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Prevention. Care. Recovery.

Clinical Services

Operational Guidelines

July 2025
This is a living document and will be updated as required

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Useful Contact Information

Below are the contact details for various teams across ACC that can help you with any questions related to providing Clinical Services to ACC Clients.

Provider Contact Centre	0800 222 070	providerhelp@acc.co.nz
Client/Patient Helpline	0800 101 996	
Provider Registration	04 560 5211	registrations@acc.co.nz
ACC eBusiness	0800 222 994, Option 1	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	
	0800 400 503	health.procurement@acc.co.nz
Engagement and Performance Managers (EPMs)	EPMs can help you to provide the services outlined in your contract. Contact the Provider Helpline or visit this page to submit a query to our provider relationship team	
Clinical Notes	Health Link (EDI: ACCSPECR)	clinical.notes@acc.co.nz
Prior Approvals Team	For submission of CSARTP's requesting prior approval	prior.approval@acc.co.nz
Surgery Assessment Team	For urgent or unusual queries that require attention/escalation. Requests for adding cover for non-prior approval procedures should also be sent here. Do not use this email for regular queries.	surgeryassessmentteam@acc.co.nz
Elective Surgery Documentation	For email submissions of ARTP's	ARTPS4ESU@acc.co.nz
	For all supporting documentation such as	disop@acc.co.nz

	operation notes, discharge summaries, supply cost and implant invoices	
	For general medical notes related to ARTP submissions	ESCMednotes@acc.co.nz

Useful Links

Website	For more information about ACC, please visit: www.acc.co.nz ACC's website can provide you with a lot of information, especially our Health Providers tab.
Provider Updates	This monthly publication updates suppliers, providers and vendors on what's happening across ACC's business. For more information and to subscribe to email updates, visit this page on our website.
Provider Registration	For more information on how to register with ACC as a health provider, please visit our website: Register with us as a health provider

1. Introduction

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 contract, the contract 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. Purpose

The purpose of Clinical Services is to fund:

- specialist assessment to determine diagnosis, causation, and the treatment pathway including non-surgical treatment, procedures and/or diagnostics
- specialist physician services
  specialist assessment to determine diagnosis, causation, and the treatment pathway including non-surgical treatment, procedures and/or diagnostics.

The Clinical Services contract works in conjunction with the Elective Surgery Services 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.

Notes:

- 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).
- The client must have an accepted claim. Assessments must be directly related to the covered injury and must require a specialist opinion.

3. Who can hold this contract?

The Clinical Services 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:

- a medical practitioner registered under the Medical Council of NZ and holds a vocation scope of practice in one of the listed areas at Clause 6.1.1.1 of the contract, or
- a dental practitioner registered under the Dental Council of NZ who 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

Notes:

- Medical Case Reviews and Medical Single Discipline Assessments can only be requested by ACC.
- Patients are not able to self-refer.

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 should 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 Services Contract

The Clinical Services contract works in conjunction with the Elective Surgery Services 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 which are not covered by the Elective Surgery Services contract.

For further information specific to elective surgery services, please refer to the Elective Surgery Services Operational Guidelines and Elective Surgery Services Contract.

6. General Assessments

General assessments are carried out by named providers as the treating specialist. Where the treating specialist determines that the client's personal injury was not caused by an 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.

Table 1 of the contract contains the complete list of clinical service assessment codes.

Notes:

- Our payments system will hold any invoices for more than one consultation per day, this information will be checked before payment is released.
- 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. The purpose of an initial assessment is to determine the client's:

- specific diagnosis and whether this is causally linked to the covered accident event
- treatment pathway (and appropriate funding mechanisms) to address the specific diagnosis

If a specific diagnosis and/or causal link cannot be determined without further diagnostic investigations, then this should be completed during the subsequent assessment (see section 6.2).

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.

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 will be justified in the clinical notes.

Initial assessments should include the provision of all the following (where appropriate):

- 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
- confirmation of causal link
- completion of the necessary assessment report and treatment plan.

6.1.1. 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.

