SERVICE SCHEDULE FOR CLINICAL SERVICES

CONTRACT NO: _____

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING CLINICAL SERVICES

1.1 The Term for the provision of Clinical Services is the period from the date of both signing by both parties ("Start Date") until the close of 30 June 2024 ("End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

1.2 Prior to the End Date, the parties may agree in writing to extend the Term of this Service Schedule for a maximum of two further terms off two years each. Any decision to extend the Term of this Service Schedule will be based on:

1.2.1 the parties reaching agreement on the extension in writing prior to the End Date; and,

1.2.2 ACC being satisfied with your performance and delivery of the Services; and

1.2.3 all other provisions of this Contract either continuing to apply during such extended Term(s) or being re-negotiated to the satisfaction of both parties.

1.3 There is no obligation on the part of ACC to extend the Term of this Service Schedule, even if the Supplier has satisfactorily performed all the Services.

2. SERVICE LOCATION (PART B, CLAUSE 4)

_____.

3. ROOMS/OFFICE BASED SURGERY FACILITIES (PART B, CLAUSE 6.2.2)

Rooms Based Procedures (Table 5) and Clinic Based Procedures (Tables 4 and 6) are only able to be provided at the following facilities in accordance with Part B, clause 6.2:

Facility Name

4. NAMED PROVIDERS (PART B, CLAUSE 6.3)

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

5. SERVICE ITEMS AND PRICES (PART B, CLAUSE 16)

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
Clinical Service Assessments							
	■		CS100	CS10	Simple Assessment (Initial)	$194.48	Per consultation
	■		CS1T	CS1T	Simple Assessment (Initial) - Telehealth	$194.48	Per consultation
	■		CS200	CS20	Complex Assessment (Initial)	$297.99	Per consultation
	■		CS2T	CS2T	Complex Assessment (Initial) - Telehealth	$297.99	Per consultation

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CS250	CS25	Simple Pre-operative Anaesthetic Assessment (Initial)	$194.48	Per consultation Must meet requirements in clause 7.2
			CS260	CS26	Complex Pre-operative Anaesthetic Assessment – (Initial)	$297.99	Per consultation Must meet requirements in clause 7.2
			CS400	CS40	Second Opinion Assessment	$194.48	Per consultation
			CS500	CS50	Reassessment	$194.48	Per consultation
			CS61	CS61	Subsequent Assessment (Simple)	$131.71	Per consultation
			CS61T	CS61T	Subsequent Assessment (Simple) - Telehealth	$131.71	Per consultation
			CS62	CS62	Subsequent Assessment (Complex)	$194.48	Per consultation
			CS62T	CS62T	Subsequent Assessment (Complex) - Telehealth	$194.48	Per consultation
			CS70	CS70	Anaesthetic Telehealth consultation for administrative or clarification purposes	$67.21	Per consultation
			CS83	CS83	Neurophysiological consultation by a neurologist including testing which may be administered by a neurophysiologist commissioned by a neurologist	$549.43	Neurophysiological study and consultation by Neurologist

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
	■		CS84	CS84	Simple Neurophysiologica l Follow up	$183.88	Simple Neurophysiologic al Follow up and consultation by Neurologist
	■		CS85	CS85	Complex Neurophysiologica l Follow up	$549.43	Complex Neurophysiologic al Follow up and consultation by Neurologist
	■		CS900	CS90	Second Opinion Assessment (Complex)	$297.99	Per consultation
Moonboots and Simple Orthotics							
			CSE1	CSE1	Moonboot – limited to one moonboot per claim	Actual and reasonable costs (up to $329.66)	Per claim
			CSE2	CSE2	Simple Orthotics – limited to one orthotic per claim	Actual and reasonable costs (up to $329.66)	Per claim
Clinical Services Diagnostic Procedures (approved surgical request required)							
			CSD1	CSD1	Echocardiogram (Echo)	$591.82	Per test
			CSD2	CSD2	Stress Echo	$1,029.88	Per test
			CSD3	CSD3	Respiratory Spirometry	$98.27	Per test
			CSD4	CSD4	Exercise Treadmill	$466.58	Per test
			ECG	ECG	Electrocardiogram	$67.21	Per test
Clinical Service Diagnostic Procedures							
			CSD10	CD10	Flow and residual test	$141.32	Per test
			CSD40	CD40	OCT scan – unilateral	$243.94	Per test
			CSD41	CD41	OCT scan – bilateral	$296.86	Per test
			CSD42	CD42	Visual Field Test – unilateral	$86.58	Per test

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSD43	CD43	Visual Field Test – bilateral	$110.92	Per test
			CSD44	CD44	Orthoptic assessment – child	$144.20	Per test
			CSD45	CD45	Orthoptic assessment – adult	$166.80	Per test
			CSD46	CD46	Fluorescein angiography	$567.46	Per test
			CSD47	CD47	Corneal Topography	$205.55	Per procedure
			CSD15	CD15	Internal Examination for Maternal Birth Injury	$106.43	Per procedure
Clinical Services Pain Diagnosis and Treatment							
			CSP30	CS30	Initial non-guided injection: non-spinal	$79.60	Per procedure
			CSP30A	C30A	Secondary non-guided injection: non-spinal	$46.08	Per procedure
			CSP31	CS31	Initial non-guided injection: spinal	$123.15	Per procedure
			CSP31A	C31A	Secondary non-guided injection: spinal	$46.08	Per procedure
			CSP32	CS32	Initial ultrasound-guided injection	$220.98	Per procedure
			CSP32A	C32A	Secondary ultrasound-guided injection	$93.21	Per procedure
			CSP33	CS33	Initial image-guided injection: non-spinal	$390.13	Per procedure
			CSP33A	C33A	Secondary image-guided injection: non-spinal	$132.50	Per procedure

