

17 May 2022



Your Official Information Act request, reference: GOV-017963

Thank you for your email of 25 April 2022 asking for the following information under the Official Information Act 1982 (the Act):

 ACC business rules and statistical modelling that has been undertaken in determining claim, as relevant to all decisions - the one(s) ACC has accepted, and the one(s) ACC is refusing

On 12 May 2022, you advised you did not require staff names as part of this response. As such, this information has been marked as *out of scope*.

The information provided are those we've determined specifically relate to claim.

As this claim was manually assessed for cover, we've have included with our response the policies and

procedures that were applicable during the course of this claim up until the review application was received.

Attached are the following documents:

- Accept Claim
- Allocate Task for Mental Injury
- Allocate Task for non-complex Cover
- Applying the Two-part Test to Determine Cover for Mental Injury Because of Physical Injury
- Arrange Mental Injury Assessment for Cover
- Assess Claim for Cover __ Late Lodged
- Assess Cover for an Additional Injury or Change in Diagnosis
- Claim Lodgment
- Consequential Injury Claims Policy
- Conversion Probability Threshold
- Cover criteria for personal injury
- Cover Criteria for Physical Injury
- Cover criteria for pre-existing conditions Policy
- Criteria for Work-related Personal Injury 'Place of Work'
- Decline Claim
- Definition of Accident Policy

- Extend Cover Decision Timeframe
- Issue Recovery Decision
- Make Cover Decisions for Mental Injury Caused by Physical Injury
- Make Cover Decisions for Work-Related Mental Injury Claims
- Mental injury Because of a Physical Injury Policy
- Mental Injury Policy
- Monitor Cover Decision Timeframes ___ Held Claim
- Provide Internal Guidance Written
- Request Clinical Records
- Resolve Provider Competency Issue
- Seek Internal Guidance
- Statutory Timeframes for Mental Injuries Policy
- Timeframes to Determine Cover Policy
- Verify Claim Information
- Work-Related Mental Injury Policy

As this information may be of interest to other members of the public

ACC may decide to proactively release a copy of this response on ACC's website in future. All requester data, including names, contact details and any identifying information, will be removed prior to release. The released response will be made available www.acc.co.nz/resources/#/category/12.



If you're concerned 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

Sara Freitag

Acting Manager Official Information Act Services

Government Engagement & Support

Accept Claim v16.0



Summary

Objective

To advise a client that we've accepted their claim. This process addresses accepting PICBA claims only, it does not include accepting specialist claims.

Background

A staff member has investigated a claim and determined that it meets criteria for cover and can accept it.

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Confirm injury outcome status

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

a Review the outcome status of the injury or injuries in Eos and update if necessary. The default outcome status is Provisional however this should be updated to Approved or Declined in certain scenarios. See the Injury outcome status definitions guide below.

Injury outcome status definitions

NOTE What if ACC is accepting some of the injuries but declining others?

Leave the outcome status for the accepted injuries as Provisional and update the outcome status for the injuries you're declining to Declined.

NOTE: If you've received medical records that confirm the injury or injuries being covered, then you must change the outcome status for the accepted injuries to Approved after you've created the CVR43 cover letter. This is because Eos will only populate the details of the accepted injuries in the letter when the outcome status is Provisional

Assign an outcome status and an outcome date to an injury code

2.0 Communicate cover decision

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

a Determine which cover letter should be sent to the client using the guide below.

Cover Letter Quick Reference Guide

NOTE What if the guide says you should send the automatic CVR40 letter?

- Ensure the Send Auto Accept Letters radio button is set to Yes.
- Go to step 3.0 to update the cover status in

NOTE What if the guide says you should create and send a letter that is not the automatic CVR40 (ie CVR43, CVR45, CVR47, CVR70, WSI02 or CVR41)?

- Ensure the Send Auto Accept Letters radio button is set to No.

b Generate the relevant accept cover letter in Eos that you identified using the guide above.

NOTE What if the claim is for a mental injury?

Go to the Issue Recovery Decision process
PROCESS Issue Recovery Decision

Upload an Incomplete Electronic Document

NOTE What if the client's address is not verified? FOR CLAIMS ASSESSMENT

- If the address is verified but not valid, it is okay to send a letter to the client. However, if speaking with the client as part of the assessment process, please ensure the address details are verified.
- If the address is not verified and not valid, add a note in the contact for the document stating: 'Letter not sent to client as address is invalid.' Send a copy of the accept cover letter to the provider who lodged the claim instead.

