He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Elective Surgery 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 Elective Surgery Services to ACC Clients.

Provider Contact Centre	0800 222 070	providerhelp@acc.co.nz
Client/Patient Helpline	0800 101 996	
ACC eBusiness	0800 222 776	ebusinessinfo@acc.co.nz
Provider Registration	registrations@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: 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	
Elective Surgery Invoicing Team	For post-operative queries relating to invoicing: electivesurgeryinvoices@acc.co.nz Queries and/or requests pertaining to elective surgery retrospective reimbursement or HNZ-TWO back-dated requests should be sent to: purchaseorderteam@acc.co.nz	
Elective Surgery Documentation	For email submissions of ARTPs	ARTPS4ESU@acc.co.nz
	For all supporting documentation such as operation notes, discharge summaries, supply cost and implant invoices	disop@acc.co.nz
	For general medical notes related to ARTP submissions	ESCMednotes@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

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 and Elective Surgery Services page.
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
Provider Education	Our provider education webinars are for health providers looking for an informal way to keep up to date and learn more about working with us. These cover a range of topics across three formats: Beginner's guides, how-to guides, and special interest topics. • The beginner's guide to ACC for medical specialists • How to write a successful surgical ARTP for medical specialists • How to get surgical ARTPs right - those who support medical specialists • How to Invoice for Elective Surgery Other useful videos can be found on our Provider videos page.

Enabling rapid decisions on ACC cover and entitlement - Consideration factors	The following consideration factors have been jointly developed between ACC's Clinical Services and respective medical groups/associations (e.g. NZOA), to outline factors ACC staff consider when making decisions on cover and entitlement requests: • General consideration factors for surgery funding requests • Lumbar disc pathologies • Facet joint injuries • Foot and ankle injuries • Hip labral tears • Rotator cuff tears • Wrist and hand injuries • Shoulder surgery • Traumatic internal derangement of the knee • Osteochondral fractures of the knee • Locked knee • Acute separation of osteochondritis dissecans (OCD) lesion • Temporomandibular joint internal derangements • Endoscopic sinus surgery • Traumatic cataract
Disc Replacement Protocol forms	If you are submitting an ARTP request for disc replacement surgery, you are required to complete and attach the following forms with your submission: • Lumbar Disc Replacement Protocol • Cervical Disc Replacement Protocol
Non-core Self Calculating Sheet	Self-calculating pricing spreadsheet used to determine the cost of a non-core procedure.

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 Services contract is held by **elective surgery suppliers** (also referred to as 'lead suppliers' or '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 clause 14 of the contract for further details around the service specific requirements.

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

Generally, a supplier is a hospital, and the named provider is a specialist who works within the hospital.

3. What does the contract cover?

The following services are covered in the Elective Surgery Services contract:

- 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.

Note:

- Some services covered by the Elective Surgery Services contract require prior approval from ACC.
- 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. Please note that prior approval must be requested for custom implants, including a pricing estimate.
- 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 (i.e. no co-payments can be invoiced).

The following services are **not** covered in the Elective Surgery Services contract:

- Public Health Acute Services (PHAS), as defined in 'Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 (SR 2002/71)'.
- In-rooms wrist and hand procedures. These procedures are to be performed using the WALANT (wide-awake, local anaesthetic, no torniquet) surgical technique. These services are covered by the Clinical Services contract and should be applied for via a Clinical Services ARTP (CSARTP).
- Prosthetics. These are provided as aids and appliances.
- Outpatient allied health follow-up after discharge. These are covered by the Specified Treatment Provider 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 Services 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.
- Interpreters and/or translation services. These are considered a part of the package of hospital-based care.

Note: Some services that are not covered by the Elective Surgery Services contract may be provided under a separate ACC contract.

4. Seeking prior approval for surgery from ACC

Written approval is required from ACC **before** 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 Appendix 4 of this document.

If prior approval is not obtained, the surgery invoice will be declined. Surgeries requiring prior approval cannot be retrospectively funded.

If the surgery request is a prerequisite to access medical insurance AND the specialist does not believe that the condition requiring surgery is accident related, please do not submit an ARTP to ACC. These cases should be discussed directly with the client's insurer.