Notes:

- Initial assessments can only be claimed once per claim.
- 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. Following the first subsequent assessment, where treatment needs are not injury related, it is the providers responsibility to refer the client back to their primary care provider for ongoing management.

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.

Subsequent assessments may include the provision of all of the following (where appropriate):

- consider progress and updating treatment plan, taking into account any relevant test results
- review of and/or amendment to any existing diagnosis and confirmation of causal link
- arranging access to, and the provision of, any necessary radiological investigation, including High Tech Imaging or interpretation of diagnostic films/reports
- performing any necessary and appropriate procedure(s)
- prescription of any necessary pharmaceuticals
- 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

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.

Notes:

- 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.
- 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, confirmation of causal link 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. The purpose of the consultation needs to meet the requirements as outlined in 6.1 and 6.2. 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. Nor should providers utilise Telehealth consultation for the purposes of "check-in" phone calls. 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 undertaken when a second opinion is required 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 includes the provision all of the following (where appropriate):

- 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 and confirmation of causal link
- 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.

6.4.1. 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.

6.4.2. 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.

Notes:

- Reassessments cannot occur within 12 months of the initial assessment.
- 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 and Neurophysiological study – this includes testing (i.e. Nerve conduction studies) which may be administered by a neurophysiologist, commissioned by an Internal Medicine Specialist or Neurosurgeon.
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.

6.7. Referrals for further imaging and/or treatment following assessments

Prior approval is required for some procedures, diagnostic imaging/treatment and/or further treatment. It is the treating specialist's responsibility to obtain prior approval from ACC, and if provided, arrange the necessary referrals.

6.7.1. High Tech Imaging Services

The High Tech Imaging Services (HTIS) contract is designed for clients to access necessary and appropriate investigations, treatments and procedures for an ACC-covered injury. When referral for high-tech imaging services is indicated, it is the responsibility of the treating specialist to provide the HTIS supplier with a clear clinical rationale, demonstrating a causal link between the indications for the High-Tech Imaging procedure and the injury-related pathology at that single body site.

In addition, it is the responsibility of the treating specialist to ensure prior approval has been obtained before a HTIS procedure takes place (where required). The High-Tech Imaging Services contract and operational guidelines outlines what procedures require prior approval from ACC.

Repeat scans for new and/or persisting symptoms from the same body site need to consider the pathology identified on the previous imaging, be clinically justifiable and demonstrate that same causal relationship to the covered, injury-related pathology at that body site.

ACC should be contacted to confirm funding if there is any uncertainty about the causal relationship between the requested scan and an ACC covered injury.

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 must ensure 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 continue to be processed in the absence of an 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. Preoperative anaesthetic telehealth consultation – CS70

This consultation is a phone call to a client to serve as an initial or informational form of consultation 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 of the contract contains the complete list of pre-operative clinical service consultation codes.

8. 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 can 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 by another treatment provider as set out under Clause 4.2 within the contract.

8.1. Declining a referral

The provider may decline a referral if:

- they cannot meet timeframes as set out under Clause 7.1 within the contract
- 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.

8.2. 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.

8.2.1. 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 service schedule (Clauses 7.2.2 to 7.2.6).

8.3. 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.

8.3.1. 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.

8.4. 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 all of 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.

8.5. 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 contract.

8.6. 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.

8.7. "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 of the contract contains the complete list of MCR and MSDA codes.

9. Surgical treatment pathway

When it is determined that a client requires elective surgery, consideration is required to determine whether the procedure can be undertaken via your Clinical Service or if the proposed procedure falls under the scope of the Elective Surgery Services contract.

The list of in-rooms and clinic-based procedures that proceed under the Clinical Services contract is outlined in Tables 4-6 of the service schedule. Please refer to section 10 of this document for further information.

When the procedure cannot be performed via your clinical services contract, prior approval must be requested from ACC via the Surgical Assessment Report and Treatment plan (ARTP) (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.

The process for submitting a Surgical ARTP is outlined in the sections below and in the Elective Surgery Services Operational Guidelines.

