Elective Surgery
Operational Guidelines
Effective 1 July 2023

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

Summary of changes 1 July 2023

Clause	Overview of Change
Appendix 2 – Red List Procedures	○ Descriptions added for 'Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures' to only be performed by credentialled Tier 3 providers.
Appendix 3 – H1 Priority Classification	○ Addition of SHU91

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Useful Contact Information

Please see below contact details for several teams across ACC that can assist you with any queries you have in the course of providing Elective Surgery Services to ACC clients.

ACC's Provider Contact Centre	Ph: 0800 222 070	Email: providerhelp@acc.co.nz
ACC's Client/Patient Helpline	Ph: 0800 101 996	
Provider Registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Register with us as a health provider (acc.co.nz)	
ACC eBusiness	Ph: 0800 222 994, Option 1	Email: ebusinessinfo@acc.co.nz
Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team:	
	Ph: 0800 400 503	Email: health.procurement@acc.co.nz
Website	For more information about ACC, please visit: www.acc.co.nz	
Provider Updates	This monthly publication updates Suppliers, Providers and Vendors on what's happening across ACC's business. https://www.acc.co.nz/for-providers/provider-updates/	
Engagement and Performance Managers (EPMs)	EPMs can help you to provide the services outlined in your contract. Contact the Provider Helpline or visit this link for details of who the EPMs in your region are.	
Elective Surgery Invoicing Team	This team can assist with post-operative queries relating to invoicing via: Email: electivesurgeryinvoices@acc.co.nz PLEASE NOTE: All supporting documentation such as operation notes, discharge summaries, supply cost and implant invoices should be sent to: Email: disop@acc.co.nz	
Elective Surgery Documentation	ARTPS4ESU@acc.co.nz	For email submissions of ARTP's
	disopnotes@acc.co.nz	For operation notes and supporting documents
	ESCMednotes@acc.co.nz	For general med notes related to ARTP submissions
Surgery Assessment Team	This team can assist with more unusual queries that require attention/urgent escalation. Requests for adding cover for non-prior approval procedures should also be sent here. PLEASE NOTE: Don't use this for regular queries. Email: surgeryassessmenteam@acc.co.nz	

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

1. Introduction

This is a guideline to assist the implementation of the Elective Surgery 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 Elective Surgery 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. The guidelines can also be found under "Contracts" in the Resources area of the ACC website.

2. Who can hold this Contract?

The Elective Surgery Contract is held by Suppliers who undertake surgical treatment at a facility that:

- holds current certification with the Ministry of Health under the Health and Disability Services (Safety) Act 2001; and/or
- holds current accreditation under the NZS 8164:2005 Standard for Day-stay Surgery and Procedures.

Please refer to the Elective Surgery Contract for further details around the Service Specific Requirements of this Contract.

The Suppliers may only utilise the services of Specialist Medical Practitioners who are Named Providers under their Contract. A Named Provider is either:

- a Medical Practitioner including an appropriate limited scope registration with the Medical Council of New Zealand or who holds or is deemed to hold vocational registration that is relevant, or
- an oral surgeon or maxillofacial surgeon vocationally registered with the Dental Council of New Zealand.

A Supplier is generally a hospital and the named provider is a specialist who works within the hospital.

3. What does the Elective Surgery Contract cover

- Surgical procedure, inpatient stay and Specialist follow-up prior to discharge.
- Post-discharge care by a Specialist for a period of six weeks, including the clinically necessary replacement of dressings or casts.
- Radiology during inpatient stay.
- Inpatient nursing and allied health treatment.
- Equipment for up to six weeks after discharge. This includes manufactured items likely to help a Client restore their independence and remain safe in daily living. Examples include shower stools, crutches, walking frames, wheelchairs.
- Orthotics for up to six weeks' post-discharge. This covers the fitting and fabrication of orthoses, and related technical aids used to support or correct the function of the trunk, and upper and lower extremities. Examples include splints, shoulder braces.
- Surgical Implants and implant specific equipment (as defined within Appendix Two of the Contract). More detailed information of what ACC considers as inclusions and exclusions for implant costs may be provided in future. In the meantime, if you have any surgical implants and implant specific equipment queries please email electivesurgeryinvoices@acc.co.nz rather than the Claims Contact Centre.

Notes:

- ACC pays for implants separately from the cost of treatment, paying the supply cost to the Supplier. The Supplier gives proof of cost to the Treatment and Support Team (via disop@acc.co.nz) in the form of an invoice or similar evidence.
- Some of these above services require prior approval from ACC.
- Inpatient support (such as attendant care and nursing services) is included in the contracted price. Prior approval for funding of additional inpatient supports must be sought before admission and will be considered on a case by case basis.
- The price for each service is the total amount chargeable and no additional amount may be charged to ACC, or the client e.g. no co-payments can be invoiced.

The following services are not covered in the Elective Surgery Contract:

- Prosthetics. These are provided as aids and appliances.
- Outpatient allied health follow-up after discharge. These are covered by the Cost of Treatment Regulations or appropriate Contracts (e.g. Allied Health Services Contract).
- Diagnostic imaging services required after the date of discharge. These are covered by the High-Tech Imaging (HTI) Contract, and the Radiologist Cost of Treatment Regulations.
- Home help, attendant care and childcare.
- Transport and accommodation costs that are additional to the treatment for a Client or an escort.
- Orthotics or long-term equipment for independence required beyond six weeks' post-discharge.

Note: some of these services may be provided under a separate ACC Contract.

4. Seeking prior approval for surgery from ACC

Written approval is required from ACC before any Elective Surgery and/or certain other procedures are accepted as funded by ACC unless is it a procedure listed in the Non-Prior Approval (NPA) Procedures List found in 22 (Appendix 4) of this document.

The Surgical Assessment Report and Treatment Plan (ARTP) is used to request approval of surgical treatment. Named Providers (i.e. the Specialist) are required to submit an ARTP, via the Elective Surgery Supplier (generally the hospital), for all surgery requests. The ARTP should be submitted within seven working days of assessing the Client. The Elective Surgery Supplier is responsible for ensuring the ARTP meets ACC requirements for submission.

The specialist conducting diagnostic and assessment procedures under the Clinical Services Contract is likely to be the party who initially drafts the ARTP. The specialist should lodge this draft with the Elective Surgery supplier, **not** send it directly to ACC. The Supplier should ensure it meets ACC standards, particularly around prognosis, before submitting the ARTP to ACC.

The Elective Surgery Supplier should send the ARTP to the Treatment and Support Team via artps4esu@acc.co.nz.

The Surgical ARTP online is the only version of the ARTP that will be accepted.

The ARTP should provide ACC with the information needed to make a decision on the surgery request. It is better to send in as much information as possible for a quicker decision to be made, e.g., x-ray reports, referral. If the information cannot be understood or requires clarification, ACC will contact the Named Provider.

Medicare Benefits Schedule-Extended (MBSE) codes are no longer required to be provided on the ARTP form.

Whilst ACC don't expect you to write pages, we offer a couple of pointers to help with quicker decision-making once ACC has the ARTP:

- Prognosis field - Please be specific about prognosis, rehabilitation timeframes and expected journey (including return to work); comments like "good" or "will get better" are not helpful for decision making purposes.
- Identify any reasonable follow up care that may be needed.

The ARTP will identify the type of procedure being requested. If the surgery is for Non-core procedures (see section 7 of this document for further information about Non-core), an accurate estimation of costs including implants must also be provided. This should be done by using the ACC self-calculating Non-core pricing sheet. For more information refer to Clause 31 of the ACC Elective Surgery Contract.

The Treatment and Support Team will assess the surgery request and advise the Supplier and the Client of ACC's decision. The Elective Surgery Supplier will be notified of the decision via email and the Client will be notified by a letter sent via post. If the surgery request is declined, the Treatment and Support Team will also advise the Client by phone.

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

5. Non-prior Approval (NPA) Procedures

5.1. What are NPA Procedures?

These are procedures codes that represent clinically low risk elective surgeries which we rarely decline, such as the removal of metalware. The list of these is included in the table at Appendix 4 of this document.

Procedures that meet the corresponding conditions in the NPA Procedures List are exempt from the funding approval process, this means they can be provided to the Client without completing an ARTP. These procedures do not require prior approval from ACC. You may complete the treatment and following the standard invoicing process from clause 13 in the Operational Guidelines.

