



31 March 2022

Kia ora [REDACTED]

**Your Official Information Act request, reference: GOV-017061**

Thank you for your email of 3 March 2022, to [REDACTED] ACC's Review Specialist, asking for the following:

- *Copy of Acc decision matrix followed , ie that lead to the basis of this decision*

Due to the nature of your request, it was referred to the Government Engagement & Support team to respond to under the Official Information Act 1982.

On 4 March you further requested information about [REDACTED] which we attempted to clarify with you on 10 March. As we received no response, we are refusing this portion of your request in reliance of section 18(d), because the information is publicly available at Medical Council of New Zealand website.

**Assess claim for cover - Physical Injury caused by accident (PICBA)**

We interpreted your request to be the process of assessing a claim for cover and the overall process of claim lodgement. Please find attached:

1. *Assess Claim for Cover \_\_ PICBA*
2. *Claim Lodgement*

**If you're concerned about this response, please get in touch**

You can email me at [GovernmentServices@acc.co.nz](mailto:GovernmentServices@acc.co.nz)..

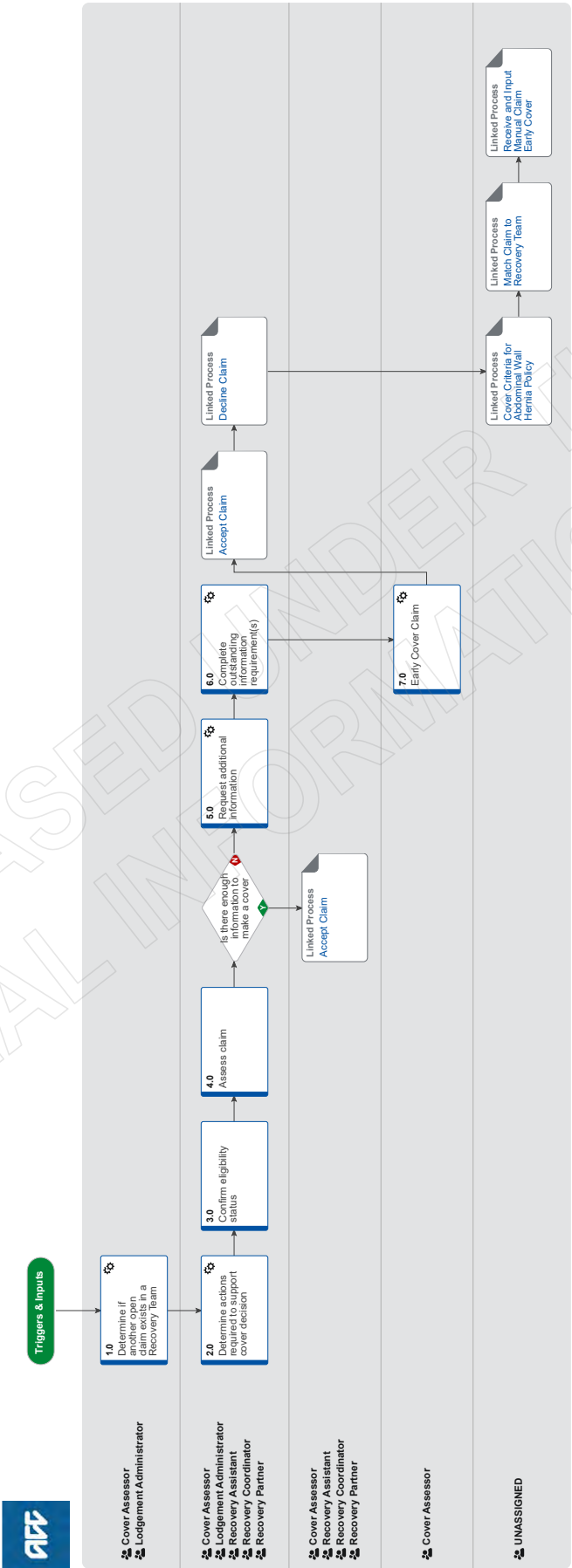
If you are not happy with this response, you can also contact the Ombudsman via [info@ombudsman.parliament.nz](mailto:info@ombudsman.parliament.nz) or by phoning 0800 802 602. Information about how to make a complaint is available at [www.ombudsman.parliament.nz](http://www.ombudsman.parliament.nz)

Ngā mihi

Sara Freitag  
**Acting Manager Official Information Act Services**  
Government Engagement & Support



RELEASED UNDER THE OFFICIAL INFORMATION ACT



## 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.

Owner

[Out of Scope]

Expert

## 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.

Refer to the 'ACC7913 Primary Abdominal Wall Hernias, Including Groin Hernias - A Guide to ACC Cover' document for further guidance.