4.1. Surgical Assessment Report and Treatment Plan (ARTP)

The Surgical Assessment Report and Treatment Plan (ARTP) is used to request approval of surgical treatment. Named providers are required to submit an ARTP, via the elective surgery supplier for all surgery requests. The ARTP should be submitted within seven business days of assessing the client.

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 must send this draft to the elective surgery supplier, not to ACC directly.

The elective surgery supplier is responsible for ensuring the ARTP meets ACC standards and requirements for submission, before submitting the ARTP to ACC.

The supplier should send the ARTP to the Treatment and Support Team via ARTPS4ESU@acc.co.nz or via HealthLink mailbox (ACCEARTP).

The surgical Assessment Report and Treatment Plan (ARTP) template found on our website is the only version of the ARTP that will be accepted.

4.2. How to complete an ARTP

The ARTP should provide ACC with the information needed to make a decision on the surgery request. All mandatory fields (*) must be completed. 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 any information is missing or is unclear, ACC may have to request further information which can lead to delays for your patient. If the information cannot be understood or requires clarification, ACC will contact the named provider.

Here are some tips to assist with quicker decision-making once ACC receives the ARTP:

- Complete all mandatory fields (*) and ensure that you have selected an option in all drop down/check-box fields.

- Ensure you have provided a clear causal medical link between the accident event and condition requiring surgical treatment.
- State the specific diagnosis that is to be treated in the proposed surgery/procedure. If you know the READ/SNOMED/ICD code that matches the specific diagnosis, please also include this.
- Co-morbid or other relevant diagnoses should only be included in the 'Pre-existing factors' field.
- Be specific about prognosis, rehabilitation timeframes and expected journey (including return to work); as well as any additional reasonable follow-up care that may be required.
- Provide a clear description of the proposed treatment and specify the procedure code. If there is no applicable procedure code, then the request needs to be submitted as non-core with a completed non-core pricing sheet (including estimate of implant costs, if applicable). Further information on the difference between core and non-core procedures can be found in section 8 of this document and clause 31 of the contract.

Note:

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

4.3. 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.

5. Non-Prior Approval (NPA) Procedures

These are procedure codes that represent clinically low risk elective surgeries which we rarely decline. The list of NPA procedure codes is included in the 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 obtaining prior approval (i.e. submission of an ARTP is not required). You may complete the treatment and follow the standard invoicing process from section 14 of this document.

However, **cover criteria must be met before proceeding with the NPA procedure** as this can impact future entitlements for the client. If cover is not added to the claim prior to surgery proceeding, the invoice will be declined.

You can easily request additional cover by emailing surgeryassessmentteam@acc.co.nz with the following information, you will receive a response within 1 business day:

> **Subject:** Add Cover: [Client Name - Claim Number]
>
> **Body:**
>
> Can the following injury(s) be added to this client's claim for NPA procedure eligibility:
>
> [Insert Read Code(s) and/or diagnoses you wish to add]

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 must be followed (see clause 20 of the contract).
- When NPA cover criteria is met and urgent/acute surgery is indicated within a week of the date of injury, these cases should be managed under the Public Health Acute Services (PHAS) pathway and invoices will be declined if submitted to ACC for such cases.
- NPA procedures are included in the process for requesting and invoicing multiple procedures (see section 15 of this document).

- 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 relevant 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.

If transfer is to occur from a contracted supplier to a non-contracted supplier, you must contact ACC in the first instance.

7. Determining ARTP Priority

The ARTP priority reflects the urgency by which surgery is required and determines how the Treatment and Support team should assess the ARTP in comparison with others. The ARTP priority 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 criteria at the time of their surgical consultation, as specified in Table 1. 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 (noting that there is no order of importance).

Table 1. High Priority Classification and Criteria

Priority Code	Classification	Criteria
H1	Clinically urgent	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.
H2	Home help required	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.
H3	Receiving weekly compensation	The client was employed at the time of the accident and is receiving weekly compensation from ACC.
H4	Risk of losing paid employment	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.