Cover criteria **must** be met before proceeding with the elective surgery procedure as this can impact future entitlements for the client. You can easily request additional cover by emailing surgeryassessmentteam@acc.co.nz with the following information, you will receive a response with 1 working day:

> **Subject:** Add Cover: [Client Name and Claim Number]
> **Body:** Cover you wish to be added: [Read Code] and diagnosis

Notes:

- The specialist **must** submit their Clinical Services consultation records to ACC detailing the proposed surgery, this allows for ACC to set up supports for the client e.g. Weekly compensation if requested.
- Where a specialist proceeds with a NPA procedure, and in-theatre it becomes apparent that another procedure needs to be performed, which requires prior approval – the **Retrospective funding approval for alternative unanticipated treatment or alternative treatment** process at clause 20 of the Elective Surgery contract must be followed.
- ACC may amend this list as required and will provide you with reasonable notice of any changes.
- ACC reserves the right to exclude specific Suppliers from using the NPA Procedures List. ACC will contact these suppliers directly to advise they cannot use the list. This means they must complete the funding approval process and complete an ARTP to obtain ACC approval prior to providing treatment to the client.

6. Transfer of Lead Supplier

The Contract states the expectation that, where a Client agrees to be transferred from one lead supplier to another, the receiving lead supplier will make reasonable demands of the sending supplier concerning medical notes and so on. This transfer should include any approval letter and purchase orders. Where such transfers happen frequently between two suppliers, we recommend that standard protocols be agreed between them, in order that neither party and especially ACC's Client is inconvenienced.

7. Determining ARTP priority

The ARTP priority (that is, the urgency with which the Treatment and Support Team should assess the ARTP compared with others) should be clearly stated on the ARTP.

ACC utilises a two-tier system to classify the priority of an ARTP. The classifications are either 'High' or 'Routine'

High priority applies if the Client meets one (or more) of the following criteria at the time of their surgical consultation:

a) The Client's current condition is considered clinically urgent, meaning the condition meets clinical criteria AND will be treated under specific surgery codes as set out in Appendix 3;
b) The Client will require paid assistance (home help or attendant care) to assist with activities of daily living if the proposed treatment is not carried out within 30 days;
c) The Client was employed at the time of the accident and is receiving weekly compensation from ACC;
d) The Client is at risk of losing their job because they are unable to continue in paid employment while waiting on the requested treatment and the proposed treatment is likely to reverse/improve the relevant loss of function.

If the Client does not meet any of these criteria, the ARTP should be classified as 'Routine'. The priority classification does not override the clinical determination. When completing the ARTP please ensure that priority codes are indicated as below (noting that there is no order of importance)

H1 – clinically urgent

H2 – home help required

H3 – receiving weekly compensation

H4 – risk of losing employment

Please note:

- It is expected that acute fractures requiring surgical fixation are managed under PHAS where clinically indicated and capacity is available.
- We note some acute fractures that do not require fixation within 1 week through the PHAS pathways are not listed individually. However, all acute fractures would be H1
- Although codes have been included, not all requests within these codes constitute H1 conditions. Multi-tendon rotator cuff tears (SHU92, SHU90) for example may be H1 if acute with pseudo paralysis, but not if chronic.
- We are working on non-orthopaedic H1 codes and will communicate once these have been added.

7.1. Meeting priority timeframes

Surgery approved through a high priority ARTP is expected to be undertaken within one month of the surgery being approved. If a Supplier is unable to meet this requirement for high priority surgery ACC

needs to be notified immediately. ACC may, at its sole discretion, either endeavour to agree with the Supplier and the Client an extension of the timeframe, or work with other Suppliers to make alternative arrangements for the provision of the surgery.

ACC provides feedback to Suppliers regarding performance against the one-month requirement.

This is the key performance indicator under the Contract. This data is used to generate discussions, rather than operate as a 'pass/fail' target.

Suppliers will receive data about their Named Providers' achievement of these priority timeframes also. It is the responsibility of the Supplier to initiate discussions with the Named Provider to understand and improve performance in this regard.

Note: During times of reduced capacity e.g. Covid-19 Protection Framework Traffic Light Level Red, we ask that procedures are prioritised in the following order:

- H1
- H2, H3, H4
- Routine

This doesn't replace the clinical decision-making required in each individual case. We expect that appropriate clinical risk assessments continue to inform your decisions.

7.2. Changing a Client's priority

If a Named Provider or Supplier becomes aware of change in the Client's condition or circumstances that warrant a change of surgery priority classification, they should contact ACC to discuss this.

ACC may request a change to the Client's priority classification if the Client's circumstances have changed and they then meet any one of the above criteria for 'High' priority (or no longer meet any of the criteria and their surgery can be prioritised as 'Routine'). ACC will confirm the priority classification on the surgery approval letter.

7.3. Review

These criteria will be reviewed periodically to ensure they are fit for purpose for all parties.

8. Types of procedures

The Elective Surgery Contract covers 'Core' and 'Non-core' procedures.

A "core procedure" is a package of care surrounding a particular surgical intervention. A "non-core procedure" is a package of care surrounding an unusual surgical intervention or unusual condition relating to the Client. Non-core procedures will be priced and approved on a case-by-case basis, using the non-core codes described on the non-core price calculation spreadsheet.

"Red List" procedures are those which have been assessed by the relevant professional body (most commonly a sub-committee or Society associated with the New Zealand Orthopaedic Association) as requiring a specially trained surgeon. The application process for surgeons who seek to perform such procedures is outlined in clause 12 of these operational guidelines. Please note that until confirmation of approval has been issued in writing from ACC on the advice of the professional body, providers can not undertake any of the Red List procedures for ACC.

Appendix 2 contains the list of NZOA recommended ACC Red List procedures. This list will be updated on an annual basis after all relevant Subspecialty Societies have met.

The list of Red Listed surgeons will be updated quarterly to ensure both ACC and NZOA have the most up to date information.

Type of Procedure	Description
Core (Non-Red List Core)	**Core procedures** are listed in the Contract under 'Service Items and Prices' (Part A, clause 4) All Contracted Specialists who are named under an Elective Surgery Contract can request Core procedures that are not classified as Red List procedures as required. Suppliers can also access associated items such as ward stay or (under specific approved circumstances) specialist in-ward follow up visits.
Non-core	**Non-core procedures** are not included within the list of 'Service Items and Prices' (Part A, clause 4). **Non-core procedures are usually either:** • a less common treatment procedure, or • a combination of a Core treatment procedure and a procedure that is not listed or an additional service item that is required due to the Client's condition (including co-morbidities). Further information around multiple procedure requests is outlined under Section 14 below. **Non-core procedures are not:** • Core procedures that the provider has not agreed to a Contracted price for; and/or • Core procedures undertaken by a non-Contracted Provider. This would be a Cost of Treatment Regulations (Regulations) procedure. All Contracted Specialists who are named under an Elective Surgery Contract can request Non-core procedures as required.
Red List Core	Some of the Core procedures are classified as being 'Red List' procedures. Red List procedures are relatively complex, high cost and low volume procedures (see above). Suppliers can also access associated items such as ward stay or (under specific approved circumstances) specialist in-ward follow up visits.

9. Further clarification code usage and add-ons

9.1. Botox Injections

Codes have been developed for Botox injections for spasms or contractures. These codes can be used for all body sites. These codes must be included on the ARTP for prior approval.

AFT300	Botox for release of spasm/Contractures 1 body site. May be used as an equivalent for other body sites.

	Does not include costs for Botox ampoules. These are billed separately using the add-on block AFTABOTOX (see below)
AFT301	Botox for release of spasm/Contractures 2 body sites. May be used as an equivalent for other body sites. Does not include costs for Botox ampoules. These are billed separately using the add-on block AFTABOTOX (see below)
AFT302	Botox for release of spasm/Contractures 3 body sites. May be used as an equivalent for other body sites. Does not include costs for Botox ampoules. These are billed separately using the add-on block AFTABOTOX (see below)
AFT303	Botox for release of spasm/Contractures 4 body sites. May be used as an equivalent for other body sites. Does not include costs for Botox ampoules. These are billed separately using the add-on block AFTABOTOX (see below)
AFTABOTX	Orthopaedic Botox. For costs of Botox ampoules used with the codes AFT300 - AFT303

9.2. Wrist and Hand

For procedures where bone grafts are not included, GOP01 and GOP02 can be used as add-ons when required.

