He Kaupare. He Manaaki. He Whakaora.
prevention. care. recovery.

13 February 2024

[redacted]

Kia ora [redacted]

Your Official Information Act request, reference: GOV-029961
Thank you for your email of 12 January 2024, asking for information under the Official Information Act 1982 (the Act). Please find our responses to each of your questions below.

Our response

1. *How does ACC record the history of accident created by the medical professional*

ACC records information about a person's injury from details in the ACC45 claim form, which is completed by treatment providers, on behalf of clients, when the claim is lodged. The ACC45 includes information about the client and their injury and also has a free-text field 'accident description' where a person can provide a brief description of how their accident happened.

The information on an ACC45 helps ACC makes a decision on whether it can provide cover for the accident as well as what account should fund it. For example, injuries caused by motor vehicles on a public road are funded by the Motor Vehicle Account.

The majority of ACC claims are immediately accepted via ACC's automated claim processing system. Claims that are more complex, and cannot be automatically accepted, are referred to cover assessors for manual review. Further information on how we use claim information is available on our website at: www.acc.co.nz/about-us/how-we-collect-and-use-your-information/how-we-use-claim-information/?stage=Live

2. *Does a patient sign-off or otherwise agree to statements that the medical professional reports them to have made to ACC?*

The patient is required to sign and date the ACC45 claim form before ACC can accept it.

3. *How does ACC use the medical professional's history of accident description and the patient's statements to determine causation and therefore cover;*

You can find information on how ACC assesses claim information and makes decisions on our website at:

https://www.acc.co.nz/im-injured/how-we-manage-your-claim/how-we-assess-claims/

As noted above, the majority of claims are automatically accepted by ACC. For claims which require an ACC staff member to assess cover, then there are processes to guide the decision making. For example, ACC has the process Assess Claim for Cover: Simple PICBA claims, which is used for physical injury claims caused by accident. Please find this attached. There is a range of policies for other types of injury, such as dental injuries, work-related gradual process, and mental injuries.

4. *Can a report of the events of the accident and onset of symptoms, recorded by the medical professional, be used as evidence of what happened if the patient has not signed off on them;*

As noted above, ACC will only accept a claim if it has been signed and dated by the client. It is therefore unclear when the scenario you have described might occur.

To provide a proper answer to your question we would need to form an opinion on the matter. This is outside of our obligations under the Official Information Act 1982, which refers to information that is 'held' by an agency. We are therefore refusing this part of your request as the information is not held. This decision is made under 18(g) of the Act.

Further information on what qualifies as official information can be found on page seven of the Ombudsman's guide *Making Official Information requests – A guide for requestors* which is available online at:
view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.ombudsman.parliament.nz%2Fsites%2Fdefault%2Ffiles%2F2023-02%2FMaking%2520official%2520information%2520requests%2520-%2520A%2520guide%2520for%2520requesters.docx&wdOrigin=BROWSELINK

5. *Can two differing descriptions, for example where the GP then the specialist give different descriptions of events, be used as evidence of the patient 'changing their story', for the purpose of declining ACC cover?*

As with question 4, you have described a very specific scenario, and a response would require us to form an opinion or provide an explanation rather than to provide 'held' information. For this reason, we are also refusing this part of your request under section 18(g) of the Act.

However, we can note that ACC will seek clinical opinions to ensure that a correct diagnosis is provided, and so that the client gets the right help and reduces the chances of an adverse outcome. In very specific circumstances, such as with Treatment Injury claims, ACC might ask a specialist for advice about the description because that has a direct bearing on causation and whether there was a physical injury or not. ACC would only decline a claim if the evidence received confirms that the injury was not caused by accident.

As this information may be of interest to other members of the public
ACC may decide to release a copy of this response on ACC's website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available www.acc.co.nz/resources/#/category/12.

