Pain Medicine Physician	Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary non-guided injection: non-spinal	CSP30A	Secondary injection and/or aspiration, including the use of local anaesthetic and/or steroid into joint, bursa, or around peripheral nerve.		To be used when performing more than one injection in a consultation
Initial non-guided injection: spinal	CSP31	Initial injection and/or aspiration, including the use of local anaesthetic and/or steroid into spinal joint, or nerve.		Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary non-guided injection: spinal	CSP31A	Secondary injection and/or aspiration, including the use of local anaesthetic and/or steroid into spinal joint, or nerve.		To be used when performing more than one injection in a consultation
Ultrasound-Guided Injections				
Initial ultrasound guided injection	CSP32	Initial injection and/or aspiration, including the use of local anaesthetic and/or steroid into joint, bursa, or around peripheral nerve. Requiring Ultrasound.	Orthopaedic Specialist Musculoskeletal Medicine Specialist Sports & Exercise Physician Anaesthetist Specialist Pain	Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary ultrasound guided injection	CSP32A	Secondary injection and/or aspiration, including the use of local anaesthetic and/or steroid into joint, bursa, or around peripheral nerve. Requiring Ultrasound.		To be used when performing more than one injection in a consultation

			Medicine Physician	
Image-Guided Injections 'Imaging' includes the use of x-ray, fluoroscopy, or image intensifier only				
Initial image guided injection: non-spinal	CSP33	Initial injection and/or aspiration, including the use of local anaesthetic and/or steroid into joint, bursa, or around peripheral nerve. Requiring imaging	Orthopaedic Specialist Musculoskeletal Medicine Specialist Sports & Exercise Physician Anaesthetist Specialist Pain Medicine Physician	Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary image guided injection: non-spinal	CSP33A	Secondary injection and/or aspiration, including the use of local anaesthetic and/or steroid into joint, bursa, or around peripheral nerve. Requiring imaging		To be used when performing more than one injection in a consultation
Initial image guided injection: spinal	CSP34	Initial injection and/or aspiration, including the use of local anaesthetic and/or steroid into spinal joint, or nerve. Requiring imaging		Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary image guided injection: spinal	CSP34A	Secondary injection and/or aspiration, including the use of local anaesthetic and/or steroid into spinal joint, or nerve. Requiring imaging		To be used when performing more than one injection in a consultation
Initial image guided injection: atlantoaxial	CSP35	Initial lateral atlantoaxial injection steroid and/or local anaesthetic Requiring imaging		Prior approval required for 3rd and each subsequent injection Consultation not included
Secondary image guided injection: atlantoaxial	CSP35A	Secondary lateral atlantoaxial injection steroid and/or local anaesthetic Requiring imaging		To be used when performing more than one injection in a consultation

Nerve Blocks

Medial branch block (Simple)	CSP15	Injection of small volumes of local anaesthetic into the medial branches of the lumbar or cervical dorsal rami to see whether one or more of the related z-joints are responsible for a patient's back pain. Up to and including 2 levels	Anaesthetist Pain Medicine Specialists Musculoskeletal Specialists Neurologists	Prior approval required for 3rd and subsequent injection Consultation not included
Medial branch block (Complex)	CSP16	Injection of small volumes of local anaesthetic into the medial branches of the lumbar or cervical dorsal rami to see whether one or more of the related z-joints are responsible for a patient's back pain. 3+ levels		Prior approval required for 3rd and subsequent injection Consultation not included
Radiofrequency Neurotomy - lumbar (Simple)	CSP17	A needle inserted beside a spinal nerve has current passed through it to produce heat and coagulate the nerve proteins. Up to and including 2 levels		Prior approval required Consultation not included
Radiofrequency Neurotomy – lumbar (Complex)	CSP18	A needle inserted beside a spinal nerve has current passed through it to produce heat and coagulate the nerve proteins. 3+ Levels		Prior approval required Consultation not included
Radiofrequency Neurotomy – cervical (simple)	CSP19	A needle inserted beside a spinal nerve has current passed through it to produce heat and coagulate the nerve proteins. Up to and including 2 levels		Prior approval required Consultation not included
Radiofrequency Neurotomy – cervical (complex)	CSP20	A needle inserted beside a spinal nerve has current passed through it to produce heat and coagulate the nerve proteins. 3+ Levels		Prior approval required Consultation not included

Note: Injections do not include autologous blood injections (ABI), platelet-rich plasma (PRP) injections and/or prolotherapy. ACC does not fund these procedures.