9.3. Foot and Ankle

There are three add-on codes for Foot and Ankle available. One for orthopaedic Botox (above) and two for minor or major bone grafts (below). These can only be used in conjunction with codes AFT300 – AFT303 and must be included on the ARTP.

ORAMINB	Minor bone graft (add on) for use with procedure codes that don't already include bone graft For bone harvested from a site other than the operation site or the iliac crest.
ORAMAJB	Major bone graft (add on) for use with procedure codes that don't already include bone graft For bone harvested from the iliac crest.

9.4. Ophthalmology

The following two add-on codes have been developed:

OPTAFRAG	Fragmatome Use. Add on to be used in conjunction with OPT101-OPT133.
OPTAEYEB	National Eye Bank fee. Add on to be used in conjunction with OPT106

9.5. Spinal

New spinal codes (300 series) have been added to the contract 1 May 2023. As these codes have been developed using up-to-date inputs, the expectation is that ESR non-core codes will **not** be invoiced to ACC unless there are exceptional circumstances.
Exceptional circumstances must be supported in the documentation supplied to ACC at invoicing.

Anaesthetic costs have been applied in the new codes based on the NZSA Relative Value Guide 2021:

Time Costs	Based on time units of 1 unit per 15 mins for the first TWO hours and every 10 mins from the start of the THIRD hour
Base Units	For each procedure as per the Guide. The units for Spine include loading for positioning

9.6. Otolaryngologist (Ear, Nose and Throat)

An add-on code is available to be used when a turbinoplasty is performed in conjunction with OTY103 – OTY109 as there is no code for turbinoplasty alone.

OTYATURB*	Endoscopic Powered Inferior Turbinoplasties. Add on to be used in conjunction with OTY103 - OTY109.

**This code covers the material costs for a powered turbinoplasty.*

9.7. Imaging

These codes are to be used for invoicing the use of image intensifiers in theatre. 'Time in theatre' is the total time that the machine is under the control of the radiographer and is equivalent to the number of time blocks that radiographer is required.

The pricing for these codes become cumulative once the image intensifier is required for more than 150 minutes, for example:

- if required for 180 minutes the provider can bill IMAGE5 in combination with IMAGE1.
- if required for 240 minutes the provider can bill IMAGE5 in combination with IMAGE3.

IMAGE1-5 are the only codes ACC will fund image intensifier in theatre use under. No ESR codes should be used for this.

Note: The radiographer's costs are included in imaging codes. These costs must **not** be billed separately using the ESR13 code.

9.8. 3D Imaging

These codes (3DIMAGE1-4) are to be used for invoicing the use of 3D Intraoperative imaging. Time in theatre is the total time that the machine is under the control of the radiographer and is equivalent to the number of time blocks that radiographer is required.

Note: The radiographer's costs are included in 3D imaging codes. These costs must **not** be billed separately using the ESR13 code.

9.9. Orthotics

The hire of knee scooters does not require prior approval and can be billed using the ESR11 code with the core code with evidence of actual and reasonable cost.

9.10. Surgical Implants

The cost of implants used during a procedure are over and above the core cost for that procedure.

The Supplier invoices ACC separately for implants and ACC pays the Supplier's actual cost. The Supplier is expected to charge ACC the best price the supplier has been able to achieve from the implant vendor, and to make their best efforts to obtain the lowest price possible.

ACC requires Suppliers to provide invoices for all implants over $10,000 (excluding GST). It also requires Suppliers to retain Supplier Implant Invoices so that ACC may review these upon request.

The list of implants can be found in Section 40 of the Contract.

Note: All specialised customised implants and bio models require prior approval via the original ARTP. Once approved ACC will pay the actual cost of these after the procedure has been completed.

9.11. Unusually Complex Clients

Where a client is admitted for an elective surgery and has cover for an injury that requires additional nursing support due to a significant functional disability e.g. Spinal cord injury, dense hemiplegia, ACC will consider additional payment for this support.

Note: This request should be supplied to ACC on the ARTP and will require supporting documentation of the additional supports at invoicing.

10. Interpretation of Specific Non-Core Codes

10.1. ESR01 and ESR02 - Theatre Time

ACC is unable to provide average theatre times for procedures as there are public-private commercial negotiations that are often undertaken which such data may compromise. Each supplier should be able to define their own average theatre time (patient in/patient out) and therefore explain any variance they want ACC to pay for.

10.2. ESR04 – Requests for Anaesthetic Modifiers

This code relates to Anaesthetic modifiers that can be claimed for things such as:

- ASA3 or above
- Patients under the age of 1 or over the age of 80
- Nerve Blocks
- High BMI, and more.

ACC currently uses the RVU Anaesthetic 2021 Edition as a guide in our decision making and pricing; thus, ACC does not guarantee that the pricing will exactly match that of the RVU guide.

Please see the ACC's guidelines for requesting Anaesthetic modifiers in Appendix 1

10.3. ESR09 – 2nd Surgeon – Consultant

ACC uses a variety of data to calculate the 'per minute' price for a 2nd surgeon. We acknowledge however that there is a commercial relationship between the Supplier and surgeon, and they are able to come to their own arrangements within the funding available.

The time for the 2nd surgeon starts from when they enter theatre until they exit theatre, where their entrance and exit reflect a clinical necessity for their presence. ACC will not pay for an observing surgeon who is not actively contributing to the procedure.

While the 2nd surgeon doesn't have to be a named provider on the supplier's contract, they **must** be a surgeon who is fully registered with the NZ Medical Council in a vocational scope of practice for surgically related specialities (the same requirements as becoming a named provider). ACC will not pay for a trainee or qualified medical practitioner who is not a vocationally registered specialist.

10.4. ESR10 – 2nd Surgeon – Assistant

This code is available for an assistant surgeon when appropriate to the surgery. It is used for funding assistant surgeons who are qualified medical practitioners.

Note: Nurse assistants cannot invoice under this code as their costs are included in the core code costs, or for non-core under the ESR01 and ESR02 theatre time prices.

10.5. ERS12 – Unique Supplies (consumables, drugs – extra to base)

This code is available to cover supplies additional to the base calculations. The non-core self-calculating sheet has the breakdown of base supplies under ESRNC2 as $686.36 excluding GST.

The process for calculating and invoicing of non-core itemised and priced supplies lists (ESR12) is as follows:

- Total supplies used **minus** the Base Rate of **$686.36** excluding GST (which may be adjusted from time to time by a variation of the Contract).

This code is for supply costs only. An itemised list **must** be provided in support of these costs and is **not** to include any other charges.

For suppliers who are unable to calculate their itemised supply costs, the sliding scale is available to use. The sliding scale is based on theatre time to assist recovering some costs and has already factored in the subtraction of $686.36 for the base supplies under ESRNC:

- $500 – 0-60 mins
- $1000 – 61-120 mins
- $1500 – 120-240 mins
- $2000 – 240-360 mins
- $3000 – > 360 mins

10.6. ESR13 – Unusual and Unspecified Costs

This is not to be used for items already included in other contract fees. A written explanation must be provided to ACC detailing why the charge is an exception to the normal fees and costs.

All ESR13 invoices require evidence of the cost eg. Hire equipment must include the hiring company's invoice, ambulance transfer must include St John's invoice.

ACC will not pay any additional costs for equipment charges, sterilising and handling fees. These costs are included in the flat rate fee for ESRNC.

Costs cannot be claimed for routine pre-operative assessments on the day of admission. This includes medical assessments and ECGs.

10.7. ESR18 – Follow up visits – set fee per visit

This code is for follow-up Specialist consultations only during the 6-week post discharge period, not for specialist follow-up visits in ward prior to discharge.

However, we allow one exception: Where the specialist has prior approval via an ARTP, on a case-by-case basis, for in-hospital post-operative consultations ("in-ward follow-ups") for a complex surgical case, such as (but not limited to) neurosurgery or maxillofacial surgery, where such consultations would be considered a clinically necessary episode given the nature of the surgery and the timeframe to discharge.

In this instance, there must be:

- an invoice with the date of the in-hospital consultation,
- clinical notes (combined across all ward consultations rather than for each visit. Ward notes or a footnote in the patient's progress notes would not be sufficient), and original Purchase Order number.