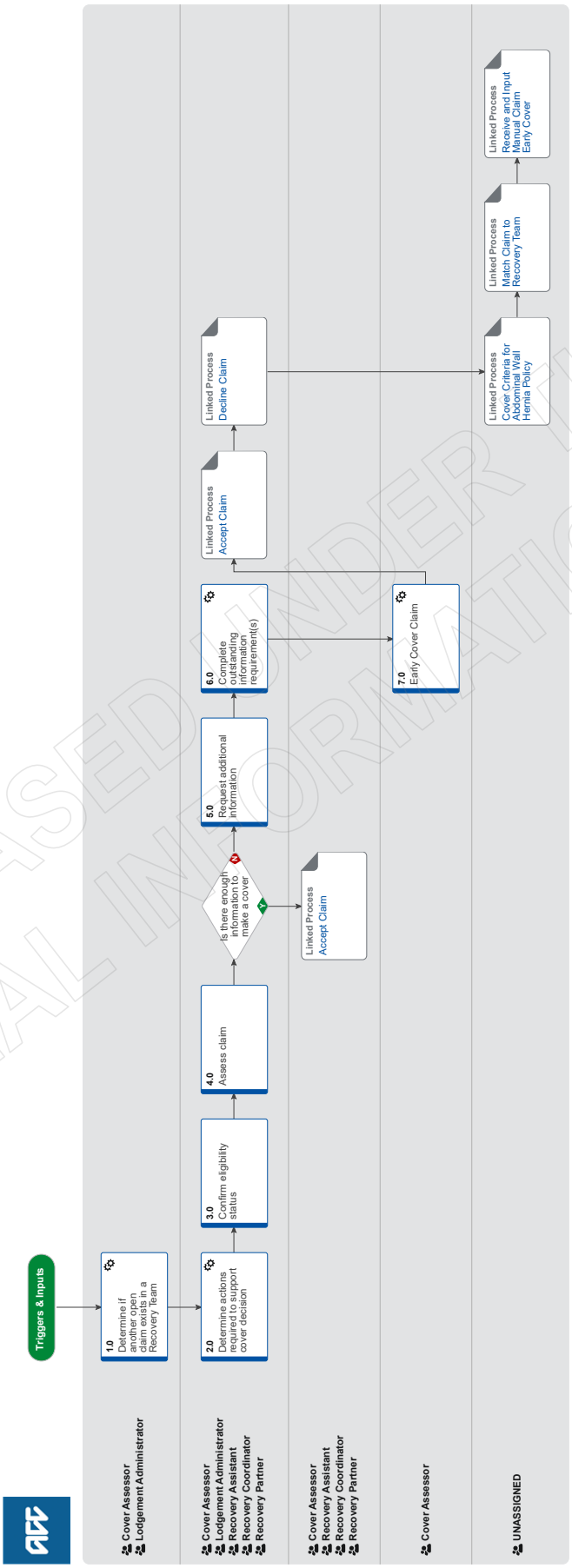
If you have any questions about this response, please get in touch
You can email me at GovernmentServices@acc.co.nz.

If you are not happy with this response, you can also contact the Ombudsman via info@ombudsman.parliament.nz or by phoning 0800 802 602. Information about how to make a complaint is available at www.ombudsman.parliament.nz.

Ngā mihi

Christopher Johnston
Manager Official Information Act Services
Government Engagement

Assess Claim for Cover :: Simple PICBA claim v40.0



Assess Claim for Cover :: Simple PICBA claim v40.0

Summary

Objective
To review claim information and determine what the cover decision should be, where the Cover Decision Service has not been able to accept the claim.

this process does not apply to the Remote Claims Unit, Te Ara Tika or any specialist teams (Hearing Loss, Dental, Treatment injury etc.).

Background
Eos sends a Confirm Cover Decision task for someone to make a manual cover decision. This task type will include a Cover Decision Required information requirement and one or more of the following cover decision information requirements:

- Cover Assessment Required
- Check Eligibility - Overseas
- Check Eligibility - Dates
- Case Alias Check Required

The task may also include information requirements for information only, such as Address Invalid, Client Address Matches Previous Home Address.

Global Process Owner

Global Process Expert

Variation Expert

[Out of Scope]

Procedure

1.0 Determine if another open claim exists in a Recovery Team

Cover Assessor, Lodgement Administrator

a In Eos, check for any open claims.

NOTE **How do you check there is an active managed claim?**
The yellow indicator on the General Screen shows the client has an active managed claim.

NOTE **What if there is an active managed claim?**
Go to Match Claim to Recovery Team.
End of Process.

PROCESS Match Claim to Recovery Team

2.0 Determine actions required to support cover decision

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Open the [Confirm Cover Decision] task.

Do a task with information requirements

b Review the outstanding information requirements to identify what aspects of the claim need to be resolved.

NOTE **What if you need to contact the client or provider at any stage during this process?**
Ensure you resolve as many outstanding requirements in a single contact as possible.

NOTE **What if this is a mandatory data request for a DHB.**
Use the Provider Spreadsheet.