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSP34	CS34	Initial image-guided injection: spinal	$627.67	Per procedure
			CSP34A	C34A	Secondary image-guided injection: spinal	$227.37	Per procedure
			CSP35	CS35	Initial image-guided injection: atlantoaxial	$435.04	Per procedure
			CSP35A	C35A	Secondary image-guided injection: atlantoaxial	$167.74	Per procedure
			CSP15	CS15	Medial Branch Block (Simple)	$1,117.85	Per procedure
			CSP16	CS16	Medial Branch Block (Complex)	$1,453.21	Per procedure
Yes			CSP17	CS17	Radiofrequency Neurotomy – Lumbar (Simple)	$2,907.44	Per procedure
Yes			CSP18	CS18	Radiofrequency Neurotomy – Lumbar (Complex)	$3,873.10	Per procedure
Yes			CSP19	CS19	Radiofrequency Neurotomy – Cervical (Simple)	$3,873.10	Per procedure
Yes			CSP20	CS2X	Radiofrequency Neurotomy – Cervical (Complex)	$4,608.41	Per procedure
Clinical Service Treatment							
			CST1	CST1	Removal of wire/screws	$22.39	Per procedure
			CST21	CT21	Reapplication of plaster casts/ thermoplastic splints above knee	$209.08	Per application

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CST22	CT22	Reapplication of plaster casts/ thermoplastic splints above elbow	$174.22	Per application
			CST31	CT31	Reapplication of plaster casts/ thermoplastic splints below knee	$174.22	Per application
			CST32	CT32	Reapplication of plaster casts/ thermoplastic splints below elbow	$150.96	Per application
			CST11	CT11	Closed reduction of displaced/ fracture of nasal bones	$708.07	Per procedure
			CST12	CT12	Flexi Cystoscopy	$763.65	Per procedure
			CST14	CT14	Flexi Cystoscopy (with 300 units Botulinum Toxin)	$3,217.48	Per procedure
			CSAB	CSAB	Urology Baskets	Actual and reasonable costs	Per item
			CSAD	CSAD	Urology Dilators	Actual and reasonable costs	Per item
			CSAG	CSAG	Urology Grasping and Biopsy Forceps	Actual and reasonable costs	Per item
			CSAW	CSAW	Urology Guidewires	Actual and reasonable costs	Per item
			CST15	CT15	Supra Pubic Catheter Insertion	$573.83	Per procedure
			CST16	CT16	Supra Pubic Catheter Change	$573.83	Per procedure
			CST17	CT17	Removal of foreign bodies (not eye (under local)	$483.70	Per procedure

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CST18	CT18	Urodynamic studies	$1,226.65	Per procedure
			CST23	CT23	Revision of Scar/s < 5cm	$745.14	Per procedure
			CST24	CT24	Revision of Scar/s 5-10cm	$1,124.10	Per procedure
			CST25	CT25	Revision of Scar/s 10-20cm	$1,413.16	Per procedure
			CST28	CT28	Excision post traumatic inclusion cyst	$732.31	Per procedure
			CST40	CT40	Lid/Adnexa - lid surgery – minor	$798.62	Per procedure
			CST41	CT41	Removal foreign body – eye	$422.37	Per procedure
			CST42	CT42	YAG Laser Capsulotomy	$478.06	Per procedure
			CST60	CT60	Tympanostomy/ Myringotomy	$616.66	Per procedure
			CST61	CT61	Myringoplasty - simple +/- patch	$1,396.60	Per procedure
			CST80	CT80	Laser treatment – (for dermatologists and plastics only)	$1,095.54	Per procedure
Medical Case Reviews and Medical Single Discipline Assessments							
			CSM1	CSM1	Standard Medical Case Review (MCR) This service must be requested by ACC	$1,216.77	Per Medical Case Review
			CSM1T	CSM1T	Standard Medical Case Review (MCR) – Telehealth This service must be requested by ACC	$1,216.77	Per Medical Case Review

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSM2	CSM2	Complex Medical Case Review (MCR) This service must be requested by ACC	$1,807.79	Per Medical Case Review
			CSM2T	CSM2T	Complex Medical Case Review (MCR) – Telehealth This service must be requested by ACC	$1,807.79	Per Medical Case Review
			CSA1	CSA1	Standard Medical Single Discipline Assessment (SDA) This service must be requested by ACC	$741.95	Price per Medical Single Discipline Assessment
			CSA1T	CSA1T	Standard Medical Single Discipline Assessment (SDA) – Telehealth This service must be requested by ACC	$741.95	Price per Medical Single Discipline Assessment
			CSA2	CSA2	Complex Medical Single Discipline Assessment (SDA) This service must be requested by ACC	$1,083.91	Per Medical Single Discipline Assessment
			CSA2T	CSA2T	Complex Medical Single Discipline Assessment (SDA) – Telehealth This service must be requested by ACC	$1,083.91	Per Medical Single Discipline Assessment