11. Outpatient Post Discharge/Post Procedure Care

Post discharge/post procedure care begins following discharge from the Treatment Facility and ends six weeks after discharge.

Post discharge care includes the replacement and/or removal of casts and dressings. There are a couple of exceptions listed in the Clinical Services Contract for reapplication of plaster casts/thermoplastic splints able to be invoiced within 6 weeks of discharge. If it is anticipated that the casting will be complex and may need multiple changes, this should be noted on the ARTP so Prior Approval can be given.

Where a replacement cast, stitch removal or dressing change can reasonably be conducted at the supplier's facility it should be. Where that is not possible (for example the travel time for a Client would be onerous) the provider or primary care provider may use the appropriate Cost of Treatment Regulation code.

Section 11.3 of the Contract sets out what the post discharge/post procedure care includes. If further Specialist care is needed at the end of six weeks, this is provided under the Clinical Services Contract or under appropriate Regulations.

12. Significant Complication, Transfer of Care

12.1. Abandoned during surgery/ Significant complication transfer of care

Where surgery is abandoned in theatre, Section 31.7 Elective Service Contract: Significant complication transfer of care applies.

The suppliers may invoice for non-core costs up to and including the time the client is transferred or discharged.

12.2. Return to theatre for approved elective surgery

When a return to theatre has been required during an admission for ACC approved elective surgery, provision has been made to consider such costs retrospectively.

Theatre charges for the additional procedure may be sent as a separate retrospective non-core invoice* for which a new purchase approval will be issued subject of course to ACC approving the retrospective costs.

** Costs for return to theatre should be recorded under a new purchase order for tracking and reporting purposes.*

13. Red List Providers

Named Red List Providers that are listed in Part A Clause 3.2 of the Contract can perform their approved Red list procedures as well as all non-red core procedures and non-core procedures.

It is important to note that Named Providers **cannot** perform Red List procedures until they receive confirmation of Red List approval from ACC. This is to ensure that ACC systems have been updated so invoices will not be rejected.

13.1. Application by orthopaedic surgeons

Application by orthopaedic providers to be a named Red List provider should be done directly through New Zealand Orthopaedic Association (NZOA), who will advise ACC and the applicant of the outcome – see clause 17.6.2 of the Contract. Due to the required external evaluation from the relevant sub-speciality group the decision-making process can take time. If you have any queries about the application, you should contact NZOA.

Once the decision is made NZOA will advise the provider and ACC that they have been listed on the Red list. ACC will then confirm with the Red List-approved provider that they are now able to perform Red List procedures for ACC under this Contract.

Note: ACC reserves the right to decline to accept new Named Red List providers.

13.2. Application by non-orthopaedic surgeons

In cases where Red List procedures are identified in other scopes of practice, application to be a named Red List provider should be done through ACC. Due to the required external evaluation from the relevant specialty or sub-speciality group the decision-making process can take time. If you have any queries about the application, please contact our Health Procurement team (health.procurement@acc.co.nz).

Note: ACC reserves the right to decline to accept new Named Red List providers.

14. Invoicing

Invoices should be submitted to the ACC Treatment and Support Team in accordance with clause 31 of the Contract. All invoices must be submitted to ACC within 12 months of the treatment provided or they will not be paid.

Please ensure that:

- Service dates should be the actual date of surgery; payment rates are based on discharge date.
- Purchase Order number (if applicable), Admission and Discharge dates to be entered on comments field of e-schedule.
- Operation Notes/Discharge Summaries and Suppliers Invoices for Implants to be emailed to disop@acc.co.nz
- Payment will be declined if required supporting documentation have not been received within 5 working days.
- Supporting documentation for **Implants** are required prior to, or same date as the electronic schedule.
- When supporting documentation is requested after a schedule has been submitted, the payment will be declined, and the schedule will need to be resubmitted.
- It is preferable but not essential to have the Client's claim number or purchase order on the notes. Instead the subject line of your email should have the Client name and purchase order number (unless the procedure is listed on the Non-Prior Approval Procedure List).
- Core and Non-core procedure prices do not include the cost of surgical implants.
- One schedule per client is submitted for all surgery.
- Actual number of units to be entered in unit field for non-core surgery.
- If requesting payment for exceptional costs, please ensure you provide the rationale behind these costs and any supporting documentation.

- Invoice queries to be emailed to electivesurgeryinvoices@acc.co.nz and not individual ACC staff or the Provider Helpline.

15. Requests and invoices for multiple procedure

Suppliers are able to request a combination of Core and Non-core procedures or request two or more different types of Core procedure to be performed at the same time.

If	Then
Treatment for a Claim involves two Core procedures from the Contract that will be carried out during the same theatre session.	Suppliers should submit one ARTP detailing both Core procedures. For invoicing, the total price will be: • The price of the most expensive of the procedures plus; • 40% of the price of the second procedure.
Treatment for a Claim involves three or more Core procedures from the Contract that will be carried out during the same theatre session.	Suppliers should submit a request for a Non-core procedure. This request is done on an ARTP and any additional information to support the request should also be sent at the same time. The price for the surgery will be determined in accordance with the process set out in clause 31 to 33 of the Contract.
The procedure is expected to involve a combination of core and non-core elements or, due to unforeseen circumstances, a combination of core and non-core elements was required at the time of treatment provision.	Where the main component of a procedure is equivalent to a Core procedure, but additional service items are required, the Supplier must apply for the approval of the procedure. Where the additional service items were unplanned, invoice the procedure as a Core Procedure with the additional service items listed as Non-core units (ESR service codes) and submit the clinical information to support the additional units. Additional services may include but are not limited to additional ward stay, High Dependency Unit care and 2nd Surgeon Consultant where deemed clinically appropriate. If the Supplier applies for a procedure as Non-core, where the main component of a procedure is equivalent to a Core procedure, but additional service items are expected to be required, the Supplier must provide clinical information with the invoicing to support costs. ACC may decline an application for approval as a Non-core procedure and approve the procedure as a Core procedure with additional service items.

16. Service Monitoring and Reporting

16.1. ACC Collected data

ACC introduced performance measures to the Elective Surgery Contract effective 1 May 2017. Under clause 29 of the Contract the following measures are monitored:

Performance Measurement	Description	Frequency
Volume of ACC surgeries performed by supplier	a) 75% of high priority surgery is provided within 30 days of the date of ACC's decision to approve surgery or the decision to proceed with surgery if Part B clause 18.7 applies, and b) 80% of routine priority surgery is provided within 6 months of the date of ACC's decision to approve surgery or the decision to proceed with surgery if Part B clause 18.7 applies.	ACC – Quarterly Reports on previous quarter
Measure of surgeries performed by body site	1) (a) Average days by facility and surgeon for High priority surgery to be undertaken. 2) (b) Average days by facility and surgeon for Routine priority surgery to be undertaken.	ACC – Quarterly Reports on previous quarter

The performance measures will be monitored by ACC. Suppliers are **not** required to submit data on these measures to ACC. Feedback on the performance measures will be provided to Suppliers through their Engagement and Performance Manager (EPM).

16.2. Supplier Provided Reporting

Under Clause 30, suppliers are to report on the following quality improvement and quality indicator reporting requirements:

1. their participation in quality improvement activities,
2. the results of such initiatives,
3. the benefits to be expected for ACC clients from these activities, and
4. the results of Patient Reported Experience Measure (PREM) using a tool generally accepted in the sector as being robust – noting changes over time.

There is no formal reporting required for points 1 – 3, the EPMs will have a discussion with each of their suppliers about any new or ongoing quality improvement activities.

With the exception of Public Hospitals, suppliers must provide their EPM with a copy of their most recent Patient Reported Experience Measure survey results.

Te Whatu Ora PREM reporting is publicly available and ACC will obtain these reports.

Please note we are not asking that you change your surveys; if you have an existing survey this can be provided to your EPM. The essence of PREMs is to drive continuous quality improvement from the patient's perspective, therefore, we are interested to know how facilities use the survey information to improve patient services on an ongoing basis and how it helps them drive improvements. We also like to see a copy of the survey questions, so we can understand what you monitor to improve your patients experience.