Do not use this contact list if you are requesting medical notes via a PO. Provider spreadsheet is used purely for mandatory data requests only.

Provider Spreadsheet

NOTE **What if the claim is for a hernia?**
ACC covers a sudden abdominal wall rupture caused by an accident. The force of the accident should be such as to tear through the layers of the abdominal tissues. The hernia protrudes through the rupture but the covered physical injury in these cases is the rupture and not the hernia.

The most common type of hernia is located in the groin region. This is known as an inguinal hernia, and about 80% of hernias are inguinal. The diagnosis of an inguinal hernia caused by an accident is partially made on the basis of an early presentation following the event, unless there are extenuating circumstances. An early presentation means a client sought medical attention and was diagnosed with hernia by a medical practitioner or nurse practitioner within 10 days of the event.

Significant groin pain due to an event is one important indicator when causation of an inguinal hernia is being considered. The other indicators are:

- the event involved an unusual, sudden, unexpected force, as opposed to a controlled movement - these hernias are typically associated with handlebar or lap seatbelt injuries, or crushing of the abdomen
- the client ceased activity due to the groin pain caused by the event
- there is no prior history of a non-traumatic inguinal hernia on the same side
- the clinical examination by the medical practitioner or nurse practitioner confirms pain, tenderness, and a lump in the groin region.

If cover has been requested for an inguinal hernia, call the client and complete the 'ACC6261 Cover Assessment - Initial Call Summary - Hernia' script (This version contains criteria at the bottom of the document to help you assess cover) . If you're unable to reach the client on the phone, post the ACC6261 Cover Assessment - Questionnaire to client - Hernia script to the client and have them complete it that way. (This version does not contain the criteria as the client does not need to see this).

For all other hernia's please refer to the 'ACC7913 Primary Abdominal Wall Hernias, Including Groin Hernias - A Guide to ACC Cover' document for further guidance.

ACC6261 Cover Assessment - initial call summary - hernia

ACC6261 Cover Assessment – Questionnaire to client - Hernia

ACC7913 Primary Abdominal Wall Hernias, Including Groin Hernias - A Guide to ACC Cover.pdf

NOTE **Has the client been sent an automatic electronic notification advising them that we've received their claim?**

In general, when a claim is held and sent for a manual cover decision to be made, the client is automatically sent an electronic notification advising them that we've received their claim and are considering it. You can check the [Contact] tab to see whether this notification has been sent.

NOTE **What are the scenarios when this automatic electronic notification isn't sent?**

Automatic claim notification isn't sent if the:
• Client is managed by the Remote Claims Unit or Te Ara Tika branch
• Claim type is Sensitive or Fatal
• Client is deceased
• Client is under 16 years old
• Client has a Safe Contact on their party record
• [Stop Notification] attribute on the client party record is set to [Yes]
• Claim is for a serious injury (determined by the injury diagnosis code)
• Outstanding Case Alias Check Required information requirement is there
• Client has an invalid mobile number.

If the client's mobile number is invalid, a [Notification] task will be created but cancelled automatically. For all other scenarios above, no [Notification] task will be created.

NOTE **What if you're related to or know the client or any of the other parties associated with the claim?**

Then you must not make a cover decision for the claim. Transfer the task back to the department it came from and include the reason for the transfer.

c Check if the claim has the default provider ID: J99966.

NOTE **What if the claim has the default provider ID?**

• Check if there's a contact on the claim that states the diagnosis is outside provider competency.
• If there is, then resolve the provider competency issue before you continue with this process. Go to Resolve Provider Competency process below to do this and start at step 3.0 of this process.

#Workaround: Resolve Provider Competency WORKAROUND process is required because Eos raises the Provider Competency Issue information requirement before the cover decision service has run. As registration is incomplete at this stage, a Lodgement Administrator cannot add a purchase order to the claim, which is needed to complete the process. They must add a default provider to the claim to get it through the cover decision service where registration becomes complete. We'll need to create a standard Resolve Provider Competency Issue process if changes are made in Eos to only raise this IR after the cover decision service has run (or if admin staff are given permission to enter the default provider ID and suppress this IR before the cover decision service has run).

PROCESS Resolve Provider Competency Issue

NOTE **What if claim type or claim type tick needs to be added or changed?**

If after or during assessment it is determined that the claim type tick needs to be changed or added, you can update on the general tab under claim type. Click edit and tick the relevant box.