Table 6 – Pre-operative Clinic Based Procedure

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Echocardiogram (Echo)	CSD1	Ultrasound scan of the heart (for Clients pre-operatively only)	Cardiologist Cardiac Sonographer	• Surgical ARTP must be approved prior to undertaking
Stress Echocardiogram (Stress Echo)	CSD2	Stress induced by exercise machine or Pharmacological agent if machine stress not appropriate and recorded via ultrasound (for Clients pre-operatively only)	Cardiologist Cardiac Sonographer	• Surgical ARTP must be approved prior to undertaking
Respiratory Spirometry	CSD3	Pulmonary function test, which measures the volume of air inspired or expired as a function of time (for Clients pre-operatively only)	Cardiologist Respiratory Technician	• Surgical ARTP must be approved prior to undertaking
Exercise treadmill	CSD4	Machine exercise while being monitored for ECG and Blood Pressure (for Clients pre-operatively only)	Cardiologist Technician	• Surgical ARTP must be approved prior to undertaking

Electrocardiogram (ECG)	ECG	An electrocardiogram is a recording of the electrical activity of the heart.
		
		The referring Named Provider is responsible for ensuring the treatment provider to whom they refer the Client has suitably qualified and trained staff to undertake the procedure and that all quality and safety standards are met.
			Medical Staff
			
			Technician
				• Surgical ARTP must be approved prior to undertaking
				• This procedure fee can be charged when an ECG is not part of an assessment (i.e. completed offsite).
				• Public Hospitals are responsible for ECGs related to public health acute services
				• This diagnostic test is included in the consultation price if part of:
				  ○ A preoperative anaesthetic assessment OR
				  ○ a cardiology assessment second opinion

10.2. Further notes regarding clinic-based procedures

10.2.1. Flexi Cystoscopy Add-On codes

Flexi Cystoscopy add-on codes for urology baskets, dilators, grasping and biopsy forceps or guidewires (CSAB-CSAW) are available. These codes can be invoiced in conjunction with Flexi Cystoscopy procedure code (CST12).

10.2.2. Urodynamic Studies

The service item CST18 (Urodynamic Studies) is available without prior approval and reflects the cost of a simple, in-rooms procedure. For more complex clients (such as spinal) the supplier is able to seek additional funding by submitting a Clinical Services ARTP (CSARTP) outlining the additional costs for approval.

10.2.3. Pre-operative procedures

These procedures occur after the surgery has been approved but do not form part of the package of care under the Elective Surgery contract. Accordingly, they may be charged for under the Clinical Services contract.

Pre-operative tests are used to determine 'fit for surgery' status and must all have an approved surgical request before being undertaken. These tests cover:

- Echocardiogram
- Stress echo
- Respiratory spirometry
- Exercise treadmill
- Electrocardiogram (ECG).

Note: If a surgical ARTP has not been approved before these tests are performed, ACC will decline payment.

Note: Non-prior approval (NPA) surgical procedures are exempt from this requirement and may be performed as necessary once the decision has been made to proceed with a NPA surgery.

10.2.4. Interventional procedures (Injections)

The Clinical Services Contract complements the Pain Management Services contract to provide more efficient and timely access to diagnosis and treatment for clients who have an ACC covered injury and are experiencing pain.

These interventions are intended only for clients whose complexity does not warrant referral to the pain management service. For such clients who do not have a specific chronic pain diagnosis (measured by the OREBRO score), the referral pathway would be through Clinical Services contract for diagnosis and treatment. Injection codes have been developed for these diagnostic and treatment procedures. ACC expects that clinicians requesting these procedures will perform the required workup to ensure only clients suitable for the interventions receive them.