17. Contracted and Regulation Surgery

The following funding categories can be used for elective surgery:

Contracted surgery	This is the funding route that can be used by Suppliers who hold a current Elective Surgery Contract. This is the most common funding route used: ○ Contract holders are paid the Contracted price specified in the Elective Surgery Contract. This price

	covers the surgical treatment and the six weeks' post-discharge from hospital care. ○ Implants are not included in the Contracted price. ACC will pay the Supplier's cost price for implants used and these should be invoiced separately, at the lowest price the supplier can obtain. ○ The Supplier **cannot** charge the Client with any additional co-payment[1] for the services.
Regulation surgery (non-Contracted surgery)	This is the funding route that can be used for non-Public Hospital Suppliers who do not hold a current Elective Surgery Contract. ACC is liable to pay or contribute to the cost of surgery under regulation 18 of the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 ('non-Contracted surgery'). This includes all procedures listed on the Contract procedure list. ○ Private hospitals are paid at 60% of the Contracted rate. ○ If the procedure is Non-core, private hospitals are paid 60% of the Non-core price. ○ All implants are paid at 100%. ○ Private Hospitals may charge the Client a co-payment. The Surgeon requesting approval for Regulation surgery is responsible for ensuring that payment is made to the hospital, anaesthetist and others from the ACC contribution amount. The Surgeon can request that a hospital takes on this role. If the hospital agrees, then the hospital is responsible for distributing payments to all parties concerned. Suppliers should note that ACC is only required to pay for 'the generally accepted means of treatment for such an injury in New Zealand….' (see Schedule 1, clause 2 (2) (b) of the Accident Compensation Act 2001).
Regulation surgery (non-Contracted surgery) – Public Hospitals	Public Hospitals may choose to invoice actual costs of treatment under Regulations noting that ACC may decline to pay if the injury is not a covered injury. In addition, Suppliers should note that ACC is only required to pay for 'the generally accepted means of treatment for such an injury in New Zealand….' (see Schedule 1, clause 2 (2) (b) of the Accident Compensation Act 2001). Note that, if a Public Hospital holds the Elective Surgery Contract, it cannot invoice under Regulations instead (see Standard Terms and Conditions Clause 8.12). Public Hospital taking this route are advised to continue to seek ARTP approval, and to invoice using the Elective Surgery Contract code structure, to avoid payment being declined or evidence of actual cost being required.

[1] A co-payment is any amount paid by the Client to cover the remaining costs between ACC's contribution and the total amount charged by a non-Contracted provider.

Under ACC's Standard Terms and Conditions (Clause 8.12), a Supplier under the Elective Surgery Contract may not choose to invoice ACC under Regulations for a procedure covered by the Elective Surgery Contract.

It is important that Clients are made aware of the option to have their surgery fully funded through a Contracted Supplier. ACC has a legal requirement to inform the Client that surgery can be performed by a Contracted Provider at no cost to the Client, even though this may mean the Client receives treatment from an alternative, Contracted provider other than the clinician whom they have originally consulted. This information is provided directly to the Client in a decision letter. The Client must sign the letter and return it to ACC to demonstrate their understanding and consideration of all the options available. Failure to complete this process can result in delays to treatment, so Suppliers and Providers are expected to assist Clients in this process.

A discussion regarding options will need to occur after the approval decision for surgery, when all information is available. This will result in a second consultation regarding surgical options, which can be invoiced using the Clinical Services Contract.

ACC requires the completed documentation before any payments can be made for the provision of surgery.

18. Clauses Relating to District Health Boards

18.1. Consideration of Funding without prior approval

The ARTP should always be submitted prior to surgery with the priority identified (high 1-4 or routine).

ACC will consider retrospective payments under the ES contract from DHBs only, as per Clause 39.3 of the Contract. There are strict criteria for these to be considered.

- Only urgent, non-acute surgeries that are completed within 7 days of the expiry of the PHAS period will be considered. (Patients that remain an inpatient at the time of the surgery are acute and will not be considered under this option) and;
- Consideration will only apply to these requests which are received within one calendar month from the date of surgery. Requests outside of this timeframe will not be considered.

The DHB must email purchaseorderteam@acc.co.nz (subject: DHB Retrospective Consideration) for Treatment & Support Manager consideration. The email must contain the claim details, PHAS end date and the reason prior approval has not been gained before the surgery has been completed.

If the application is denied for cover or not meeting these criteria, the DHB is responsible for funding these surgeries from other sources.

ACC reserves the right to remove this flexibility if, in our view, the process is being misused. This process is not intended to substitute process failings. The intent is to recognise those rare scenarios where time and/or exceptional circumstances have prohibited the DHB in seeking prior approval.

19. Appendix 1 - Guidelines for requesting Anaesthetic modifiers

Requested Modifier	Acceptable	Units	Notes
Pre-op telephone conversations	✗	0	These activities are completed prior to admission – must be provider under the Clinical Services Contract.
Face to face visits with patients prior to the day of surgery	✗	0	
Face to face visits on the day of surgery	✗	0	N/A
Cancellation of case on day of surgery after assessment and management of the relevant issues.	✓	2	Abandoned surgery. See table below for examples of when ACC can accept costs.
<u>Time Units:</u> These are already built into the theatre rate. Please see the guidelines for the non-core ESR01 & ESR02 Codes. Note there is no special rate for out of hours service.	✗	0	Anaesthetic time starts when the anaesthetist commences exclusive and continuous care of the patient and ceases when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel. This will include time spent before and after surgery e.g. time relating to the insertion of blocks and time spent involved in PACU care post-surgery
Age if >1, and/but <2, 70-80 year old	✓	1	
Age if <1 or >80	✓	2	
ASA 1	✗	0	N/A
ASA 2	✗	0	N/A
ASA 3	✓	2	
ASA 4	✓	4	
Emergency Case	✓	2	
Awake Intubation	✓	2	However accomplished.
Positioning non-core	✓	2	Any position which is **not** supine, lithotomy or lateral or spinal procedures.
Body Mass Index (BMI): BMI <35	✗	0	N/A
BMI 35-40	✓	1	

BMI >40		2	
BMI >50		3	
Arterial Line, CVL, PA Catheters expected of the anaesthetic and surgery		0	N/A
Arterial line, CVL, PA Catheter insertion as separate procedures not expected of the anaesthetic or surgery		2	
<u>High Dependency Unit (HDU) care with the anaesthetist at home providing cover:</u> Base pricing recognising availability Telephone Calls which require significant management change Any face to face visit that results in significant management change	  	4-6 1 unit per call 4 units per visit plus time.	Maximum 18 units per HDU day (including phone calls and face to face visits)
ICU Care where anaesthetist lives in hospital and provides cover		0	This cost is included in the ESR07 cost (ICU).
<u>Ward Care:</u> Visits to the ward or PACU to review the case. SIMPLE:		Up to 2 units per visit, with a maximum of 2 visits per day	Non-complex visits involving epidurals, IV fluids or simple pain management.
COMPLEX: Note the NZSA review group recognises the very first post-operative visit on the day after surgery can range from a simpler brief meeting to a more complex problem solving and explanation visit. Any face-to-face visit less than 15 minutes Any face-to-face visit longer than 15 minutes	  	 0 Up to 2 units (plus up to 2 more units with justification)	 This cost is included in the package of care. Complex visits with significant documented management issues.

Continuous Regional Block Plexus/Nerve Catheter Care (which stays in the patient overnight or for several days)		Up to 3	Anaesthetic notes need to be provided to ACC.
Prolonged PACU care		Time units or refer to 'Ward Care' section	On occasion PACU care will be prolonged. The time units should reflect the PACU care, but additional documentation should be provided if a PACU time greater than 15 minutes is being claimed for.

Abandoned surgery

This table provides examples of when ACC can pay anaesthetic modifier costs if there is a cancellation of case on the day of surgery after assessment and management of the relevant issue(s).