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

Notes:

- It is expected that acute fractures requiring urgent surgical fixation are managed under PHAS.
- 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. It is the responsibility of the elective surgery supplier to ensure priority timeframes are met. 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. Meeting priority timeframes is a key performance indicator under the contract (see section 16 of this document).

Suppliers will receive data about their named providers' achievement of these priority timeframes. It is the responsibility of the supplier to initiate discussions with their named providers to understand and improve performance in this regard, which is subject to continual monitoring and discussion with Engagement and Performance Managers (EPM).

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. The supplier is responsible for ensuring they are aware of ACC's surgery priority classification following approval.

8. Types of procedures

The Elective Surgery Services 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 section 9 of these operational guidelines.

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.

Note: 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.

Table 2. ACC procedure classifications and descriptions

Type of Procedure	Description
Core (non-red list)	Core procedures are listed in the contract under 'Service Items and Prices' (Part A, Table 1: Core Service Items and Prices) All contracted specialists who are named under an Elective Surgery Services 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, Table 1: Core Service Items and Prices). 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). Non-core codes are listed in the contract under 'Service Items and Prices' (Part A, Table 2: Non-core Service Items and Prices). Further information around multiple procedure requests is outlined under section 15. 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 Services 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. 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.

ACC reserves the right to decline to accept new named red list providers.

9.1. 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.

9.2. 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).

10. Further clarification of code usage and add-ons

10.1. Botulinum toxin injections

Codes have been developed for botulinum toxin (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

10.2. Bone Grafts

The following two add-on codes can be used for procedures where bone grafts are not included, excluding foot and ankle procedures. These codes must be included on the ARTP.

GOP01	Bone Graft - any area, minor or small *from a site other than the initial surgical site
GOP02	Bone Graft - any area, major *from a site other than the initial surgical site.

There are two add-on codes for foot and ankle procedures that require minor or major bone grafts (below). These can only be used in conjunction with foot and ankle procedures where bone grafts are not included. These codes 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.

10.3. Ophthalmology

The following two add-on codes have been developed for eye procedures only.

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

10.4. Spinal

New spinal codes (300 series) were 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.

Notes:

- Biogels and haemostatic agents (such as Floseal, Tisseel and Duraseal) cannot be invoiced in addition to the SPN300 series spinal codes. During the previous revision of the spinal codes, it was apparent that these products had consistent use in lumbar spinal procedures, and were incorporated into the service item pricing for all spinal code sets to allow for exceptions or occasions of use.
- These remain billable for code sets outside of spinal, which have not yet been updated to include these costs (such as OTY).

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 2 hours and every 10 mins from the start of the 3rd hour
Base Units	For each procedure as per the Guide. The units for spine include loading for positioning

Disc Replacements

ARTP submissions for cervical or lumbar disc replacement (arthroplasty) must include a completed and signed copy of the relevant protocol form:

- Cervical Disc Replacement Protocol
- Lumbar Disc Replacement Protocol

10.5. 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.

This code covers the material costs for a powered turbinoplasty.

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

Endoscopic sinus surgery (ESS)

For ACC to fund endoscopic sinus surgery (ESS), certain criteria must be met. Please refer to Enabling rapid decisions on endoscopic sinus surgery (ESS) for further information.

10.6. 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 becomes 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.

10.7. 3D Imaging

These codes (3DIMAGE1-4) are to be used for invoicing the use of 3D Intraoperative imaging for spinal and skull surgeries. If 3D Intraoperative imaging is required for another body site, prior approval should be sought.

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.

10.8. 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.

Prior approval with clinical justification must be sought for high cost (over $500) orthotics with core and non-core surgeries.

10.9. Surgical Implants

Implants must be invoiced separately to the procedure cost.

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.

Examples of implants can be found in clause 43 of the contract.

Customised implants, high-cost allografts and bio models

All specialised customised implants, high-cost allografts, and bio models require prior approval via the original ARTP. Please ensure that an estimate of costs and clinical indication for the use of customised implants and/or bio models are included with the ARTP submission. Once approved ACC will pay the actual cost of these after the procedure has been completed.