NOTE **What if claim if determined to be a Treatment Injury Claim**

Add TI (Treatment Injury) tick in EOS General screen and transfer claim to Treatment injury administration queue

NOTE **What is claim is an Early cover Application via Early Cover Inbox**

Go to step 7.0

NOTE **What if claim is a Maternal Birth Injury PICBA claim?**

If this is a Maternal Bith Injury claim, transfer it to MBI queue.

3.0 Confirm eligibility status

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check if one or both of the following information requirements are outstanding:
• Check eligibility - dates
• Check eligibility - overseas

NOTE **What if one or both of these information requirements are outstanding?**

They must be completed before you continue with this process. Go to the Verify Claim Information process below to do this.

PROCESS Verify Claim Information

NOTE **What if you've completed the information requirements and determined that the client is not eligible for cover?**

If the client is not eligible for cover, then you must decline the claim. Go to step 6.0 Complete outstanding information requirements to complete the information requirements and then decline the claim.

4.0 Assess claim

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Review criteria for cover by reading the policies linked below.

- Cover criteria for personal injury Policy
- Cover for visitors to New Zealand Policy
- Cover for injuries suffered outside New Zealand Policy
- Criteria for injury occurring outside New Zealand Policy
- Eligibility of late claims Policy
- Mental Injuries Policy

NOTE **What if it's a change or additional diagnosis?**
In addition to the cover criteria outlined in the linked policies, you need to consider
• how much time has passed from the date of lodgement and the date of the accident?
If the new injury would generally have a short recovery period yet the request to add the diagnosis is made sometime after this period, seek clinical advice.
• what are the differences between the original diagnosis and the new diagnosis?
• how likely that the described accident caused new injury?
• how likely that the underlying conditions (if any), gradual process or ageing caused new injury?

b Consider if you have enough information to assess claim against the cover criteria. Review the traffic light for cover decisions, Lodgement Administrators to review information in the Registration Reference Book to help determine this and relating documents below.

- Claims Assessment Traffic Light
- Complex Regional Pain Syndrome (CRPS)
- Requesting clinical records from District Health Boards
- Contacts for requesting District Health Board clinical records
- Timeframes to determine cover (Policy)

NOTE **What information do you need to consider for the change or additional diagnosis request?**
• the date of claim lodgement, the date of the accident and the date we received the request to change/add diagnosis
• the original diagnosis and the new diagnosis
• the description of the accident
• the information on daily activities, age and pre-existing health conditions if applicable
• medical evidence; eg clinical notes, specialist reports and correspondence, x-ray, MRI and other scan results if applicable

NOTE **What if the claim is for hernia?**
For an Inguinal Hernia contact the client and complete the ACC6261 Cover Assessment - Initial Call Summary - Hernia document. If unable to contact the client or client would like to complete by themselves you can post the ACC6261 - Cover Assessment - Questionnaire to client - hernia to the customer along with CVR12. (Please note there is a difference between the two forms).

For other type's of hernia please refer to the 'ACC7913 Primary Abdominal Wall Hernias, Including Groin Hernias - A Guide to ACC Cover' document for further guidance.

PROCESS Cover Criteria for Abdominal Wall Hernia Policy

- ACC6261 Cover Assessment - initial call summary - hernia
- ACC6261 Cover Assessment - Questionnaire to client - Hernia
- ACC7913 Primary Abdominal Wall Hernias, Including Groin Hernias - A Guide to ACC Cover.pdf

NOTE **What if the cover or additional diagnosis request is for Post Concussion Syndrome?**
ACC no longer accepts 'post-concussion syndrome' as a covered injury.

Use the "claims assessment traffic light" to aide with a cover or additional diagnosis request.

NOTE: ACC is not reviewing existing cover. If a kiritaki (client) has cover for post-concussion syndrome that remains.

The intent of the position statement is not to restrict entitlements. It is to ensure cover is considered correctly.

- Post-concussion syndrome ACC position statement
- Guidelines for accepting cover for Concussion

c Review all information and determine whether the claim meets the criteria for cover.

NOTE **What if the claim does not meet the criteria for cover?**
Go to the Decline Claim process.

PROCESS Decline Claim

Is there enough information to make a cover decision?

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

YES.... **PROCESS** **Accept Claim**

NO.... Continue

5.0 Request additional information

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine who can provide the additional information and request them to submit the information.

NOTE **What if you need to ask the client or provider for additional information at lodgement?**
Go to 'Contact Client or Provider for Information at Lodgement' process.