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSN1	CSN1	Non-attendance fee is payable when a Client fails to attend a scheduled appointment for a MCR without giving two working days prior notification to the Service Provider. The Service Provider must notify the Client's Claims Manager	$528.31	Per Client (Max 1)
			CSU	CSU	Un-booked Appointment time is payable when a Supplier travels to an area outside their usual service area at the request of ACC and there is an unfilled appointment time within the block booking. Only payable for appointments which are never filled and where the Non-Attendance fee cannot be claimed. Maximum of 4 hours per day	$153.45	per hour or part thereof
In Rooms Hand Procedures							
	■	■	CSH01	CSH1	Removal of 1-3 Foreign bodies in the same anatomical region	$2,160.88	Per procedure

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSH02	CSH2	Removal of 4 or more Foreign bodies in the same anatomical region	$2,732.22	Per procedure
			CSH03	CSH3	Removal of K wires	$1,868.23	Per procedure
			CSH04	CSH4	Repair extensor tendon – digit/hand/wrist/forearm Simple – 1 tendon	$3,321.59	Per procedure
			CSH05	CSH5	Repair extensor tendon – digit/hand/wrist/forearm Complex – 1 tendon and nerve or 2 tendons	$4,273.81	Per procedure
			CSH06	CSH6	Repair flexor tendon – digit/hand	$4,464.26	Per procedure
			CSH07	CSH7	Repair flexor tendon- wrist/forearm Simple – 1 tendon	$3,321.59	Per procedure
			CSH08	CSH8	Repair flexor tendon – write/forearm Complex – 1 tendon and nerve or 2 tendons	$4,273.81	Per procedure
			CSH09	CSH9	Repair Digital nerve	$2,560.34	Per procedure
			CSH10	CSHX	Fingernail bed repair	$2,351.32	Per procedure
			CSH11	CH11	Amputation of digit	$2,732.22	Per procedure
			CSH50	CH50	Tenolysis flexor tendon – simple – digit/hand/wrist/forearm	$2,732.75	Per procedure

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSH51	CH51	Trigger finger release	$2,732.75	Per procedure
			CSH52	CH52	Tenolysis extensor tendon – simple – digit/hand/wrist/forearm	$2,542.30	Per procedure
			CSH53	CH53	De Quervain's (Radial styloid tenosynovitis) release	$2,550.79	Per procedure
			CSH54	CH54	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	$3,322.12	Per procedure
			CSH55	CH55	Implant cost for nerve implant	Actual and reasonable costs	Per item
			CSH56	CH56	Neurolysis of digital nerve or superficial radial nerve	$2,542.83	Per procedure
			CSH57	CH57	Carpal Tunnel (includes neurolysis)	$2,732.75	Per procedure
			CSH58	CH58	Fingernail bed reconstruction	$2,748.66	Per procedure
			CSH59	CH59	Revision amputation digit simple (Nail Spicule Excision) (updated)	$2,161.41	Per procedure

Prior Approval required	Includes Consultation	Rooms Based Procedure	Service Item Code	Short code for electronic billing	Service Item Definition	Prices (Ex GST)	Pricing Unit
			CSH60	CH60	Revision Amputation digit complex including revision amputation simple and terminalisation of the phalanx, removal of neuroma(s) and neurolysis) (updated)	$2,732.75	Per procedure

6. RELATIONSHIP MANAGEMENT (PART B, CLAUSE 15)

Level	ACC	Supplier
Client	Recovery Team/Recovery Team Member	Individual staff or operational contact
Relationship and performance management	Engagement and Performance Manager	Operational contact/National Manager
Service management	Portfolio Team or equivalent	National Manager

7. ADDRESSES FOR NOTICES (STANDARD TERMS AND CONDITIONS, CLAUSE 23)

NOTICES FOR ACC TO:

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

NOTICES FOR SUPPLIER TO:

_____
_____
_____ (for deliveries)
_____
_____
_____ (for mail)
_____
_____ _____
Marked: Attention: _____ _____, _____
Phone: _____
Mobile: _____
Email: _____

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B. SERVICE SPECIFICATIONS FOR CLINICAL SERVICES

1. PURPOSE

1.1. ACC wishes to purchase Clinical Services.

1.2. The purposes of the Service are to:

1.2.1. Provide timely access to specialist assessment and treatment services for Clients who have an accepted claim for cover.

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

1.2.3. Allow Suppliers to carry out a procedure as part of the assessment (in accordance with Clause 9); or

1.2.4. Provide specialist assessment for Clients who have an accepted claim for cover or have been referred by ACC for an assessment which may help determine cover; and

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

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

2. SERVICE OBJECTIVES

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

2.1.1. Clients receive an appropriate and timely assessment to identify their injury related treatment needs;

2.1.2. Clients receive timely access to necessary advanced diagnostic imaging services;

2.1.3. Clients receive timely and appropriate access to clinic-based treatment and procedures;

2.1.4. Appropriate, efficient management of those Clients who require surgical intervention;

2.1.5. Medical Case Review for referred Clients meet the requirements of Clause 6.5.2 – 6.5.6;

2.1.6. Single Disciple Assessments for referred Clients meet the requirements of Clause 6.5.7.

3. SERVICE COMMENCEMENT

3.1. Eligibility for Service:

3.1.1. Clients must have an accepted ACC claim and the treatments and assessments must be directly related to the covered injury and must require a specialist opinion; and

3.1.2. The Supplier will provide Clinical Services Assessments and/or Treatment only to eligible Clients who have been referred to the Supplier in accordance with this Clause 3.