Professional body endorsement is recommended for all specialised customised implants, high-cost allografts and bio models.

10.10. 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.

11. Interpretation of specific non-core codes

11.1. 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.

Please note that units of theatre time should be exact and are not able to be rounded (i.e. if the procedure took 58 minutes, ESR01 should not be rounded to 60 minutes).

11.2. 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 NZSA Relative Value Guide 2021 Edition to guide 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.

11.3. ESR05 – Ward stay

This code is available to cover the costs of an overnight ward stay.

If surgery has been approved for a core code that includes a day stay, and there becomes a requirement for an overnight ward stay, a ward stay top up should be requested. This should be billed under ESR13 using the following formula: ESR05 – ESR16 = ESR13 (ward stay top up rate).

11.4. ESR09 – 2nd surgeon (consultant)

This code is available for a 2nd consultant surgeon when appropriate to the surgery.

ACC's expectation is that core code procedures are to be performed by a single qualified specialist who is experienced in the techniques required for the surgery. Where the assistance of a second specialist is clinically indicated to ensure the success of a core code procedure,

prior approval for the 2nd surgeon must be sought from ACC before surgery has taken place. All ESR09 requests must include clear rationale as to why the 2nd surgeon is required.

If approved, the 2nd surgeon's presence and role should be clearly noted in the operation notes. If this is not clearly documented in operation note at invoicing, ESR09 may be declined requiring invoice resubmission as ESR10.

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.

11.5. 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.

11.6. ESR12 – Unique Supplies

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 ESRNC.

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 (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 the Base Rate 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

11.7. 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 e.g. 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.

11.8. ESR18 – Follow up visits

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. Specialists with prior approval via an ARTP can conduct in-hospital post-operative consultations for complex surgical cases, like neurosurgery or maxillofacial surgery, if such consultations are clinically necessary before 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.

12. 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, as well as the removal of stitches/sutures/staples. 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.

Clause 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.

13. Significant complication, transfer of care

13.1. Abandoned surgery/Significant complication transfer of care

Where surgery is abandoned in theatre or pre-operatively, clause 31.7 of the Elective Surgery Services contract applies.

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

This below 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).

Table 3. Examples of when ACC can pay costs, including anaesthetic modifiers

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

13.2. 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, noting 'RTT' (return to theatre). A new purchase order approval will be issued on receipt of invoice, subject to ACC approving the retrospective costs.

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 by the elective surgery supplier within 12 months of the treatment provided or they will not be paid.

14.1. What to include

One schedule per client is to be submitted for all surgeries. Make sure you include on the invoice the:

- purchase order number in the comments field of the e-schedule.
- admission and discharge dates in the comments field of e-schedule.

Supporting Documentation

- Supporting documentation for supplier's invoices (including implants) are required prior to, or same date as the electronic 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 business days.
- When supporting documentation is requested after a schedule has been submitted, the payment will be declined, and the schedule will need to be resubmitted.

Notes:

- Service dates should be the actual date of surgery; payment rates are based on discharge date.
- Actual number of units are to be entered in unit field for non-core surgery. Please do not use the time field.
- It is preferable but not essential to have the client's claim number or purchase order on the notes. The subject line of your email must have the client's name and purchase order number (unless the procedure is listed on the NPA procedure list).
- Core and non-core procedure prices do not include the cost of surgical implants.
- 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.
- Payment will be based on the procedure that was performed. At times, this may differ from the procedure (and therefore pricing) that was originally approved by ACC.

15. Requests and invoices for multiple procedures

Suppliers cannot request a combination of core and non-core procedures, or request more than two core code procedures to be performed at the same time.

Table 4. Examples of how to request and invoice for multiple procedures

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 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, additional theatre time, High Dependency Unit care. ACC may decline an application for approval as a non-core procedure and approve the procedure as a core procedure with additional service items. Conversely, ACC may decline an application for approval as a core procedure (or combination of core procedures) and request the procedure is resubmitted as non-core.