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

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

The Surgical ARTP is the only version that will be accepted and can be downloaded: Assessment Report and Treatment Plan (ARTP) template

The Surgical ARTP must include:

- Current specific diagnosis. If you know the READ/SNOMED/ICD code that matches the specific diagnosis, please also include this.
- Specialist clinical opinion on the link between diagnosis, mechanism of injury and treatment required (causal link)
- Prognosis, rehabilitation timeframes and expectations for recovery
- A clear description of the proposed treatment and procedure code(s).
- Any supports required
- Supporting documentation e.g. referral, clinical notes, radiology reports

Complete the ARTP with as much detail as possible and ensure all mandatory fields (*) are completed. At times, more information may be requested and will need to be provided for ACC to make a thorough assessment of the request. This may lead to delays for your patient. 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 or via HealthLink mailbox (ACCEARTP).

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

9.2. ARTP Assessment

The Treatment and Support team will assess the surgery request and advise the supplier and the client of ACC's decision. The supplier will be notified of the decision via email and the

client will be notified by a letter either via email or post. If the surgery request is declined, the Treatment and Support team will also advise the client by phone unless otherwise specified.

Once the proposed surgical procedures are approved, the supplier is responsible for arranging the earliest possible mutually appropriate date for treatment with the client.

Note: Some procedures may have additional requirements during the assessment process. These may include, but are not limited to, bariatric surgery, limb amputation to treat pain and organ removal.

9.3. 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 Services contract. This contract purchases a package of care from an elective surgery 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 chooses treatment with a provider who either does not hold the Elective Surgery Services contract or is not a named provider on an Elective Surgery Services contract, 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 Services 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 fund 60% of the price for the surgery listed in the Elective Surgery Services contract (noting that these prices includes a full package of care from admission to discharge + 6 weeks). For non-core surgery, we will pay 60% of the non-core price.

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.

9.4. 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 in section 7, 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: If the client has co-morbidities, the provider must ensure they are assessed by a vocationally registered anaesthetist (preferably the anaesthetist who will attend the surgery) – see section 7. 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 Elective Surgery Supplier for review and dispatch to ACC. For example:

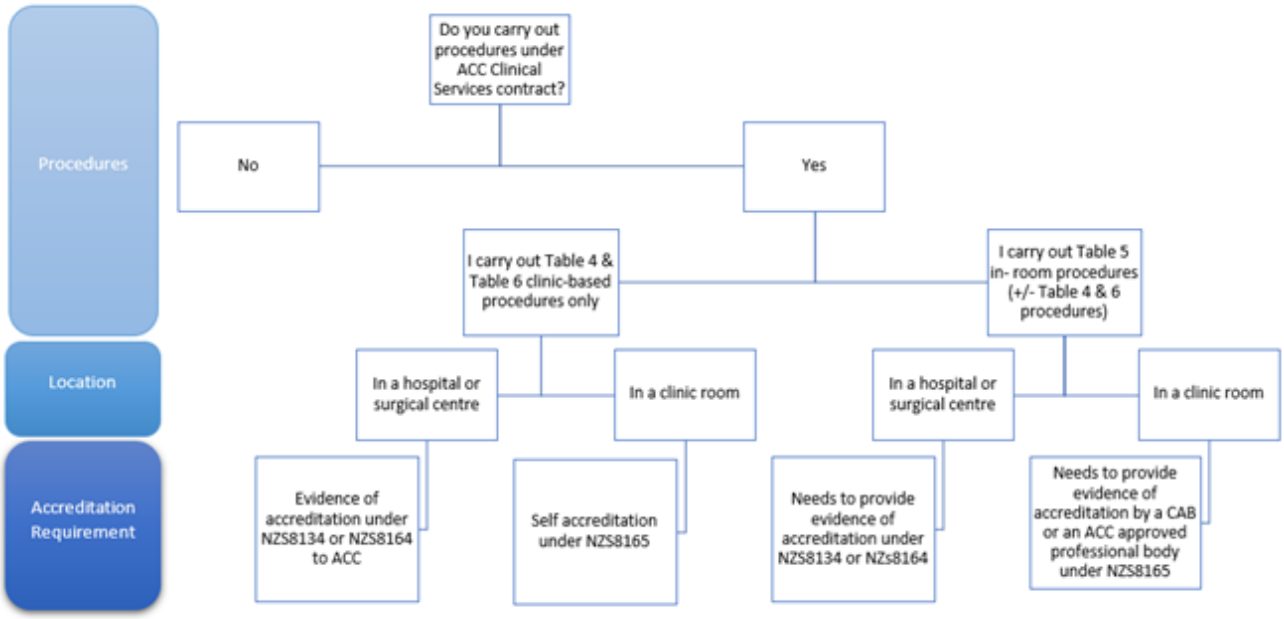
> An anaesthetic assessment under the Clinical Services Contract identifies that a client needs intensive monitoring, HDU, or ICU. The anaesthetist and referrer should identify a surgical Lead Supplier who has the resources to treat this patient safely. The draft ARTP referred to that Lead Supplier will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