3.1.3. ACC will not pay the Supplier for services provided and/or for time spent with a person who does not fulfil the criteria outlined in Clause 3.1.1 and 3.1.2, or where funding is not approved in accordance with Part B, Clause 9, or where prior approval (if required) is not received.

3.1.4. Clinical Services may not be provided while a Client's covered injury is being managed acutely under Public Health Acute Services (PHAS) provisions of the Accident Compensation Act 2001 by any District Health Board or other treatment provider commissioned by a DHB to provide PHAS care.

3.1.5. Specialist follow up and care provided to an ACC Client within six weeks of the Client being discharged from Elective Surgery is covered within the cost of the funding package for the Elective Surgery procedure and will not be invoiced against the Clinical Services contract, with the exception of post-discharge recasting as indicated in Part A of this Service Schedule (codes CST 21, 22, 31 or 32).

3.2. Referral process

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

(a) A Vocationally Registered Medical Specialist; or

(b) The Client's General Practitioner; or

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

(d) ACC.

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

3.2.3. ACC will not pay for services where Clients self-refer or are referred other than by those as described in Clause 3.2.1 or Clause 3.2.2 (whichever is relevant).

3.2.4. The Supplier may decline a referral if:

(a) The Supplier cannot meet timeframes as set out in Clause 6.4; or

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

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

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

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

3.3. Prior Approval

3.3.1. ACC funding approval is required for some consultations and procedures. Prior approval requirements are specified in the tables throughout this service schedule.

3.3.2. Where ACC approval is required the Supplier must submit a Clinical Services Assessment Report and Treatment Plan (CSARTP) In addition to the requirements above, ACC may, from time to time, specify by notice and/or on the ACC website that particular Assessment and/or Treatment Services also require prior approval in accordance with Part B, Clause 9.

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

4. SERVICE LOCATION AND SPECIFIED AREA

4.1. The Service will be provided by the Supplier for Clients who usually reside in the geographical areas as specified in Part A, Clause 2.

5. SERVICE REQUIREMENTS

5.1. The Supplier will provide Clinical Services in accordance with this Service Schedule which include as appropriate components as described in Clause 6.

6. SERVICE SPECIFIC QUALITY REQUIREMENTS

6.1. Competency

(a) The Supplier must use the services of appropriately qualified Medical Practitioners who are registered under the Medical Council of New Zealand who hold a vocational scope of practice in at least one of the following areas:

- Anaesthesia
- Cardiology
- Cardiothoracic surgery
- Dermatology
- General surgery
- Gynaecology
- Internal medicine
- Musculoskeletal medicine
- Neurosurgery
- Obstetrics
- Occupational medicine
- Ophthalmology
- Oral and maxillofacial surgery
- Orthopaedic Surgery
- Otolaryngology Head and Neck Surgery
- Paediatric surgery
- Paediatrics
- Pain medicine
- Palliative medicine
- Plastic and reconstructive surgery
- Rehabilitation medicine
- Sports medicine
- Urology
- Vascular surgery, or

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

- Oral surgery
- Oral and maxillofacial surgery.

6.2. Procedures

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

6.3. Facility Accreditation

6.3.1. In addition to the requirements specified in clause 27 of the Standard Terms and Conditions, the supplier will ensure that each facility listed in Part A, clause 3 meets and maintains the following requirements (whether the facility is operated by the Supplier or an approved subcontractor):

6.3.1.1. Hold current certification with the Ministry of Health, under the Health and Disability Act 2001 (NZS 8134:2021 Ngā paerewa Health and Disability Services Standard); and / or

6.3.1.2. Hold current accreditation with the NZS8164:2005 Standard for Day-stay Surgery and Procedures;

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

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

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

6.3.1.6. Provide ACC, upon request, with evidence that these requirements are met.

6.3.2. If the facility is accredited under clause 6.2.2(b), the Supplier will:

6.3.2.1. For Room Based Procedures (Table 5) undertake an external audit for compliance, or a professional association approved by ACC;

6.3.2.2. Clinic Based Procedures (Tables 4 and 6), provide evidence that they have undertaken a self-audit against the Rooms/Office Based Surgery and Procedures, New Zealand Standard 8165:2005. The Supplier is responsible for annually reviewing their self-audit and notifying ACC of any change;

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

6.3.2.4. Room Based Procedures (Table 5) and Clinic Based Procedures (Tables 4 and 6) may only be provided at a facility specified in Part A, Clause 3.

6.4. Named Providers

6.4.1. Names

The Supplier will utilise the services of only the Specialists named in, Part A, Clause 4 (the "Named Providers") in the course of providing Clinical Services for Clients.

6.4.2. Addition of Specialists

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

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

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

6.4.3. Removal of Specialists

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

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

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

6.5.1. Ensure the Initial Assessment occurs within a clinically appropriate timeframe following receipt of referral. Where the supplier cannot meet this timeframe, the Client should be advised to discuss options with the referrer, unless ACC and the Supplier agree a different timeframe.