Note: The above table also applies to non-prior approval (NPA) procedure codes. For example:

- If two NPA procedure codes are requested, prior approval is not required. However, ACC will only fund 40% of the second procedure at invoicing.
- If three or more NPA codes are requested, suppliers will need to seek prior approval from ACC via an ARTP request for a non-core procedure.

16. Service monitoring and reporting

16.1. ACC collected data

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

Table 5. Performance measurement under the Elective Surgery Services contract

Performance measurement	Description	Frequency
Volume of ACC surgeries performed by supplier	1. 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 2. 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. Average days by facility and surgeon for High priority surgery to be undertaken. 2. 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 PREM survey results.

Health New Zealand - 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

17.1. Contracted Surgery

This is the funding route that can be used by suppliers who hold a current Elective Surgery Services contract. This is the most common funding route used.

Contract holders are paid the contracted price specified in the Elective Surgery Services 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 for the services.

17.2. Private Regulation Surgery (non-contracted surgery)

This is the funding route that can be used for private hospital suppliers who do not hold a current Elective Surgery Services 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.

- Non-contracted suppliers are paid at 60% of the contracted core price.
- If the procedure is non-core, private hospitals are paid 60% of the non-core price.
- All implants are paid at 100%.
- Non-contracted suppliers 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 AC Act 2001).

Under ACC's Standard Terms and Conditions (Clause 8.12), a supplier under the Elective Surgery Services contract may choose to invoice ACC under Regulations for a procedure covered by the 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.

17.3. Public Regulation Surgery (non-contracted surgery)

Health New Zealand – Te Whatu Ora 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 AC Act 2001).

Note that, if a Health New Zealand – Te Whatu Ora hospital holds the Elective Surgery Services contract, it cannot invoice under Regulations instead (see Standard Terms and Conditions Clause 8.12).

Health New Zealand – Te Whatu Ora hospitals taking this route are advised to continue to seek ARTP approval, and to invoice using the Elective Surgery Services contract code structure, to avoid payment being declined or evidence of actual cost being required.

18. Clauses relating to Health New Zealand – Te Whatu Ora

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 contract from the Health New Zealand – Te Whatu Ora hospitals only, as per Clause 39.2 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 Health New Zealand – Te Whatu Ora hospital must email purchaseorderteam@acc.co.nz (subject: HNZ – Te Whatu Ora 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, Health New Zealand – Te Whatu Ora 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 Health New Zealand – Te Whatu Ora in seeking prior approval.

19. New and Emerging Treatment and Rehabilitation Interventions

ACC define new, novel, and emerging treatment and rehabilitation interventions (NETRI) as “non-established, new or experimental treatment and services, including equipment, procedures, prostheses, surgery or treatment” that:

- is still undergoing clinical trials

- are medical devices that ACC is unsure are regulated somewhere in the world (e.g., CE mark or FDA)
- have limited research published to evidence their safety, use or value
- may not have the support of the majority of health practitioners in the relevant field
- are not covered by an existing ACC policy or process

In the first instance, we expect all new and emerging treatments, implants, orthotics, equipment, interventions and/or techniques to be submitted to ACC for prior approval. Details of new procedures, surgical techniques, equipment and/or prostheses must be clearly stated on the ARTP.

These requests may be subject to additional requirements during the assessment process, regardless of endorsement from governing bodies. Consideration will be made to Schedule 1, clause 1 and 2 of the AC Act. ACC reserves the right to refusal and to ask for further information in support of your application.

Note: Decisions on NETRI may take time. When a supplier's request for NETRI is linked to an ARTP request, the client's clinical presentation and need for surgery should take preference.

Appendix 1 Guidelines for requesting anaesthetic modifiers

Requested modifier	Acceptable?	Units	Notes
Pre-op telephone conversations	No	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			
Face to face visits on the day of surgery	No	0	
Cancellation of case on day of surgery after assessment and management of the relevant issues.	Yes	2	Abandoned surgery. See section 13.1 for examples of when ACC can accept costs.
Time Units: 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	No	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	Yes	1	
Age if <1 or >80	Yes	2	
ASA 1	No	0	
ASA 2	No	0	