NOTE CLIENT ADMINISTRATION - when working on sending information for Claims Assessment. Continue to send to unverified addresses.

NOTE What if the client address is not verified -

-If an address is verified the letter can be sent regardless of whether the address is valid or invalid

If an address is not verified the letter cannot be sent regardless of whether the address is valid or invalid. Add a note in the contact for the document stating: 'Letter not sent to client as address is invalid.' Send a copy of the accept cover letter to the provider who lodged the claim instead.

- **c** Print and sign the letter.
- **d** Add the Working Together information sheet.

ACC255 K\u00f6rero mai - Working together

e Complete a privacy check to ensure you are only sending information to the client that is relevant to this claim.

NOTE Do I have to complete the privacy check myself?

In some business units a separate team will complete this privacy check. Ask your manager if this is the case for your team. If there is not a separate team responsible for privacy checking you will need to complete the check yourself.

NOTE What if I'm only accepting some of the injuries but declining others?

Now that you've created the CVR43 cover letter, you can update the injury outcome status for the accepted injuries to Approved if you've received medical records that confirm the injuries. If you haven't received medical records that confirm the injuries then leave the outcome status for the accepted injuries as Provisional.

3.0 Update cover status

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

a In Eos, change the cover status to Accept and update the cover status reason to Criteria for Cover are met.

NOTE What if the claim is for a wilfully self-inflicted injury (WSI)?

Include the following statement in the cover status change reason:

Cover accepted for physical injuries - if entitlements sought must be investigated for wilfully self inflicted by managing department.

Update Cover Status

b Add a contact to the claim explaining your cover decision rationale.

Add a client contact

c Close the Confirm Cover Decision task.

Close a Task

NOTE What if I've received a Notification Decision task?

You've received this task because the claim has a specialist claim type (WRGPDI, Hearing Loss, Mental Injury, Work Related Mental Injury, Treatment Injury, Dental). In general, it's good practice to send the automatic electronic notification to the client informing them that their claim has been accepted. However in some instances it might not be necessary, for example you may have just confirmed cover over the phone with them

- If you want to send notification, close the Notification Decision task and select Send Notification when prompted.
- If you don't want to send notification, close the Notification Decision task and select Discard Notification when prompted.

Note that Sensitive and Fatal claim types will never be sent automatic notification, and electronic notification is automatically sent for PICBA claims.

NOTE Why does a new Confirm Cover task get created?

Before you can successfully close the Confirm Cover task all Information Required tasks need to be actioned and closed. You also need to change the Cover Status on the General Screen to "Accept". If you close the Confirm Cover task before these steps have been undertaken a new Confirm Cover task will be created.

4.0 Generate and send CVR40 cover letter and CVR48 Employer Notification letter (if applicable)

Eos

- a If the Send Auto Accept Letters radio button is set to Yes and the cover status has been updated to Accept, then the CVR40 cover letter will be automatically generated. Eos transfers the letter data to an external mail house who print and send the letter to the client.
- b If the claim is accepted and is a work-related injury, then the CVR48 Employer Notification letter will be automatically generated. Eos transfers the letter data to an external mail house who print and send the letter to the client's employer.

NOTE What if the employer is noted as being Proxy, and we receive updated details?

Review Identify Clients Employer - Step 2.0

PROCESS Identify Client's Employer

4.1 Send electronic cover notification

Eos

a An electronic notification is automatically sent to the client that confirms their claim has been accepted. Note that there are some situations where this notification is prevented, for example if the claim type is Fatal or Sensitive, if the client is a minor or deceased, if the claim is managed by the Remote Claims Unit or Te Ara Tika (previously Wellington Central Branch), if the client has a Safe Contact on their party record, if the Stop Notifications attribute on the client's party record is set to Yes etc.

4.2 Match Claim to Recovery Team

Cover Assessor, Lodgement Administrator, Recovery Team Member

a Use this process to determine the appropriate team to manage the client and their recovery.

PROCESS

Match Claim to Recovery Team

Cover Assessor, Lodgement Administrator, Recovery Team Member

Allocate Task for Mental Injury v5.0



Summary

Objective

To provide guidance on self allocation of tasks from the Mental Injury queue.

Background

This is a manual workaround for Cover Assessors who do not have WFM through Salesforce

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Get next available task

Cover Assessor

- a In Eos, View tasks, Choose Role, select Hamilton REG -Cover Assessment, click OK.
- b Use 'Get Next Task' to self-allocate the next available task in the queue.