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 of the contract. Procedures can only be performed by a named provider of the vocational type identified in these tables.

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.

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.

10.1.1. 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).

10.1.2. 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 can seek additional funding by submitting a Clinical Services ARTP (CSARTP) outlining the additional costs for approval.

10.1.3. 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).

Notes:

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

10.1.4. 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 the referral pathway would be through Clinical Services contract for diagnosis and treatment. Injection codes have been developed for these diagnostic and treatment procedures where it is deemed necessary and appropriate and related to the covered injury. ACC expects that clinicians requesting these procedures will perform the required workup to ensure only clients suitable for the interventions receive them.

Notes:

- Up to 2 injections can be provided without prior approval. Prior approval for the third and subsequent injections must be requested via CSARTP.
- 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.
- Injections do not include autologous blood injections (ABI), platelet-rich plasma (PRP) injections and/or prolotherapy. ACC does not fund these procedures.

10.1.5. Subsequent injections

Subsequent injection codes (CS30A – C35A) are intended for when more than one procedure is provided during the same consultation.

Notes:

- Where a specialist has doubt over whether the proposed treatment is appropriate, they should complete and submit a CSARTP to ensure there are no funding implications with invoices being declined.
- The subsequent injection codes are included in the prior approval limit for the primary code. For example, if CS30 and CS30A are invoiced for the first visit, any further injections will require prior approval.

10.1.6. 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 via a CSARTP can be sought at any stage if the clinical picture is unclear to ensure there are no funding implications with invoices being declined

If a radiofrequency neurotomy is clinically indicated following a diagnostic medial branch block (where facet joints are determined to be the source of pain), then prior approval must be sought via CSARTP. 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.

10.2. 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.

10.2.1. 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 Services contract. If it is determined that the procedure meets the criteria of an in-rooms procedure code under the clinical services contract, as opposed to its elective surgery equivalent, the invoice will be declined and you will be asked to resubmit with the appropriate clinical services procedure code.

10.3. 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)

Notes:

- 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.
- 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.

Notes:

- These services are limited to one per claim.
- 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.
- 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 contract and identify performance issues where they might exist.

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, or Performance Monitoring Advisor 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.

Appendix 1 – Summary of Changes Log

Summary of changes 1 July 2025

Section	Overview of Change
Useful Contact Information and Useful Links	Updated with current contact information. Useful links previously included moved to separate section.
1. About these guidelines	Renamed to '1. Introduction'
2. Introduction	Renamed to '2. Purpose'. Wording update.
4. Referral Process	Note added to clarify that patient cannot self-refer.
5. Clinical Services Contract and the Elective Surgery Services Contract	Additional sentences added to provide clarity and further information.
6. General Assessments	Addition and changes of sentences under each subsection to provide clarity regarding the purpose and expectations of general assessments. Removal of Table 1 (refer to contract). Addition of section '6.7. Referrals for further imaging and/or treatment following assessments'.
8. Medical Case Reviews and Medical Single Discipline Assessments	Moved further up document. Table 3 removed (refer to contract).
9. Surgical treatment pathway	Moved further down document. Wording update to align with updates to Elective Surgery Services Operational Guidelines.
10.Procedures and Non-Surgical Pathways	Removal of Tables 4-6 (refer to contract). Wording updates to provide clarity.

Summary of changes 1 July 2023

Section	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