ACC can pay	**ACC can't pay**
Patient found to be not fit for surgery after admission	Patient failed to turn up on the day
Patient found to have not fasted after admission	Surgeon not fit or available on the day
Patient changed their mind after admission	Unexpected lack of staff
	Unexpected overrun of surgical lists

20. Appendix 2 – Red List Procedures

20.1. Foot and Ankle Procedures

Red List Codes	Procedure Description
AFT215	Total Ankle Replacement – Simple
AFT216	Total Ankle Replacement – Complex. Includes debridement Tendo Achilles (TA) lengthening/gastric slide, removal metalware

20.2. Shoulder and Elbow Procedures

Red List Codes	Procedure Description
ELF10	Total Elbow Replacement
ELF60	Elbow Arthroscopic Surgery - Complex
ELF61	Elbow Arthroscopy proceed to open - Complex
SHU96A	Shoulder Instability Repair – Complex 2: Latarjet Procedure. Includes: Osteotomy, transfer and fixation of the coracoid process and attachments and/or other bone graft to glenoid. Not to be used in combination with other codes. Not to be used as an equivalent.
SHU14	Total Shoulder Replacement
SHU17A	Reverse Shoulder Replacement
SHU15	Arthrodesis Shoulder
Non-Core Shoulder Procedures	
Revision Shoulder Replacement	
Shoulder tendon transfers (Latissimus dorsi, Pectoralis major, Lower Trapezius)	
Superior Capsular Reconstruction	

20.3. Hip Procedures

Red List Codes	Procedure Description
HIT50A	Hip Arthroscopy Simple
HIT60A	Hip Arthroscopy Complex 1
HIT70A	Hip Arthroscopic Surgery – Complex 2

20.4. Knee Procedures

Red List Codes	Procedure Description
KNE95A	Primary Knee PCL (Posterior Cruciate Ligament) Reconstruction – Arthroscopic and/or Open – Complex (includes a KNE85A with Meniscal Repair and/or Outerbridge III – IV drilling or microfracture)

20.5. Spine Procedures

Red List Codes	Procedure Description
SPN300	Occipito -cervical fusion with instrumentation, any levels. +/- decompression. Includes bone graft
SPN301	Posterior Fusion - C1/2 with instrumentation. Includes bone graft
SPN302	Posterior C1/2 to cervical fusion with instrumentation, any levels. +/- decompression. Includes bone graft
SPN303	Posterior Cervical Fusion - Simple – Single Level with instrumentation (excludes C1/2 with instrumentation). Includes bone graft

SPN304	Posterior Cervical Fusion Complex – Single Level with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft
SPN305	Posterior Cervical Fusion - Simple – Two Levels with instrumentation. Includes bone graft
SPN306	Posterior Cervical Fusion Complex – Two Levels with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft
SPN307	Posterior Cervical Fusion - Simple – Three or more Levels with instrumentation. Includes bone graft
SPN308	Posterior Cervical Fusion Complex – Three or more Levels with instrumentation. Includes: Discectomy and/or Decompression and Posterior Laminectomy or Foraminotomy. Includes bone graft
SPN309	Cervical Laminoplasty 1-2 Levels
SPN310	Cervical Laminoplasty Complex 1-2 Levels. Includes Decompression (Foraminotomies)
SPN311	Cervical Laminoplasty 3 or more Levels
SPN312	Cervical Laminoplasty Complex 3 or more Levels. Includes Decompression (Foraminotomies)
SPN313	Posterior Cervical Decompression Simple 1 Level
SPN314	Posterior Cervical Decompression Complex 1 Level. Includes Posterior Discectomy
SPN315	Posterior Cervical Decompression Simple 2 Levels bilateral
SPN316	Posterior Cervical Decompression Complex 2 Levels bilateral. Includes Posterior Discectomy
SPN317	Posterior Cervical Decompression Simple 3 Levels or more bilateral
SPN318	Posterior Cervical Decompression Complex 3 Levels or more bilateral. Includes Posterior Discectomy
SPN327	Cervical Disc Replacement (Arthroplasty) – Single Level. Includes: Discectomy and/or Decompression
SPN328	Cervical Disc Replacement (Arthroplasty) - Two or more Levels. Includes: Discectomy and/or Decompression
SPN329	Cervical Hybrid Disc Replacement (Arthroplasty) - Two or more Levels. A single level anterior cervical intervertebral fusion in combination with a single level disc replacement. Includes: Discectomy and/or Decompression. Includes bone graft
SPN346	Revision Posterolateral Lumbar Fusion with Instrumentation – Single Level. Includes removal implants same level. Includes bone graft
SPN347	Revision Posterolateral Lumbar Fusion with Instrumentation – Single Level. Includes removal implants at another level. Includes bone graft
SPN348	Revision Posterolateral Lumbar Fusion with Instrumentation - Single Level. Includes removal implants same level. Includes Discectomy and/or decompression. Includes bone graft
SPN351	Revision Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. Includes removal implants same level. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN352	Revision Posterolateral Lumbar Fusion with instrumentation Simple - Two or more levels. Includes removal implants another level. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN353	Revision Posterolateral Lumbar Fusion with Instrumentation Complex - Two or More Levels. Includes removal implants same level. Includes Discectomy and/or decompression. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.

SPN354	Revision Posterolateral Lumbar Fusion with Instrumentation Complex - Two or More Levels. Includes removal implants another level. Includes Discectomy and/or decompression. Includes bone graft. If the procedure involves more than two levels or the procedure is more complex, non-core pricing can be used.
SPN360	Anterior Lumbar Fusion Simple – Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or. Direct lateral interbody fusion (DLIF). Includes: Discectomy and/or Decompression. Includes Access Surgeon. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN361	Anterior Lumbar Fusion Simple – Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or. Direct lateral interbody fusion (DLIF). Includes: Discectomy and/or Decompression. No Access Surgeon. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN362	Anterior and Posterior Lumbar Fusion Complex - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used in combination. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN363	Anterior and Posterior Lumbar Fusion Complex - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes bone graft. No Access Surgeon. Includes: Discectomy and/or Decompression. Not to be used in combination. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN364	Revision Anterior Lumbar Fusion - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN365	Revision Anterior Lumbar Fusion - Single Level. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. No Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core.
SPN366	Anterior Lumbar Fusion Simple - Two or more levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core
SPN367	Anterior Lumbar Fusion Simple - Two or more levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). No Access Surgeon. Includes: Discectomy and/or Decompression. Includes bone graft. Not to be used for laparoscopic/endoscopic techniques. These should be done non-core. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN368	Anterior and Posterior Lumbar Fusion Complex - Two or More Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. Includes Access Surgeon. Includes: Discectomy and/or Decompression Not to be used in combination. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.

SPN369	Anterior and Posterior Lumbar Fusion Complex - Two or More Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). And Posterolateral Lumbar Fusion with or without instrumentation. No Access Surgeon. Includes: Discectomy and/or Decompression Not to be used in combination. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN370	Revision Anterior Lumbar Fusion -Two or more Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. Includes Access Surgeon. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN371	Revision Anterior Lumbar Fusion -Two or more Levels. Anterior Lumbar Interbody Fusion (ALIF), or Lateral lumbar interbody fusion (LLIF) or Direct lateral interbody fusion (DLIF). Includes removal implants same level. No Access Surgeon. Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN372	Lumbar Disc Replacement (Arthroplasty) – Single Level. Includes Access Surgeon. Includes: Discectomy and/or Decompression
SPN373	Lumbar Disc Replacement (Arthroplasty) – Single Level. No Access Surgeon. Includes: Discectomy and/or Decompression
SPN374	Lumbar Disc Replacement (Arthroplasty) Two or more levels. Includes Access Surgeon. Includes: Discectomy and/or Decompression; If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN375	Lumbar Hybrid Disc Replacement (Arthroplasty) Two or more levels. Includes a single level anterior lumbar intervertebral fusion in combination with a single level disc replacement. Includes Access Surgeon. Includes: Discectomy and/or Decompression; Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN376	Lumbar Disc Replacement (Arthroplasty) Two or more levels. No Access Surgeon. Includes: Discectomy and/or Decompression; Includes Hybrid operation (a single level anterior lumbar intervertebral fusion in combination with a single level disc replacement). Includes bone graft. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN388	Revision Spinal Stenosis Decompression - Single Level. Includes: Discectomy, Revision discectomy
SPN389	Revision Spinal Stenosis Decompression - Two or more levels. Includes: Discectomy, Revision discectomy. If the procedure involves more than two levels and the procedure is more complex, non-core pricing can be used.
SPN355	Single Level Transforaminal Lumbar Interbody Fusion (TLIF) single interbody cage. Includes posterior lateral fusion (PLF). Includes bone graft
SPN356	Single Level Transforaminal Lumbar Interbody Fusion (TLIF) double cage. Includes posterior lateral fusion (PLF). Includes bone graft
SPN357	Double Level Transforaminal Lumbar Interbody Fusion (TLIF) single cage. Includes posterior lateral fusion (PLF). Includes bone graft
SPN358	Double Level Transforaminal Lumbar Interbody Fusion (TLIF) with double cages. Includes posterior lateral fusion (PLF). Includes bone graft