ASA 3	Yes	2	
ASA 4	Yes	4	
Emergency Case	Yes	2	However accomplished.
Awake Intubation	Yes	2	Any position which is not supine, lithotomy or lateral or spinal procedures.
Positioning non-core	Yes	2	N/A
Body Mass Index (BMI) <35	No	0	
BMI 35-40	Yes	1	However accomplished.
BMI >40	Yes	2	
BMI >50	Yes	3	
Arterial Line, CVL, PA Catheters expected of the anaesthetic and surgery	No	0	
Arterial line, CVL, PA Catheter insertion as separate procedures not expected of the anaesthetic or surgery	Yes	2	
High Dependency Unit (HDU) care with the anaesthetist at home providing cover:			Maximum 18 units per HDU day (including phone calls and face to face visits)
Base pricing recognising availability	Yes	4-6	
Telephone Calls which require significant management change	Yes	1 unit per call	

Any face to face visit that results in significant management change	Yes	4 units per visit plus time	
ICU Care where anaesthetist lives in hospital and provides cover	No	0	This cost is included in the ESR07 cost (ICU).
Ward Care*:			
Any face-to-face visit less than 15 minutes	No	0	This cost is included in the package of care
Any face-to-face visit longer than 15 minutes	Yes	Up to 2 units (plus up to 2 more units with justification)	Complex visits with significant documented management issues.
Continuous Regional Block Plexus/Nerve Catheter Care (which stays in the patient overnight or for several days)	Yes	Up to 3	Anaesthetic notes need to be provided to ACC.
Prolonged PACU care	Yes	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.

**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.*

Appendix 2 Red List Procedures

Foot and Ankle Procedures

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

Shoulder and Elbow Procedures

Red List Code	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 in combination with other codes.
SHU14	Total Shoulder Replacement
SHU17A	Reverse Shoulder Replacement
SHU15	Arthrodesis Shoulder
Non-core	Revision Shoulder Replacement
	Shoulder tendon transfers (Latissimus dorsi, Pectoralis major, Lower Trapezius)
	Superior Capsular Reconstruction

Hip Procedures

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

Knee Procedures

Red List Code	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)

Spine Procedures

Red List Code	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

Wrist and Hand Procedures

Red List Code	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: - insertion of spacer/rod • 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

Non-orthopaedic Procedures

Red List Code	**Procedure Description**
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

Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures

Red List Code	Procedure Description
Non-core	Tier 3 procedures as per the national credentialing framework.
Some instances of URL31 and URL32	For further information, including regular updates regarding Tier 3 procedures and the national credentialing framework, please refer to the Te Whatu Ora website: Female Pelvic Mesh Service – Health New Zealand | Te Whatu Ora.

Appendix 3 Procedure Codes Eligible for H1 Priority Classification

Body Site	Code(s)	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	SHU90, SHU92	Acute Multiple tendon rotator cuff rupture with pseudo paralysis
Shoulder & Elbow	SHU07	Acute clavicle fracture
Wrist & Hand	WAH 123-WAH125	Tendon lacerations for repair: extensor tendon, flexor tendon:

Wrist & Hand	WAH115, WAH168	Soft tissue injuries: UCL ligament rupture, Nail bed laceration
Wrist & Hand	WAH132	Acute nerve compression: Carpal tunnel
Wrist & Hand	WAH100-WAH103	Phalangeal bone fracture where acute fixation is indicated
Wrist & Hand	WAH104, WAH105	Metacarpal fracture
Wrist & Hand	WAH135	Carpal Bones/Scaphoid fracture
Wrist & Hand	WAH158, WAH161	Distal Radius/Ulna fracture
Hip	Non-core	Hamstring Avulsion
Hip	HIT01, HIT02, HIT03, HIT05	Severe AVN and femoral neck stress fracture that require urgent arthroplasty or fixation
Knee	KNE50, 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

Appendix 4 Non-prior Approval (NPA) Procedure List

Full procedure descriptions for the following codes can be found in Part A, 'Table 1: Core Service Items and Prices' in the contract.

For the purposes of this list, 'assessment' is defined as the initial clinical consultation between the Client and the treating specialist.