2.0 Determine if another open claim exists in a **Recovery Team**

Cover Assessor

- a In Eos, navigate to the Party Record, and check for any claims being actively managed by a Recovery Team.
 - NOTE Is there another indicator to show other actively managed claims?

The yellow indicator in the General Screen shows the client has an actively managed claim.

NOTE What if there is an actively managed claim? Go to Match Claim to Recovery Team.

This process ends.

PROCESS Match Claim to Recovery Team

3.0 Review and action task for new claim

Cover Assessor

- a Open the claim by clicking on the claim number in the

 - NOTE What if the task is for general cover but in the Hamilton REG - Cover Assessment gueue?

Transfer the claim and any associated tasks to the Registration Centre - Low Complex Dunedin queue. This process ends.

What if the task is Auto Alert 1 (New Claim) task - Or Confirm Cover Task set to Day 0

- Click on the task tab and transfer the other open tasks that you can also action (to prevent other team members taking those tasks for the same claim). e.g there is also a Contact Party and Alert Mail task open on the claim.
- Review the claim and determine if you can make a decision.

NOTE What if the Claim WRMI

Process "Make Cover Decision for Work-Related Mental Injury Claims

PROCESS Make Cover Decisions for Work-Related Mental Injury Claims

What if there is missing information that is needed to help determine making a decision?

Go to Request Clinical Records process.

PROCESS Request Clinical Records

What if you need to clarify the diagnosis, NOTE accident details or other details with the Provider?

> Contact the Provider, add a contact (in the Contact tab) in Eos recording the conversation. If able to make a decision and it does not meet criteria MICPI, WRMI then decision claim

NOTE What if a full assessment is needed to determine cover?

> Do an initial assessment and update the 'Confirm Cover Decision' task confirming you have: Checked the ACC45 Y

Checked for any duplicates Y Checked MFP/Pathway Y Checked Claim history Y

Checked Party level documents / contacts Y

NOTE What if you're unable to issue a decision and further assessment/clarification is required for a Mental Injury claim?

- Close Auto Alert 1 (New Claim) task.
- Click on the "Task" tab on the General Screen and transfer the other open tasks that you can also action (to prevent other team members taking additional tasks for the same claim). e.g. there is also a Contact Party and Alert Mail task open on the claim.
- Update the 'Confirm Cover Decision' task with the correct cover decision due date of the claim (taken from the General Screen). Transfer the task back to the Hamilton Reg - Cover Assessment queue
- If requesting medical notes create and update a "Follow Up Provider" task. Move the task date out by 5 working days and transfer the task to the Hamilton REG - Cover Assessment queue.

When requesting notes put the return email address as coverassessment@acc.co.nz.

- If you have requested information from a client (e.g questionnaire, photos etc) create and update a "Follow up Claimant Information Request" task. Move the task date out by 5 working days and transfer the task to the Registration Centre - Low Complex Dunedin queue. -Update the 'Confirm Cover Decision' task to the cover decision due date of the claim (as noted on the General Screen). Transfer the task back to the Registration Centre - Low Complex Dunedin queue.

PROCESS Make Cover Decisions for Mental Injury Caused by Physical Injury

NOTE Arrange Mental Injury Assessment for Cover Process

Go to Arrange Mental Injury Assessment for Cover Process

PROCESS Arrange Mental Injury Assessment for Cover

NOTE What if you have been unable to contact the provider of client to clarify information?

Create and update a "Follow Up Provider" and/or "Follow up Claimant Information request" task. Move the task date/s to the following working day. Transfer the task/s to the Hamilton REG - Cover Assessment queue. Record the contact attempt as a contact in the "Contacts" tab.

3.1 Review and action task

Cover Assessor

a Open the claim by clicking on the claim number in the task.

NOTE What if there are tasks that can be actioned at the same time?

Transfer the tasks into your queue to action.

b At Claim level check for any tasks that can be actioned at the same time.

NOTE What if the task is for a 'Alert you have Mail'?

Check to see if there is an associated 'Follow Up Provider' task.

- Check the original request to confirm you have received all the information requested. If information is missing, contact the Provider. Add a contact on the claim. Reset the 'Follow Up Provider' task to show what you are waiting for, move the target date for a further 5 working days and transfer back to the Hamilton REG - Cover Assessment queue.

Update the 'Confirm Cover Decision' task with activity carried out.

- -If you need to seek Internal Guidance follow the Seek Internal Guidance Process:
- If the task is a returned external psychologist or psychiatrist report, see existing CHIPS process for referring for internal Branch Advisor Psychologist comment.
- If the task is checking for an interal comment that is available, refer to existing CHIPS process regarding which sign offs are required. If all required sign offs are obtained, refer to issue cover decision process.