20.6. Wrist and Hand Procedures

Red List Codes	Procedure Description
WAH 103	Hemi-hamate reconstruction of pilon fracture

WAH112	Carpometacarpal (CMC) joint arthroplasty – Complex Includes: trapeziumectomy, debridement of joints, excision of avulsion fragments.
WAH 114	Metacarpophalangeal (MCP) joint arthroplasty – Complex . Includes: - cemented and uncemented 2 component implant – If 2 digits, each attract a separate code – If > 2 digits then this becomes a non-core procedure
WAH120	Tenolysis flexor tendon – Complex Includes: - excision of slip of FDS (flexor digitorum superficialis tendon), tenolysis plus arthrolysis of MCPJ/IPJ (Metacarpophalangeal joint/Interphalangeal joint) – If 2 digits, each attract a separate code – If > 2 digits then this becomes a non-core procedure
WAH126	Reconstruction flexor tendon using primary tendon graft Includes: - harvest of tendon graft - if two tendons, each attract a separate code, - if > 2 then this becomes a non-core procedure Excludes: tendon transfer
WAH127	Reconstruction flexor tendon - 1st Stage tendon reconstruction Includes: - insertion of spacer/rod - if two tendons, each attract a separate code, - if > 2 then this becomes a non-core procedure Excludes: tendon transfer
WAH128	Reconstruction flexor tendon - 2nd Stage tendon reconstruction Includes: - harvest of tendon graft - if two tendons, each attract a separate code, - if > 2 then this becomes a non-core procedure Excludes: tendon transfer
WAH130	Pulley reconstruction - Includes: required tenolysis, use of local tendon or free tendon graft, extensor retinacular reconstruction i.e. ECU (extensor carpi ulnaris) stabilization - if two tendons, each attract a separate code, - if > 2 then this becomes a non-core procedure
WAH134	Carpal tunnel release – endoscopic
WAH137	Scaphoid or other carpal bone reconstruction – Complex Using structural bone grafting from iliac crest and fixation. Includes: - bone graft from iliac crest and fixation - if a vascularised bone graft is required, this becomes a noncore procedure
WAH138	Wrist arthroscopic surgery – Simple Includes: - diagnostic arthroscopy and/or removal of loose bodies, simple debridement of synovitis
WAH139	Wrist arthroscopy proceed to open surgery – Simple Includes: - diagnostic arthroscopy and/or removal of loose bodies, simple debridement of synovitis
WAH141	Wrist arthroscopy - Complex 1 - (Intercarpal ligament injury) Includes: - Percutaneous K wiring of joints for intercarpal ligament injury
WAH142	Wrist arthroscopy and proceed to open - Complex 1 Includes: - Repair of intercarpal ligament and K-wiring of joints
WAH143	Wrist arthroscopy and proceed to open – Complex 1 – Includes: - Reconstruction of intercarpal ligament and K-wiring of joints
WAH146	Wrist arthroscopy and proceed to open - Complex 2 - Arthroscopic and proceed to open Proximal Row Carpectomy (PRC)
WAH147	Wrist arthroscopy and proceed to open - Complex 2 - Partial wrist fusion and Sauve- Kapandji procedure
WAH148	Wrist arthroscopy and proceed to open - Complex 2 – Total Wrist Fusion
WAH152	Wrist arthroscopy - Complex 3 TFCC injury (triangular fibrocartilage complex).

	Includes: diagnosis, debridement & open repair of TFCC (triangular fibrocartilage complex) debridement.
WAH153	Wrist arthroscopy - Complex 3. Includes: diagnosis, debridement & open repair of TFCC (triangular fibrocartilage complex) tear.
WAH154	Wrist arthroscopy and proceed to open - Complex 3. Includes: diagnosis, debridement & open repair of TFCC (triangular fibrocartilage complex) tear.
WAH155	Wrist arthroscopy and proceed to open - Complex 3 - Open TFCC (triangular fibrocartilage complex) reconstruction with tendon graft
WAH157	Wrist open surgery - Complex 3 - Open TFCC (triangular fibrocartilage complex) reconstruction with tendon graft

20.7. Non-Orthopaedic Procedures

NRV04	Reconstruction Digital Nerve with Nerve Graft
NRV05	Reconstruction Single Major Nerve with Nerve Grafts
NRV06	Neurolysis
SKP12	Insertion of tissue expander
SKP13	Removal of tissue expander(s) and reconstruction

20.8. Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures

Red List Codes	Procedure Description

Non-core
 	
Some instances of URL31/32
	Tier 3 procedures as per the national credentialing framework:
	• Removal of:
	  ○ Retropubic mid-urethral sling (MUS) (partial (vaginal) or complete)
	  ○ Trans-obturator MUS (partial (vaginal) or complete)
	  ○ Anterior/posterior vaginal prolapse mesh, body and arms, orphan arms
	  ○ Sacrocolpopexy vaginal attachment mesh
	  ○ Orphan arms
	  ○ Mesh from bladder, urethra, ureter or bowel
	  ○ Bulking agents
	• Complete removal rectopexy mesh/bowel repair
	• Reconstruction following mesh removal
	• Autologous sling revision and removal
	• Trans-obturator MUS (insertion of)

21. Appendix 3 – H1 Priority Classification

Body Site	Codes eligible for H1 priority	Clinical Criteria for H1 Priority Classification
Upper Cervical Spine	SPN300-SPN302	Documented cervical instability (abnormal motion on dynamic radiographs) in association with a SAC (Space available for the cord) of <10mm AND/OR Cord Compression (cord deformity), with clinical evidence of cervical myelopathy
Lower Cervical Spine	SPN303-SPN329 or non-core	Documented cervical instability (abnormal motion on dynamic radiographs) AND/OR Cord Compression (cord deformity) with clinical evidence of cervical myelopathy AND/OR Nerve Root Compression with Clinically Relevant Motor Weakness
Thoracic Spine	SPN330-SPN335	Documented thoracic instability (abnormal motion on dynamic radiographs) AND/OR Cord Compression (cord deformity) with clinical evidence of thoracic myelopathy.
Lumbar Spine	SPN340-SPN392 or non-core	Clinically relevant motor weakness due to cauda equina or nerve root compression
Shoulder & Elbow	Non-Core	Acute Pectoralis major rupture
Shoulder & Elbow	ELF25	Acute Biceps rupture at the elbow
Shoulder & Elbow	Non-Core	Acute Triceps rupture at the elbow
Shoulder & Elbow	SHU08 or non-core	Acute Grade 3 or greater AC joint dislocation
Shoulder & Elbow	Open SHU92, Arthroscopic SHU90, SHU91 Arthroscopic proceed to open.	Acute Multiple tendon rotator cuff rupture with pseudo paralysis
Shoulder & Elbow	SHU07	Acute clavicle fracture
Wrist & Hand	WAH 123, 124, 125	Tendon lacerations for repair: extensor tendon, flexor tendon:
Wrist & Hand	WAH115, WAH168	Soft tissue injuries: UCL ligament rupture, Nail bed laceration
Wrist & Hand	WAH 132	Acute nerve compression: Carpal tunnel
Wrist & Hand	WAH 100,101,102,103	Phalangeal bone fracture where acute fixation is indicated
Wrist & Hand	WAH104, 105	Metacarpal fracture
Wrist & Hand	WAH 135	Carpal Bones/Scaphoid fracture
Wrist & Hand	WAH 158,161	Distal Radius/Ulna fracture
Hip	Non-core	Hamstring Avulsion
Hip	HIT 01 THR, HIT 02, Hemi HIT 03 Revision, HIT 05 ORIF	Severe AVN and femoral neck stress fracture that require urgent arthroplasty or fixation
Knee	KNE50 or KNE60	A locked knee requiring management of the bucket handle meniscal tear
Knee	KNE50, KNE51 or KNE61	An acute osteochondral fracture

Foot & Ankle	AFT179	Tendo Achilles rupture
Foot & Ankle	AFT186	Complete plantar plate rupture of the great toe with sesamoid retraction
Foot & Ankle	AFT209	Syndesmosis stabilisation for definite widening on weightbearing x-rays.
Foot & Ankle	AFT205	Complete rupture ankle spring ligament
Foot & Ankle	AFT202	Complete rupture ankle medial ligament