Note: These injection codes may not be used in conjunction with the High-Tech Imaging contract. If a Radiologist performs the procedure, the Radiologist should invoice ACC under their High-Tech Imaging contract. ACC's expectation is that these procedures are to be performed by a suitably experienced specialist.

10.2.5. Subsequent injections

Subsequent injection codes (CS30A – C35A) are intended for when more than one procedure is provided during the same consultation. Up to 2 injections can be provided without Prior approval. Prior approval for the third and subsequent injections should be made using the CSARTP.

Note: Where a specialist has doubt over whether the proposed treatment is appropriate, they should complete and submit a CSARTP.

10.2.6. Medial Branch Block and Radiofrequency Neurotomy

These interventional spine procedures can be either Simple or Complex depending on clinical best practice and the number of injection sites.

Medial Branch Blocks are considered a diagnostic procedure. Up to 2 Medial Branch Block procedures can be provided without Prior Approval, however Prior Approval can be sought at any stage if the clinical picture is unclear.

A Radiofrequency Neurotomy may be requested via CSARTP following a Diagnostic Medical Branch Block where facet joints are determined to be the source of pain. The specialists undertaking these procedures must be informed by the current Spine Intervention Society (SIS) Practice Guidelines for Spinal Diagnostic and Treatment Procedures.

Note: Medial Branch Blocks and Radiofrequency Neurotomy can **only** be performed by Anaesthetists, Pain Medicine Specialists, Musculoskeletal Specialists or Neurologists.

10.3. In-rooms procedures

In-rooms procedures are listed in Table 5 of the Clinical Services Contract.

- If performed in a hospital or surgical centre accreditation under NZS8134:2021 Ngā paerewa Health and Disability Services standard or NZS8164:2005 Standard for Day stay surgery and procedures must be evidenced.
- If performed in a clinic room accreditation under NZS8165:2005 Rooms/Office based surgery and procedures by a CAB or an ACC approved professional body must be evidenced.

Note: Where a specialist wishes to perform a procedure that doesn't have a contracted code, they should complete and submit a CSARTP to ACC. This should provide details of the intended procedure, along with costings. ACC will consider and if approved, a purchase order will be supplied with an appropriate code to be used at invoicing.

Table 5 – Rooms/Office Based Surgery and Procedures

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Revision of Scar/s	CST23 CST24 CST25	Revision of scar/s – all body sites. Funded according to incision length	Plastic and Reconstructive Surgeon	Consultation included
Excision post traumatic inclusion cyst	CST28	Excision post traumatic inclusion cyst	Plastic and Reconstructive Surgeon	
Lid /Adnexa – lid surgery – minor	CST40	Minor eye lid surgery	Ophthalmologist Plastic and Reconstructive Surgeon	
Tympanostomy/Myringotomy	CST60	Surgical incision into the eardrum and insertion of grommet	Otolaryngologist	
Myringoplasty - simple +/- patch	CST61	Procedure to close a hole in the eardrum	Otolaryngologist	
Laser treatment	CST80	Laser treatment for scar management	Plastic and Reconstructive Surgeon and Dermatologist	
Removal of foreign bodies	CSH01 CSH02	Removal of foreign bodies in the same anatomical region. Funded according to number of foreign bodies	Red listed Plastic Surgeon Red listed Orthopaedic Hand Surgeon Or, member of NZ Society for Surgery of the Hand (NZSSH)	Consultation included
Removal of K wires	CSH03	Removal of K wires		
Repair extensor tendon	CSH04 CSH05	Repair extensor tendon – digit/hand/wrist/ forearm Funded according to number of tendons/nerve		
Repair flexor tendon	CSH06 CSH07 CSH08	Repair flexor tendon – digit/hand/wrist/ forearm Funded according to number of tendons/nerve and anatomical region.		