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 Calcaneus - 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 a uni-malleolar fracture which has 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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital

ELF23	Removal Flex Intramedullary Nail-Radius/Ulna incl. TEN	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
GOP21	Removal screws not elsewhere specified x1-3, incl. removal of diastasis screws	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
GOP24	Removal screws not elsewhere specified >3, incl. removal of diastasis screws	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
HIT22	Removal Intramedullary Femoral 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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
KNE81	Knee ACL Single Bundle Reconstruction, arthroscopic/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

SHU07	ORIF Clavicle	The client has cover for a 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 at a Health New Zealand – Te Whatu Ora hospital
SHU21	Removal of Intramedullary Humeral Rod	The client has cover for the original injury requiring surgery and ACC paid for original surgery or it occurred at a Health New Zealand – Te Whatu Ora hospital
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 at a Health New Zealand – Te Whatu Ora hospital
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 a phalangeal fracture 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 a phalangeal fracture 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

Appendix 5 Summary of Changes Log

Summary of changes 01 July 2025

Section	Overview of Change
Useful Contact Information	Updated with current contact phone numbers and email details for respective teams. Additional information provided around email contacts for Elective Surgery Invoicing team.
Useful Links	New section that provides links to useful information and resources on our ACC website.
2. Who can hold this contract?	Amended named provider definition to improve clarity and consistency with the contract.
3. What does the Elective Surgery Contract cover	Updated to provide clarity on what is and what isn't covered in the Elective Surgery Contract.
4. Seeking prior approval for surgery from ACC	Added paragraphs to provide clarity on: • The circumstances by which an ARTP should not be submitted to ACC • Procedures which may require additional requirements during the assessment process • Re-formatted into sub-sections for easier reading.
5. Non-prior Approval (NPA) Procedures	Updated to provide clarity on cover requirements. Update of notes section.
6. Transfer of Lead Supplier	Added sentence to clarify process if transferring from a contracted supplier to a non-contracted supplier.

7. Determining ARTP Priority	Clarified definition of ARTP priority. Addition of table for High Priority classification and criteria
9. Red List Providers	Red-List Provider section moved further up the document (to section 9).
10. Further clarification of code usage and add-ons	Updates to various sub-sections. • Botox injections section (now '10.1 Botulinum Injections') • Merger of Wrist and Hand + Foot and Ankle sections to '10.2 Bone Grafts' • Ophthalmology section (now states these add on codes are for eye procedures only) • Spinal section (added note and disc replacement section) • Addition of Endoscopic sinus surgery (ESS) to Ear, nose and throat section • 3D imaging section – now specifies that prior approval is required for body sites other than spinal and skull surgeries Orthotics and Surgical implants sections – further details re: prior approval
11. Interpretation of specific non-core codes	Updates to various sub-sections: • Sentence added to section 11.1. regarding theatre time reporting • New section added – '11.3. ESR05 -Ward Stay' ESR09 – 2nd Surgeon (consultant) section: updated to provide clarity on requirements for 2nd surgeon requests.
13. Significant complication, transfer of care	Examples of when ACC can pay costs moved into table format
14. Invoicing	Addition of note sub-section

15. Requests and invoices for multiple procedures	Addition of note sub-section
17. Contracted and Regulation surgery	Removed table and moved into sub-sections
18. Clauses relating to District Health Boards	Updated to Health New Zealand – Te Whatu Ora
19. New and Emerging Treatment and Rehabilitation Interventions	New section added to provide clarity on the requirements for requests where the surgery or treatment is new, experimental and/or emerging.
Appendix 2	Updated description under 19.8 Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures
Appendix 4	Addition of note to provide clarity on definition of 'assessment' under this NPA list

Summary of changes 01 May 2023

Section	**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 01 July 2022

Section	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

Section	Overview of Change
7.1 Meeting priority timeframes	Updated to include prioritisation approach for times of reduced capacity e.g. Covid-19 Protection Framework
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 01 February 2022

Section	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
Appendix 1 – Guidelines for requesting Anaesthetic modifiers	Updated to include table of examples where ACC can contribute anaesthetic modifier costs to abandoned surgery
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