Note - If the initial internal guidance is to seek formal written comment from a medical advisor, create an ACC6260 on the 'Documents' tab. Fill in the relevant details (claims, documents, question for clinical etc), Create an 'Organise Internal Referral' task and move the task date out by three days. Create a 'Complete Internal Referral' sub-task off the 'Organise Internal Referral' task. Link the necessary documents to the task and transfer the Complete Internal Referral task to 'Regional Clinical Advice - Central queue. If the claim is INCAP Transfer the Organise Internal Referral task to the Registration Centre - Low Complex Dunedin queue. Update the Confirm Cover decision task with the action taken.

- -Close the 'Alert you have Mail' task and the other tasks that you have actioned.
 -Update the 'Confirm Cover Decision' task with activity carried out.
- C Determine if you have enough information to make a decision.

NOTE What if you need to seek internal guidance?

Go to the Seek Internal Guidance process
PROCESS Seek Internal Guidance

NOTE What if the task is for Follow up Claimant Information Request

-If the information has not been received (check in the "Documents" tab). Follow up with the client again for the information needed. Note attempt in "Contact's" tab. Update the task move the date to the following working day and transfer back to the Registration Centre - Low Complex Dunedin queue.

-If the information has been received and you can issue a decision go to Activity 4.0 Issue Decision.

-If a decision can not be issued and further medical information is needed request the information and create and update a "Follow Up Provider" task update the date to 5 working days and transfer to the Registration Centre - Low Complex Dunedin queue. Close the Follow Up Claimant Information Request task.

-When requesting notes make sure to put the return email address as cover.assessment@acc.co.nz.

-Update the Confirm Cover Decision tasks with your action.

NOTE What if the task is 'Contact Party'?

-Click on the task tab and transfer the other open tasks that you can also action (to prevent other team members taking additional tasks for the same claim). e.g there is also an Alert Mail task open on the claim.

-Check the Contact Party task to see who has called and what the query or need is. Review the claim history before contacting the client -If an attempt is made but unsuccesul add a Contact in Eos to record the attempt. Update the 'Contact Party' task move out to the following day, and transfer the task back to the Registration Centre - Low Complex Dunedin queue. -If contact has been made close the 'Contact Party' task. Ensure that all appropriate actions or tasks that could be completed on the claim have been.

NOTE What if the task is Organise Internal Referral?

-Go to the claim and check the requested information is on the claim. This could be under the Documents tab or on the Recovery Support Tab on the General Screen. Review the internal advice provided to determine next steps.

If recommendation supports you to make a deci-

If recommendation supports you to make a decision, check CHIPS process to ensure all necessary sign offs are obtained and if so, go to Activity 4.0 Issue Decision.

-If the request is to obtain further information, follow Requesting Medical Information process.

NOTE What if the task is a 'General' task - User to enter details'

The 'General' task could relate to a number of different requests from any part of the business. You will need to review the task and the claim history to determine next steps. Action the task and closed once completed.

NOTE What if the task is a completed ACC6300 Consent Form?

Check the file to check to determine what records we require this consent form to obtain. This may include employer, Police, interim supports, previous counselling etc.

- Request these records as per existing notes request process.

d What if the task is a "Follow up Employer" task for employer records request? - Contact the employer and follow up the request. Update the contacts tab, and the task, and place the task out 5 working days.

3.2 Review and action Provider related tasks

Cover Assessor

a Open the claim by clicking on the claim number in the task

NOTE What if the task is for a Follow Up Provider task relating to a request for medical notes?

-Go into 'Tasks' and the 'Documents' tab on the claim to see if there is any associated 'Alert: You have Mail or 'AUTO: You have Mail Medical Notes added' or that the requested documents have been scanned to file. You should also check in the Party Level Documents tab, in case they have been scanned in at the Party level.

-If there are no 'Alert Mail' tasks and the information has not been received, then contact the Provider to follow up on the request. Add a contact to the 'Contacts' tab on the claim and set the task out for a further 5 working days and return the 'Follow Up Provider' task to the Registration Centre - Low Complex Dunedin queue. Update the 'Confirm Cover Decision' task with activity carried out.

If there is an associated "Alert Mail" task or AUTO: You have Mail Medical Notes and all the information you need has been received transfer all the "Alert Mail" tasks into your name and other tasks that you can action (to prevent other team members transferring additional tasks for the same claim), and determine next steps:

-If you can issue a decision go to Activity 4.0 Issue Decision.