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

(a) Contact ACC within one business day of receiving the referral;

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

(c) Notify ACC within three business days of receiving the referral in the event the Supplier has been unable to contact the Client;

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

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

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

6.6. Definition of Clinical Services

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

6.6.1. Clinical Services as set out in Clauses 7.1 and 7.2 provided by the Supplier must include as appropriate (without limitation):

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

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

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

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

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

(f) Completion of an anaesthetic pre-assessment form for a Client where surgery is recommended (including electronically by the Client) for attachment to a surgical ARTP;

(g) Submitting a surgical ARTP to an Elective Surgical Services contract holder;

(h) Submitting a non-surgical ARTP to ACC;

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

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

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

(l) Evidence that measures have been taken to set appropriate Client expectations. Where in the 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.

6.6.2. Medical Case Reviews (as set out in Clause 7.3) provided by the Supplier must include:

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

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

(c) A diagnosis/es including differentials;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.6.7. Medical Single Discipline Assessments as set out in Clause 7.3 provided by the Supplier must include:

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

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

(c) Diagnosis/es including any differentials;

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

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

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

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

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

7. CLINICAL SERVICE CONSULTATIONS

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

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

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

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

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

An Initial Assessment is an assessment of a Client which includes provision of a treatment plan that outlines the following:

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

(b) Anticipated treatment, and

(c) Any referrals required, and

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

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

7.1.2. Second Opinion Assessments

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

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

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

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

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

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

This type of assessment will be paid for:

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

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

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

7.1.3. Subsequent Assessments

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

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

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

A Subsequent Assessment is an assessment for a Client where:

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

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

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

OR

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

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

OR

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

OR

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

AND

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

7.1.4. Reassessment

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

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

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

(c) The Client must be referred back to the Service Provider for the Reassessment in accordance with Clause 3.2.

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

7.1.5. Neurophysiological consultation

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

7.1.6. Simple and Complex Neurophysiological Follow ups

(a) This is a Simple Neurophysiological Follow up consultation performed by an Internal Medicine Specialist. This follow up includes checking for innervation in selected muscles or repeating a section of the nerve conduction study. The nerve conduction study component of the Follow up may be delivered by a Neurophysiologist as a subcontractor to the specialist;

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

7.1.7. Telehealth consultation

The Supplier must ensure consultation services delivered by Telehealth must:

(a) meet the requirements of the ACC Telehealth Guide;

(b) have Client or authorised representative consent (recorded in the client notes), and with the option of an in-person meeting if the Client prefers;

(c) be accessible by the Client;

(d) be preceded by a full and complete understanding of the Client’s needs (and their whānau) and ensure Services are provided safely;

(e) meet the same required standards of care provided through an in-person consultation;

(f) have records that meet ACC requirements; and

(g) have both the Client receiving the Telehealth service, and the provider delivering the Telehealth service, physically present in New Zealand at the time the service is provided; and

(h) all Medical Case Review and Single Discipline Assessment reports completed will be in accordance with the operational guidelines.

The following Clinical Service consultations/assessments do not require prior approval and are detailed as follows:

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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Simple Assessment (Initial)	CS100	Initial Simple Assessment	Specialist	First assessment only; can only be billed once per claim
Simple Assessment (Initial) – Telehealth	CS1T	Initial Simple Assessment – Telehealth	Specialist	First assessment only; can only be billed once per claim
Complex Assessment (Initial)	CS200	Initial Complex Assessment	Specialist	First assessment only; can only be billed once per claim
Complex Assessment (Initial) – Telehealth	CS2T	Initial Complex Assessment – Telehealth	Specialist	First assessment only; can only be billed once per claim
Second Opinion Assessment (Simple)	CS400	Simple Second Opinion Assessment	Specialist	
Reassessment	CS500	Reassessment	Specialist	Cannot occur within 12 months of the Initial Assessment and must be the same specialist who provided initial assessment
Subsequent Assessment (Simple)	CS61	Simple Subsequent Assessment	Specialist	
Subsequent Assessment (Simple) – Telehealth	CS61T	Simple Subsequent Assessment – Telehealth	Specialist	

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Subsequent Assessment (Complex)	CS62	Complex Subsequent Assessment	Specialist	
Subsequent Assessment (Complex) – Telehealth	CS62T	Complex Subsequent Assessment – Telehealth	Specialist	
Neurophysiological consultation and Neurophysiological study	CS83	Neurophysiological consultation and Neurophysiological study	Neurologist 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	Neurologist Neurosurgeon	
Complex Neurophysiological Follow up	CS85	Complex Neurophysiological Follow up and consultation	Internal Medicine Specialist Neurologist Neurosurgeon	
Second Opinion Assessment (Complex)	CS900	Second Opinion Assessment (Complex) – per consultation	Specialist	

7.2. The following Clinical Service consultations can only be undertaken pre-operatively. A surgical ARTP (submitted by an Elective Surgical Services contract holder and including a pre-anaesthetic assessment form) must have been approved prior to the assessments being undertaken (except for procedures which do not require prior approval).

7.2.1. Simple and Complex Pre-operative Anaesthetic Assessments

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

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

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

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

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

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

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

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

(c) Clients with identified significant anxiety regarding anaesthesia.

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

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

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

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

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

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

7.2.2. Anaesthetic telehealth consultation

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

(b) The consultation is not a substitute for a clinical examination to determine anaesthetic status; nor is it a simple introductory call as the purpose of this is to improve the service to Clients.