22. Appendix 4 – Non-Prior Approval (NPA) Procedures

The Non-Prior Approval Procedures List

Procedure Code	Procedure Description	Conditions that must be met to be eligible for exemption from the Funding Approval Process (Part B Clause 18.7 of the Service Schedule)
AFT220	ORIF Calcaneous - Simple	The client has cover for a calcaneal fracture which has occurred within 6 weeks of assessment
AFT226	ORIF uni-malleolar fracture	The client has cover for fracture occurred within 6 weeks of assessment
AFT231	ORIF of Lisfranc fracture/dislocation - Simple	The client has cover for fracture and ligament disruption, which has occurred within 12 weeks of assessment
AFT233	ORIF phalanx fracture - Single	The client has cover for a phalangeal fracture which has occurred within 6 weeks of assessment
ELF09	ORIF Fracture Radius or Ulna	The client has cover for a radial or ulna fracture which has occurred within 6 weeks of assessment
ELF21	Removal of plate and screws - Radius	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
ELF22	Removal of plate and screws - Ulna	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
ELF23	Remvl Flex Intramedullary Nail-Radius/Ulna inc TEN	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
ELF24	Removal of Tension Band Wiring Elbow	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
GOP20	Removal of plate & screws not elsewhere specified	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
GOP21	Removl screws not elsewhr spec x1-3, inc diastasis	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
GOP22	Removal wires/pins not elsewhere specified 1 -3	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
GOP23	Removal wires/pins not elsewhere specified >3	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
GOP24	Removal screws not elsewhr spec >3, incl diastasis	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
HIT20	Primary removal of plate and screws Femur	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
HIT21	Removal of Intramedullary Femoral Rod	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
HIT22	Rmvl Intramedul Femor Rod Locking Screws x1-3 only	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
KNE13	ORIF # Tibia or Fibula	The client has cover for a tibia or fibula fracture which has occurred within 6 weeks
KNE20	Removal of plate and screws Tibia	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
KNE21	Removal of Intramedullary Tibial Rod	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
KNE22	Removal Intramedullary Tibial Rod Locking Screws	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
KNE23	Removal of Tension Wiring Patella	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB
KNE81	Knee ACL Single Bundle Reconstrctn, arthrosc/open	The client has cover for an ACL rupture.
KNE91	KNE81 w Meniscal Repair &/or Outerbridge drilling	The client has cover for an ACL rupture and meniscal tear.
OTY100	Closed reduction of Fractured Nose - Simple	The client has cover for a nasal fracture which has occurred within 6 weeks of assessment
NRV02	Delayed repair of digital nerve	The client has cover for the original injury requiring surgery.

Procedure Code	Procedure Description	Conditions that must be met to be eligible for exemption from the Funding Approval Process (Part B Clause 18.7 of the Service Schedule)
SHU07	ORIF Clavicle	The client has cover for fractured clavicle which has occurred within 6 weeks of assessment
SHU08	Open Reduction of AC Dislocation	The client has cover for an AC joint dislocation (grade 3) which has occurred within 6 weeks of assessment
SHU16	ORIF Humeral Fracture	The client has cover for a humeral fracture which has occurred within 6 weeks of assessment
SHU20	Removal of plate and screws Humerus	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB.
SHU21	Removal of Intramedullary Humeral Rod	Yes, on the assumption they have cover/ ACC paid for original surgery or it occurred in the DHB.
SHU23	Removal of plate and screws Clavicle	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred in the DHB.
SKP01	Removal of foreign body	The client has cover for the original injury requiring surgery.
WAH101	ORIF phalangeal fracture – Simple	The client has cover for fractured phalanx which has occurred within 6 weeks of assessment
WAH104	ORIF metacarpal fracture – Simple	The client has cover for a metacarpal fracture which has occurred within 6 weeks of assessment
WAH106	Corrective osteotomy of phalanx	The client has cover for fractured phalanx which has occurred within 12 weeks of assessment
WAH117	Single amputation - digit	The client has cover for the original injury requiring surgery.
WAH123	Repair flexor tendon digit or palm	The client has cover for the original injury requiring surgery.
WAH124	Repair flexor tendon wrist or forearm – proximal to the carpal tunnel	The client has cover for the original injury requiring surgery.
WAH125	Repair extensor tendon – digit or hand/wrist or forearm	The client has cover for the original injury requiring surgery.
WAH135	ORIF scaphoid or other carpal bone (Hook of Hamate)	The client has cover for a carpal fracture which has occurred within 12 weeks of assessment
WAH158	ORIF distal radius	The client has cover for a radius fracture which has occurred within 6 weeks of assessment
WAH168	Repair Nail Bed	The client has cover for a Nail injury which has occurred within 12 weeks of assessment

23. Appendix 5 – Summary of Changes Log

History of changes to Operational Guidelines

Summary of changes 1 May 2023

Clause	Overview of Change
Useful Contact Information	Updated with current contact phone and email details
5. Non-prior approval (NPA) procedures	Section added to describe what NPAs are and important notes on how to use them
9. Further clarification code usage and add-ons	○ Addition of 'Spinal' section ○ Updates of wording in 'Imaging' and '3D Imaging' sections ○ Addition of 'Unusually Complex Clients' section
10. Interpretation of specific non-core cores	○ Update of ESR09 section ○ Addition of ESR10 section ○ Update of ESR12 section ○ Addition of ESR13 section
12. Significant complication, transfer of care	Section added to provide clarity on: ○ Surgeries abandoned in theatre/Significant complication transfer of care ○ Return to theatre for approved elective surgery
14. Invoicing	Updated to provide clarity on what should be included at invoicing and where queries should be sent.
19. FAQ's	Section removed, questions addressed in relevant section of the guidelines.
Appendix 2 – Red List Procedures	○ Spinal procedures updated to the new SPN300 series codes ○ Section added for 'Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures'
Appendix 4 – Non-prior approval (NPA) procedures	Opening paragraph removed (moved further up the document to clause 5)

Summary of changes 1 July 2022

Clause	Overview of Change
Appendix 4 – Non-Prior Approval Procedures	Addition of six new codes eligible for proceeding without prior approval: ○ NRV02 – Delayed repair of digital nerve ○ SKP01 - Removal of foreign body ○ WAH117 - Single amputation - digit ○ WAH123 -Repair flexor tendon digit or palm ○ WAH124 - Repair flexor tendon wrist or forearm – proximal to the carpal tunnel ○ WAH125 - Repair extensor tendon – digit or hand/wrist or forearm

	Minor changes to the criteria for the following codes: ○ KNE81 – removal of reference to injury occurring in NZ ○ KNE91 – removal of reference to injury occurring in NZ ○ WAH135 – from 6 weeks to 12 weeks

Summary of changes 11 March 2022

Clause	Overview of Change
7.1 Meeting priority timeframes	Updated to include prioritisation approach for times of reduced capacity e.g. Covid-19 Protection Framework
21. Appendix 3 – H1 Priority Classification	Insertion of 'non-core' within the cervical, lumbar spine and shoulder & elbow codes eligible for H1 priority Correction of AC joint dislocation code (SHU08)

Summary of changes 1 February 2022

Clause	Overview of Change
5. Seeking prior approval for surgery from ACC	Updated to reflect change in Contract clause 18.7 – removal of prior approval for procedures listed in the 'Non-Prior Approval Procedures List'
7. Determining ARTP priority	Updated to reflect change in H1 priority classification
7.3 Review	Insertion to provide assurance criteria will be reviewed
13. Invoicing	Updated to reflect change in Contract clause 18.7 – purchase orders no longer required for procedures listed in the 'Non-Prior Approval Procedures List'
15. Service Monitoring and Reporting	Updated to reflect change in Contract clause 18.7
19. Appendix 1 – Guidelines for requesting Anaesthetic modifiers	Updated to include table of examples where ACC can contribute anaesthetic modifier costs to abandoned surgery
21. Appendix 3 – H1 Priority Classification	Insertion of table of codes eligible for H1 priority category
22. Appendix 4 – Non-Prior Approval Procedures	Insertion to reflect change in Contract clause 18.7 – description of non-prior approval procedures and table of procedure codes and conditions to be met