Call the client and complete the 'ACC6261 Cover Assessment - Initial Call Summary - Hernia' script. If you're unable to reach the client on the phone, post the script to the client and have them complete it that way.

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

 ACC6261 Cover Assessment – Initial Call Summary - Hernia

### 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 Wellington Central 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 - please follow - <http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/add-or-edit-claim-type/index.htm>

**NOTE What if claim is 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

**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.

-  Complex Regional Pain Syndrome (CRPS)
-  Triage Traffic Light
-  Guidelines for accepting cover for Concussion

**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 a hernia?

Contact the client and complete the ACC6261 Cover Assessment - Initial Call Summary - Hernia document

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

- ☐ ACC6261 Cover Assessment – Initial Call Summary - Hernia
- ☐ Requesting clinical records from District Health Boards
- ☐ Contacts for requesting District Health Board clinical records
- ☐ Timeframes to determine cover (Policy)

- 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 'Requesting clinical records from DHB (CHIPS)' process.

☐ **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 client's 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 :: Case Alias IR

**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 doesn'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)

## 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.

- 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 Assisted 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**

**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

**PROCESS**

**Accept Claim**

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

## Summary

### Objective

Claims can be submitted on any of the ACC-approved ACC45 injury claim form versions, electronic methods or the Accident Insurance Treatment Certificate (AITC).









Owner

[Out of Scope]













Expert

## Procedure

### 1.0 Lodging a claim








- a** When a claim is lodged, it is important to note that:
  - acceptance for lodgement does not mean a claim has been accepted for cover
  - the date of lodgement determines when the 'clock starts ticking' for the purposes of determining the correct insurer, cover and payment of statutory entitlements
  - mandatory information is required for each claim.
- b** For more details, see the related business rules below.
  -  Claim lodged using claim form
  -  Registration of a claim
  -  ACC issued claim number
  -  Claim number assignment
  -  Client consent for claim lodgement
  -  Treatment provider lodging on behalf of a client
  -  Claim lodgement: accredited employer claim
  -  Claim lodgement: non accredited employer claims

### 2.0 Client & claim records

- a** When a claim is lodged the rules about client records and claim records listed below must be followed.
  -  Client record
  -  Unique claim records
  -  One claim per claim record
  -  One client per client record
  -  One client per claim
  -  Duplicate clients
  -  Add employer when employer can be identified
  -  Add a default employer when the employer cannot be identified
  -  Matching client record to a claim record when no NHI number – system and manual lodgement
  -  Matching client record to a claim record when NHI number – manual lodgement
  -  Matching client record to a claim record when verified NHI number – system lodgement
  -  Matching client record to a claim record when non-verified NHI number – system lodgement

### 3.0 Claim lodgement methods

- a** The rules listed below define the methods of claim lodgement acceptable to ACC.





-  Claim lodgement methods
-  Claim lodgement method types
-  Client lodgement methods
-  Authorised representative lodgement methods
-  One method of lodgement
-  Treatment provider lodgement methods
-  Accident Information Definition

- b** For all non-work injuries, or work injuries received after 1 July 2000 use:
  - the ACC45 ACC injury claim form (ACC45).
















For work injuries received between 1 July 1999 and 30 June 2000 use:

- an ACC45 or AITC.

### 4.0 Collecting claim information at registration

-  Snapshot of registration
-  Storage of claim information
-  Claim information for a claim
-  Inbound documentation

### 5.0 Claim types

- a** A claim type is used to determine the allocation of a claim for a cover decision and claim management (if accepted).
  -  Assigning a claim type
  -  Mandatory claim information for claim type identification
  -  Who can assign a claim type
- b** Claim types are defined using the following rules.
  -  Complex claim type definition
  -  Non-complex claim type definition
  -  Simple dental claim type definition
  -  Assigning dental complex claim type
  -  Fatal complex claim type definition
  -  Hearing loss complex claim type definition
  -  Mental injury complex claim type definition
  -  Sensitive complex claim type definition
  -  Treatment injury complex claim type definition
  -  Work-related gradual process complex claim type definition
  -  Work-related mental injury complex claim type definition
  -  Claim type to be assigned if multiple complex claim types identified