(c) The Clinical Service pre-operative Anaesthetic assessments approval and requirements are as follows:

Table 2 – Clinical Service pre-operative Anaesthetic assessments

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Simple Pre-operative Anaesthetic Assessment (Initial)	CS250	Initial Simple Pre-Operative Anaesthetic Assessment	Anaesthetist	To be undertaken pre-operatively only; the surgical ARTP must be approved prior to this assessment being undertaken (except for procedures which do not require prior approval).
Complex Pre-operative Anaesthetic Assessment –(Initial)	CS260	Initial Complex Pre-Operative Anaesthetic Assessment	Anaesthetist	To be undertaken pre-operatively only; the surgical ARTP must be approved prior to this assessment being undertaken (except for procedures which do not require prior approval).
Anaesthetic consultation	CS70	Anaesthetic telehealth consultation	Anaesthetist	To be undertaken pre-operatively only; Appropriate for administrative or clarification purposes only

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

7.3.1. Standard Medical Case Review and Complex Medical Case Review.

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

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

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

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

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

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

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

7.3.3. If on referral a Service provider believes the Client is exceptionally complex over and above the cost available under a Complex category, please contact ACC to discuss. Any Service Item Code issued as part of a purchase order by ACC in response to such a discussion which is not listed in Part A of this Service Schedule will still require that the Provider adhere to the terms of this Service Schedule in all other respects.

Table 3 – Medical Case Reviews and Medical Single Discipline Assessments

Procedure	Code	Definition	Treatment provider	Prior Approval and/or other Requirements
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	Prior Approval and referral required from ACC
Medical Case Review (Complex)	CSM2	Medical review taking more than 3.5 hours to provide clarity about diagnosis/es and assessment of causation together with recommendations for further investigations, treatment or rehabilitation	Specialist	Prior Approval and referral required from ACC

Procedure	Code	Definition	Treatment provider	Prior Approval and/or other Requirements
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	Prior Approval and referral required from ACC
Medical Single Discipline Assessment (Complex)	CSA2	Medical assessment taking more than 2.5 hours to provide recommendations for investigations, treatment and/or rehabilitation specific to an injury that is covered by ACC	Specialist	Prior Approval and referral required from ACC

8. ASSESSMENT REPORT AND TREATMENT PLANS

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

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

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

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

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

8.2. When a surgical ARTP is required

8.2.1. Except for in-rooms procedures identified in this Service Schedule, the accountability for a Surgical ARTP rests with the Elective Surgical Services contract holder. The Named Provider will draft the ARTP, select an Elective Surgical Services contract holder, and submit the Surgical ARTP to that party.

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

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

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

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

8.2.3. The ARTP will be forwarded within 5 business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later).

8.2.4. Contents of Surgical ARTP

The ARTP document on the ACC Provider Website is the only version that is ACC approved and is the only version of the ARTP that will be accepted by ACC. The Elective Surgical Services contract holder will liaise with the Named Provider to ensure content is complete and appropriate. Particular attention will be paid to the prognosis for the Client, including as necessary further treatment, support required for a staged or total return to work or independence, medication or any other matter visible to the Named Provider and relevant to ACC's management of the Client's rehabilitation.

8.3. In rooms and non-surgical intervention

If non-surgical intervention, identified in-rooms procedures, or other rehabilitation is recommended, a non-surgical ARTP will be submitted using a form provided by ACC from time to time. If ACC has not provided a non-surgical ARTP form, a copy of reports/notes/letters or a summarised comprehensive letter outlining the recommendation must be emailed or electronically submitted to ACC.

8.3.1. By When

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

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

9. PROCEDURES

9.1. The procedures in Tables 4 – 6 must be carried out by a Named Provider (Part A; Clause 4) who is a treatment provider of the type identified in Table 4 as able to provide that procedure. Named Providers must operate within their scope of practice as defined by the Medical Council of New Zealand or specialist professional body.

9.1.1. Medial Branch Block

A Medial Branch Block injection can be either Simple or Complex. Taking into account clinical best practice and the number of injection sites:

(a) A Medial Branch Block (Simple) is performed to 2 or less injection sites; and

(b) A Medial Branch Block (Complex) is performed to more than 2 injection sites.

A Medial Branch Block injection is a diagnostic procedure performed by a vocationally registered Anaesthetist, Pain Medicine Specialist, Musculoskeletal Medicine Specialist or Neurologist. This procedure must be informed by the current Spine Intervention Society (SIS) Practice Guidelines for Spinal Diagnostic and Treatment Procedures.

(a) Medial Branch Blocks are considered a diagnostic procedure.

(b) Up to 2 Medial Branch Blocks can be provided without Prior Approval. Although, Prior Approval can be sought at any stage if the clinical picture is unclear.

(c) Funding of Medial Branch Blocks and/or positive Medial Branch Blocks does not constitute approval for subsequently requested Radiofrequency Neurotomy(s). Each prior approval request for funding of Radiofrequency Neurotomy(s) will be considered on a case by case basis.

(d) Provision of Medial Branch Blocks without prior approval should be in accordance with any relevant ACC guidelines.

9.1.2. Radiofrequency Neurotomy

A Radiofrequency Neurotomy can be either Simple or Complex. Taking into account clinical best practice, injection sites and the number of injection sites:

(a) A Radiofrequency Neurotomy – Lumbar (Simple) is performed to 2 or less injection sites;

(b) A Radiofrequency Neurotomy – Lumbar (Complex) is performed to more than 2 injection sites;

(c) A Radiofrequency Neurotomy – Cervical (Simple) is performed to 2 or less injection sites; and

(d) A Radiofrequency Neurotomy – Cervical (Complex) is performed to more than 2 injection sites.