PROCESS Contact Client or Provider for Information at Lodgement

NOTE **What if you require clinical records?**
Review the Request medical or clinical records Policy.

Go to 'Request Clinical Records' process. Note that you need to use MD09 PO code for GP and allied health professionals' notes.

If you require clinical records from DHB, go to point 3.1 in the process 'Request Clinical Records'.

PROCESS Request Clinical Records

- Request medical or clinical records Policy
- Requesting clinical records from District Health Boards
- Contacts for requesting District Health Board clinical records

NOTE **What if you require clinical advice?**
Go to 'Seek Internal Guidance' process for Tier 1 and Tier 2 advice.

PROCESS Seek Internal Guidance

NOTE **What if a client or provider cannot provide the requested information?**
Decline claim due to a lack of information. Go to step 5.0 to complete the information requirements and then to 'Decline claim' process.
PROCESS Decline Claim

b Determine if the cover decision timeframe needs to be extended.

NOTE **How much time do you have to make a cover decision?**
You have 21 days to make a cover decision on non-complicated claims from the date ACC received a request, and two months to make a decision on complicated claims from the date ACC received a request.

Refer to the Timeframes to Determine Cover Policy for complicated and non-complicated claim definitions, and more information.

Timeframes to determine cover Policy

NOTE **What if the cover decision timeframe needs to be extended?**
Go to 'Extend Cover Decision Timeframe' process.
PROCESS Extend Cover Decision Timeframe

NOTE **How to request information from NZ immigration (Customs/PAX)**
When requesting information around a clients international movements from NZ immigration - Also referred to as Customs or PAX movements, When requesting information around a client's international movements from NZ immigration - Please obtain a signed ACC6300 from the client to attach with the request and include the following blurb:
"I am currently considering a request for ACC cover and I need to confirm (x travel dates) for the following person: (client's details).

I've attached a signed copy of the ACC6300 "Authority to Collect Medical and Other Records" form, in which the client authorises ACC to collect information to determine what support ACC can provide.

This request is in line with Principle 2(2)(c) and disclosure is in line with Principle 11(1)(c) of the Privacy Act 2020."

6.0 Complete outstanding information requirement (s)

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Update the Cover Decision Required information requirement to [Complete] and also update the Cover Assessment Required information requirement to [Complete] if it's present on the claim. Ensure all Outstanding information required tasks are complete on the claim.

Complete information requirement

b Clear Information required Tab in EOS and associated tasks

c Check if there are any outstanding information requirements for missing information.

NOTE **What if there's one or more outstanding address-related information requirements (Address is Invalid, Client Address Matches Previous Home Address, Client Already Has an Address Starting Today, Client Already has a Post Address Starting Today)?**
These should be completed before continuing with this process.

Go to Update Client Address process before continuing to step c.
PROCESS Update Client Address

NOTE **What if there's an outstanding Phone Number Verification information requirement?**
This should be completed before continuing with this process.

Go to Update Client Phone Number process before continuing to step c.
PROCESS Update Client Phone Number

NOTE **What if there's an outstanding Vendor Status Removed or Facility Status Removed information requirement?**
This should be completed before continuing with this process.

Go to the Resolve Provider, Vendor or Facility Status Issue process before continuing to step c.
PROCESS Resolve Provider, Vendor or Facility Status Issue

d Check if there's an outstanding Case Alias Check Required information requirement.

NOTE **What if there's an outstanding Case Alias Check Required information requirement?**
This must be completed before continuing with this process. Go to the Identify and Link Duplicate Claims:: Case Alias IR process before continuing to Accept Claim process.

Note: A claim can only be assessed as a potential duplicate once the cover decision has been determined, as the cover decision must match the original claim for it to be considered a duplicate.
PROCESS Identify and Link Duplicate Claims :: Triggered by information requirement

7.0 Early Cover Claim

Cover Assessor

a Review the Early Cover Service information within the Traumatic Brain Injury Residential Rehabilitation service page in Promapp (If necessary).

Traumatic Brain Injury Residential Rehabilitation (TBIRR) Service Overview Service Page
https://au.promapp.com/accnz/process/fc562909-fc94

b Open the Early Cover Inbox and access the Early Cover request including the ACC7422 form.

c Read the email content and any attachment(s). Mark email as In progress in Outlook.

d In Eos, confirm that the claim hasn't yet been registered. Check for ACC45 / NHI / Client name. If the claim is not registered, forward the email and attachments to the Registration Inbox. Mark the Email as High priority & URGENT EARLY COVER in the Subject line.