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Repair digital nerve	CSH09	Repair digital nerve		
Fingernail bed repair	CSH10	Fingernail bed repair		
Amputation of digit	CSH11	Amputation of digit		
Tenolysis	CSH50 CSH52	Simple – digit/hand/wrist/ forearm Flexor/extensor	Red listed Plastic Surgeon Red listed Orthopaedic Hand Surgeon Or, member of NZ Society for Surgery of the Hand (NZSSH)	
Release	CSH51 CSH53	Trigger finger release De Quervain's (radial styloid tenosynovitis) release		
Secondary (Delayed) repair of digital nerve or superficial radial nerve	CSH54	Secondary (Delayed) Repair of Digital Nerve or superficial radial nerve: includes longer incision, more dissection, freshening of the nerve ends neurolysis and repair. Does not include cost of nerve wrap See implant code below	Red listed Plastic Surgeon Red listed Orthopaedic Hand Surgeon Or, member of NZ Society for Surgery of the Hand (NZSSH)	Prior-approval required Consultation included
Implant costs	CSH55	Cost for nerve wrap (actual and reasonable)		
Neurolysis of digital nerve or superficial radial nerve	CSH56	Neurolysis of digital nerve or superficial radial nerve		
Carpal Tunnel (includes neurolysis)	CSH57	Carpal Tunnel (includes neurolysis)		

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Fingernail bed reconstruction	CSH58	Fingernail bed reconstruction		
Revision amputation digit	CSH59 CSH60	Revision amputation digit Simple – (nail spicule excision) Complex – including revision amputation simple and terminalisation of the phalanx, removal of neuroma(s) and neurolysis		Prior-approval required Consultation included

10.3.1. In-Rooms Wrist and Hand Procedures

These procedures are to be performed using the WALANT (wide-awake, local anaesthetic, no torniquet) surgical technique. Some procedures require prior approval via the CSARTP. All procedures have a limit of two per claim – prior approval via CSARTP is required for anything outside of this.

- Procedures **must** be performed by a vocationally registered orthopaedic or plastic surgeon.
- They also **need** to be a member of the NZ Society for Surgery of the Hand (NZSSH) or a Wrist and Hand Red List approved orthopaedic or plastic surgeon.

The price of the procedure includes the collection of a patient reported outcome measure on the day of procedure and at six weeks post procedure.

This data needs to be collected by providers and submitted to us when we request it. This will help measure client improvement and better understand the value of this service. The Patient-Rated Wrist Evaluation (PRWE) has been proposed by the sector as an appropriate outcome measure for this surgery cohort.

Note: In-rooms procedures should not be invoiced under the Elective Surgery contract.

10.4. Prior Approval

Some procedures require prior approval, this is submitted to ACC using the Clinical Services ARTP (CSARTP)

The CSARTP should include:

- Current diagnosis
- Specialists clinical opinion on the link between diagnosis, mechanism of injury and treatment required (causal link)
- Prognosis and expectations for recovery
- Supporting documentation e.g. referral, clinical notes, radiology reports
- A breakdown of costs (where the procedure has no contract code)

Note: Where a specialist has doubt over whether an injury is caused by an accident or whether proposed treatment is appropriate, they should complete and submit a CSARTP.

Note: Where a specialist wishes to perform a procedure that doesn't have a contracted code, they should complete and submit a CSARTP to ACC. This should provide details of the intended procedure, along with costings. ACC will consider and if approved, a purchase order will be supplied with an appropriate code to be used at invoicing.

11. Orthotics and Moonboots

Moonboots and simple orthoses can be provided using the following codes:

- **CSE1** - Moonboots provided by Specialists are paid at actual and reasonable price (noting that wholesale prices for moonboots can be found in the $75-$100 range)
- **CSE2** - Simple orthoses provided by Specialists at a capped contract amount.

Note: These services are limited to one per claim.

Note: More expensive moonboots and orthoses, priced above the Service Item price caps, will require ACC pre-approval. Where more complex orthoses are required, referral should be made to an Orthotist.

Note: These codes should only be used for moonboots or simple orthoses being provided **outside** of Public Health Acute Services (PHAS) timeframes or >6 weeks post-discharge from Elective Surgery. They're not to be used for other aids and appliances eg. Glasses, lenses etc.