A Radiofrequency Neurotomy is performed by a by a vocationally registered Anaesthetist, Pain Medicine Specialist, Musculoskeletal Medicine Specialist or Neurologist following a diagnostic Medial Branch Block injection where facet joints are determined to be the source of pain. This procedure must be informed by the current Spine Intervention Society (SIS) Practice Guidelines for Spinal Diagnostic and Treatment Procedures.

(a) Prior approval is required for all Radiofrequency Neurotomies.

9.2. The Named Provider must comply with the conditions and requirements of each procedure as stipulated in Tables 4 – 6.

9.3. The Facility where the procedure is to be carried out must meet the requirements identified in Clause 6.2.2.

9.4. If a procedure listed in Tables 4 – 6 states "consultation included"; the consultation is included in the price of the procedure and cannot be billed in addition to the procedure price.

9.5. If a procedure listed in Tables 4 – 6 states "consultation not included" the consultation is not included in the price of the procedure and can be billed in addition to the procedure price.

9.6. Where prior approval is required an CSARTP must be completed and include the expected outcome and the timeline for the result of the procedure.

9.7. The procedures in Table 6 can only be undertaken if a surgical Assessment Report and Treatment Plan (ARTP) has been approved by ACC.

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
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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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)
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)

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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
Internal Examination for Maternal Birth Injury	CSD15	Internal examination to assess Maternal Birth Injury	Gynaecologist Obstetrician Urologist	• No prior approval • Consultation not included
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	CSP30 A	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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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	CSP31 A	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 Medicine Physician	• Prior approval required for 3rd and each subsequent injection • Consultation not included
Secondary ultrasound guided injection	CSP32 A	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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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	CSP33 A	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	CSP34 A	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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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	CSP35 A	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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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

*Injections do not include autologous blood injections, platelet-rich plasma injections and/or prolotherapy. ACC does not fund these procedures.

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		

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
Repair flexor tendon	CSH06 CSH07 CSH08	Repair flexor tendon – digit/hand/wrist/ forearm Funded according to number of tendons/nerve and anatomical region.		
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)	• Prior-approval required • Consultation included
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		
Implant costs	CSH55	Cost for nerve wrap (actual and reasonable)		

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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)		
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		

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

Procedure	Code	Definition	Treatment Provider	Prior Approval and/or other Requirements
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). • **District Health Boards** (DHBs) 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. SERVICE EXIT

10.1. This Service is complete when:

10.1.1. The Supplier completes one of the assessments identified in Part A, Clause 5 and an ARTP for the assessment carried out is completed and sent to the appropriate party/parties (where required), clinical notes or reports have been completed and correspondence with the referrer has been sent; or

10.1.2. When the transfer of clinical responsibility and care of the Client to the original referrer, the Client's General Practitioner, another Supplier qualified to assume care and contracted to ACC accordingly (such as an Elective Surgical Services contract holder) or another specialist, has occurred;

10.1.3. Whichever is the later date.

11. EXCLUSIONS

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

11.1.1. Diagnostic imaging service;

11.1.2. Clinical Psychiatric Services and Psychological Services;

11.1.3. Public Health Acute Services;

11.1.4. Pain Management Services;

11.1.5. Elective Surgical Services.

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

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

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

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

12. LINKAGES

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

12.1.1. ACC Client Service Staff;

12.1.2. Health Professionals;

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

13. PERFORMANCE REQUIREMENTS

13.1. The Supplier's performance will be measured as shown in Table 7 – Performance Measurement.

Table 7 – Performance Measurement

Objective	Performance measure	Target	Data Source
1. Service Provision	Procedures are carried out by Medical Specialists who hold registration in the appropriate vocational scope of practice	100% of Procedures are carried out or appropriately supervised by a Specialist who is a treatment provider of the type names in the Service Schedule as being able to provide that procedure, or by a Medical Technician acting under specialist supervision and within his/her regulated scope of practice	• Supplier supplies evidence to ACC • Clinical Notes
2. Cost effective	Services are necessary, appropriate and not excessive in number or duration	100% of Clinic Based Surgical Procedures performed are clinically necessary and appropriate	• Clinical notes • Operative notes • Benchmark reports monitoring the number of procedures performed by other Providers
3. Early intervention	Clinic based surgical procedures are performed within necessary time frame to allow for maximum rehabilitation	100% of Clients will have their Clinic Based Surgical Procedure within 28 days of the Assessment that determined the need for the procedure/s (this is for procedures which do not require prior approval)	• ARTP • Operative notes • Invoice

Objective	Performance measure	Target	Data Source
4. Prompt and accurate information submitted to ACC	Complete and accurate information provided to enable assessment of quality of service received	100% of documentation received within scheduled time frame ARTPs contain effective and useable prognoses 100% of Medical Case Review reports and Medical Single Discipline Assessment reports meet quality standards for reporting	• Non-surgical ARTP to Treatment Assessment Centre • Surgical ARTP via Elective Surgical Services contract holder • Medical Case Review report • Medical Single Discipline Assessment report • Operative notes • Discharge summary • Invoice