If we have enough information via the early cover documentation to support / provide cover, we can ask that lodgement accept the claim after registration & stream to Supported recovery / NGCM. If we need more information, ask that the lodgement team to Hold the claim to Cover Triage Q.

If we need more information - such as ED admin notes, ask that the lodgement team to Hold the claim to Cover Triage Q. Depending on the information provided from the DHB, If you are unsure the claim can be accepted for cover – Seek Hot line guidance from MA. Not All early Cover claims will require MA input or further notes.

If required – depending on the severity of the injuries & client status notifications, letters can be suppressed. Please ensure this is Noted in your claim accept contact on the claim & NGCM team are aware.

Example:

Good Morning / Afternoon
Can you please have the attached registered for client for Early Cover. Injuries can be covered given the Accident details.
Please accept cover & Stream this claim to NGCM for assistance request.

Thanks

Or

Good Morning / Afternoon
Can you please have the attached registered for client for Early Cover. Please hold this claim to Cover Triage as further information is required, can you please advise when this has been done.

Thanks

When the claim has been registered & transferred to the Cover Triage queue, pick up the claim, transfer to your name & action requests for medical pick up the claim & Request medical notes from the DHB as per Assess claim for cover PICBA process. Ensure Notes are requested Urgently.

Please note if needed – depending on the severity of the injuries & client status notifications, letters can be suppressed. Please ensure this is Noted in your claim accept contact on the claim & NGCM team are aware.

NOTE **What if the diagnosis on the ACC7422 does't include a read code**

The claim must have a read code for the diagnosis for the claim to be lodged. The Cover Assessor should search for an appropriate read code by either asking the provider, or by searching in the readcode finder tool. If an exact match is not able to be found, the cover assessor should look to add a read code for a lesser/ more general diagnosis (eg if the diagnosis on the ACC7422 is for a brain bleed in a specific area, but there is no matching read code, the Cover assessor may request the claim lodged with "head injury" when sending through to lodgement)

e If able to accept claim, Update claim status and Follow Match Claim to Recovery Team.
** NOTE - Early cover claims are to be matched to SUPPORTED or PARTNERED recovery. Not Assissted or Enabled.

ACC7422 Early cover application form

NOTE **What is claim is registered and currently managed by recovery teams**

If the claim is allocated to a case owner in supported or partnered recovery – File away the Early Cover documents, email the staff member to advise early cover application has been received & to consider any further assistance or Injuries and transfer the claim to the case owner in supported or partnered recovery.

NOTE **What if the claim has already been registered?**

File away the early Cover application form & name documents on EOS i.e. CT Scan / Ambulance Reports

If the claim is held, check all injuries both in EOS & on the early cover documents are able to be covered with the information provided from the DHB – some may require full medical notes (Urgent) – refer to Assess claim for cover / PICBA process.

If required – depending on the severity of the injuries & client status notifications, letters can be suppressed. Please ensure this is Noted in your claim accept contact on the claim & NGCM team are aware

If the claim is in Actioned cases – check all injuries are covered, add any additional injuries to the claim from the information we hold. Re-check / Re-run the EMS tool & stream to appropriate NGCM Team – most transfer to supported recovery.

NOTE **What if the claim hasn't been registered and no claim form is attached to the request?**

Email the provider back, marked as high priority asking them to provide Relevant Information, ACC45 – as well as CT Scans / ACC18 / Ambulance information / ED notes etc. Note Some staff who complete the Early Cover forms at the hospitals are unable to access full notes so medical notes request will need to be actioned (Assess claim for cover – PICBA – Marked as Urgent)

NOTE **What if the ACC45 has previously been used?**

If the ACC45 has been previously used (Not for the current client) & dummy claim number is to be allocated – Forward the email to Hamilton Registration inbox as Lodgement will need to allocate a new number & register the claim. Refer to Start of Step D.

Client searches

Guide to completing the new ACC early cover referral form FINAL.dotx

PROCESS **Accept Claim**
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS **Decline Claim**
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS **Cover Criteria for Abdominal Wall Hernia Policy**
UNASSIGNED

PROCESS **Match Claim to Recovery Team**
UNASSIGNED

PROCESS **Receive and Input Manual Claim :: Early Cover**
UNASSIGNED