12. Providing Clinical Notes/Records

Reports, notes or letters related to Client's assessments and treatments **must** be submitted within 7 working days of the assessment/treatment.

These notes can be sent to ACC via electronic transmission using Healthlink EDI; **ACCSPECR** or can be sent by email to claimsdocs@acc.co.nz.

More information on what products are available to do this can be found here: Sending patient notes (acc.co.nz)

13. Service Monitoring

13.1. How will performance be monitored?

Service monitoring for this service is based on an outlier approach by comparing supplier billing data, across a number of metrics, with those of their peers. The purpose of the monitoring is to understand how our suppliers operate, to ensure that suppliers adhere to Part B, Clause 2 of the service schedule, and identify performance issues where they might exist.

ACC will provide suppliers with their reports on a six-monthly basis; these reports will include (but is not limited to):

- General claim data (spend, volume, claim count, average consults per claim)
- Complex vs. simple initial and subsequent assessments
- The use of reassessment codes
- Neurology assessments
- Medical Case Reviews, Medical Single Discipline Assessments and DNA codes – ratios of simple, complex and exceptional
- Exception reporting for consultations invoiced within the 6-week post elective surgery discharge period
- Exception reporting for reassessment codes invoiced within 12 months of a consultation

Suppliers might be asked to meet with their Engagement and Performance Manager to discuss their data and any outlier results. If the service monitoring identifies performance issues your Engagement and Performance Manager will work with you on a resolution.

14. Payments

14.1. How do I get paid?

Payment will only be made for services provided by the contract holder (if an individual) or by named providers on a contract held by a multi-provider entity such as a hospital.

ACC's method of invoicing for services is electronic billing which makes the process faster, easier, and more efficient. Instructions on how to send in invoices electronically can be found on the ACC website. ACC needs the completed documentation before paying for the service provided.

The payment will be made to the supplier who holds the contract. If you are a provider named on a supplier's contract you will need to discuss with the supplier how they will forward payment to you.

Note: The Clinical Services contract is a named provider contract – you need to include your service provider's unique Provider Number when billing us for any services delivered under this contract. This will allow us to pay you promptly.

14.2. Invoicing for specialist tests and procedures

Please send invoices directly to the processing centre (providerinvoices@acc.co.nz) and not to the Recovery Team Member. However, if the specialist test is not listed in the Clinical Services contract or the Cost of Treatment Regulations, then the specialist would need to send a CSARTP to (prior.approval@acc.co.nz) for consideration. If approved, they will be provided with a purchase order number which can then be quoted on their invoice and sent directly to the processing centre.

15. Appendix 1 – Summary of Changes Log

History of changes to Operational Guidelines

Summary of changes 1 July 2023

Clause	Overview of Change
(Page 5) Useful Contact Information	Updated with current contact phone and email details
3. Who can hold this contract	Wording update
6. General Assessments	○ Wording update ○ Addition of DNA information
6.3. Telehealth Assessments	Wording update to align with ACC Telehealth Guide
6.6. Neurophysiological Assessments	References to 'Neurologist' replaced with 'Internal Medical Specialist'
8. Surgical treatment pathway	○ Clarification on what is required in the ARTP ○ Addition to the approval process ○ Wording update to non-contracted surgery
9. Medical Case Reviews and Medical Single Discipline Assessments	Reordered and wording updated Addition of provider search tool details
10. Procedures and non-surgical pathways	Updated to include: ○ Flowchart for accreditation ○ Clarification on what is required in the CSARTP ○ Tables 4, 5 and 6 from the contract ○ New injection codes
12. Providing clinical notes	New clause inserted
Appendix I – FAQs	Removed and replaced in relevant sections of the operational guidelines
Appendix II – FAQs for MCRs	Removed and replaced in relevant sections of the operational guidelines
Appendix III – CSARTP	Removed, is available on ACC website
Appendix I – Summary of changes log	Place holder for history of changes to these guidelines