14. SERVICE AND REPORTING REQUIREMENTS

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

14.2. Medical Case Review and Medical Single Discipline Assessment reports will include:

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

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

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

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

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

14.3. The following table outlines the timeframes and responsibilities for delivering the Service.

Table 8 – Service timeframes

Information	Frequency	When
Surgical ARTP	For all Clients for whom surgery is recommended by the Named Provider	Within seven business days of the Specialist completing the consultation or receiving any diagnostic tests, pathology services or second opinion (whichever date is the later)
Non-surgical ARTP (include referrer details)	For all Clients for who a non-surgical intervention is recommended	Within 7 business days of the Specialist completing the consultation
Clinic Based Procedures that do not require prior approval	For all Clients for who a non-surgical intervention is recommended	Within 28 days of the Assessment that determined the need for the procedure/s
Medical Case Review report	For all Clients who are referred for a Medical Case Review	Within eight business days of the Specialist completing the consultation
Medical Single Discipline Assessment report	For all Clients who are referred for a Medical Single Discipline Assessment	Within eight business days of the Specialist completing the consultation

15. RELATIONSHIP MANAGEMENT

15.1. To ensure the continuing effective operation of the service, formal working relationships are to be maintained as defined in Part A, Clause 6.

16. PAYMENT AND INVOICING

16.1. ACC agrees to pay the prices for Services set out in Part A, Clause 5.

16.2. 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 prior notification to the Service Provider.

16.3. In addition to the invoicing requirements outlined in Clause 10 of the Standard Terms and Conditions, the Supplier will provide an invoice that specifies the Named Provider as outlined in the Operational Guidelines.

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

APPENDIX ONE – DEFINITIONS AND INTERPRETATION

In this Service Schedule, unless the context otherwise requires:

"Assessment Report and Treatment Plan" and **"ARTP"** is the report used to request approval for surgical and non-surgical treatment - available on ACC's website (www.acc.co.nz)

"Clinical Based Procedures" are the procedures listed in Tables 4 & 6 of this service schedule.

"Complex Initial Assessment" is an initial assessment that takes more than 45 mins to complete and can only be used once per claim for each specialist.

"Complex Medical Case Review" 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 complex medical case review is expected to more than 3.5 hours and less than 7.5 hours.

"Complex Medical Single Discipline Assessment" is initiated by ACC and is used to obtain recommendations for the best onward treatment or rehabilitation. A complex medical single discipline assessment is expected to take more than 2.5 hours and less than 4.5 hours.

"Complex Second Opinion Assessment" is an assessment that takes more than 45mins, and carried out when a second opinion is needed from an anaesthetist or other specialist while the client is being assessed, diagnosed and/or having their ongoing care options considered.

"Complex Subsequent Assessment" is a follow up assessment that takes more than 30 mins

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

"In-person" means the named provider and client are physically present in the same room;

"In-Rooms Wrist and Hand Procedures" are procedures performed using the WALANT (wide-awake, local anaesthetic, no torniquet) surgical technique.

"Named Provider" means a vocationally registered medical specialist who has been added to Part A, Clause 4 of this service schedule for the purpose of delivering services.

“Operational Guidelines” is a living document produced by ACC to reflect the processes and procedures to be followed in support of this Service. It can be found on ACC’s website (www.acc.co.nz) by typing in “Clinical Services” under the resource section or in the main search box;

“Pre-operative Anaesthetic Assessment - Simple” is an anaesthetic assessment that takes less than 45 mins, performed once the surgery has been approved by ACC (where applicable) and used to inform surgical planning to optimise outcomes and avoid cancellations due to client complexities.

“Pre-operative Anaesthetic Assessment - Complex” is an anaesthetic assessment that takes more than 45 mins, performed once the surgery has been approved by ACC (where applicable) and used to inform surgical planning to optimise outcomes and avoid cancellations due to client complexities

“Reassessment” are used for subsequent assessments by the provider who carried out the initial assessment where – the client had been discharged from the care of the provider and a new referral has been sent more than 12 months after the initial assessment.

“Referrer” means vocationally registered medical specialist, general practitioner, any other treatment provider as defined in the Accident Compensation Act 2001 or ACC. With the exception of Medical Case Reviews and Medical Single Discipline Assessments where the referral can only be ACC.

“Rooms Based Procedures” are the procedures listed in Table 5 of this service schedule.

“Simple Second Opinion Assessment” is an assessment that takes less than 45mins, and carried out when a second opinion is needed from an anaesthetist or other specialist while the client is being assessed, diagnosed and/or having their ongoing care options considered

“Simple Initial Assessment” is an initial assessment that takes less than 45 mins and can only be used once per claim for each specialist.

“Standard Medical Case Review” 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 standard medical case review is expected to take up to 3.5 hours.

“Standard Medical Single Discipline Assessment” is initiated by ACC and is used to obtain recommendations for the best onward treatment or rehabilitation. A complex medical single discipline assessment is expected to take up to 2.5 hours.

“Simple subsequent Assessment” is a follow up assessment that takes less than 30 mins

"Telehealth" in accordance with the ACC Telehealth Guide this term refers to the real-time (synchronous) delivery of health care services through the medium of communication technologies where client and provider are in separate locations. Telehealth refers specifically to health care interactions that replace in-person consultations, and excludes brief communications (e.g. brief check-in either via video, phone or text messaging; or information sharing), communications not for the purpose of delivering health care services (e.g. liaison, social networking), asynchronous interactions (e.g. email and sometimes also text messages), or for administrative purposes (e.g. making an appointment).

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