-If you need to seek internal guidance go to the Seek Internal Guidance process.

-If further information is required, request the information and update the 'Follow Up Provider' or 'Follow Up Claimant Information Request' task as per templates, move the task out for 5 working days (provider) or the following day (client) and transfer the task to the Registration Centre - Low Complex Dunedin queue.

Note - If the initial internal guidance is to seek formal written comment create an ACC6260 on the 'Documents' tab. Fill in the relevant details (claims, documents, question for clinical etc), Create an 'Organise Internal Referral' task and move the date out by three working days. Create a 'Complete Internal Referral' as a subtask off the Organise Internal Referral task. Link all the necessary documents to the task and transfer the Complete Internal Referral task to 'Regional Clinical Advice - Central queue. Transfer the 'Organise Internal Referral' task to the Registration Centre - Low Complex Dunedin queue. -Update the Confirm Cover decision task with the action taken.

PROCESS Seek Internal Guidance

3.3 Review and action ACC18 related tasks

Cover Assessor

a Open the claim by clicking on the claim number in the task.

NOTE What if it's an ACC18 task, but relates to an actively managed claim in a Recovery Team?

Go to Match Claim to Recovery Team process.

PROCESS Match Claim to Recovery Team

NOTE What if it's an ACC18 task but relates to a claim in an 'Actioned Cases' queue?

- -Review the information and determine whether this is for an additional diagnosis request.
- -Update the diagnosis on the Injury tab and put to "investigating"
- -Review the 'Traffic Light' Tool to establish if the injury is one you're able to issue a decision.
- -If you're able to issue a decision go to Activity
- 4.0 Issue Decision
- -If you are unbale to make a decision review the Assess Cover for an Additional Injury or Change in Diagnosis process.
- -If further assessment is required create a 'Follow Up Cover' task with the target date as one day prior to the due date (This is to manage the timeframe and prevent a deemed decision), transfer this task to the Registration Centre - Low Complex Dunedin queue.

Note - The date of the ACC18 tasks must reflect the Cover Decision due date on the diagnosis. This will need to be calculated manually (21 days from the date we received the ACC18 or 90 days it the diagnosis is late lodged).

For Late Lodged - This is 2months from date of lodgement

PROCESS Assess Cover for an Additional Injury or Change in Diagnosis

4.0 Issue Decision

Cover Assessor

a Accept claim, decline claim, or accept and decline claim.

NOTE What if you can accept cover?

Go to Accept Claim, and follow this process, however please replace CVR41 letter with CVR51 (Mental Injury) letter

PROCESS Accept Claim

NOTE What if you are declining the claim?

Go to 'Decline Claim'.

PROCESS Decline Claim

Allocate Task for non-complex Cover v6.0



Summary

Objective

To self allocate tasks from the Non-Complex cover queue.

Background

This is a manual workaround for Cover Assessors who do not have workflow management (WFM) through Salesforce.

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Get next available task

Cover Assessor

- a In Eos, View Tasks, Choose Role, select Registration Centre - Low Complex Dunedin queue, click [OK].
- b Use 'Get Next Task' to self-allocate the next available task in the queue.

2.0 Determine if another open claim exists in a Recovery Team

Cover Assessor

a In Eos, navigate to the Party Record, and check for any claims being actively managed by a Recovery Team.

NOTE Is there another indicator to show other actively managed claims?

The yellow indicator in the General Screen shows the client has an actively managed claim.

NOTE What if there is an actively managed claim?

Go to Match Claim to Recovery Team.

This process ends.

PROCESS Match Claim to Recovery Team

3.0 Review and action task for new claim

Cover Assessor

a Open the claim by clicking on the claim number in the

NOTE

What if the task is for a Mental Injury but in the Registration Centre - Low Complex Dunedin queue?

Transfer the claim to Hamilton Reg - Cover Assessment queue (make sure all associated tasks are also transferred). End of process.

NOTE

What if the task is Auto Alert 1 (New Claim) task - Or Confirm Cover Task set to Day 0

- Click on the task tab and transfer the other open tasks that you can also action (to prevent other team members transferring additional tasks for the same claim). Eg there is also a Contact Party and Alert Mail task open on the claim.
- Review the 'Traffic Light' Tool to establish if the injury is one you're able to issue a decision on.
- If you're able to issue a decision go to Activity 4.0 Issue Decision.
- TOOL Add or change diagnosis decision traffic light

NOTE What if you're unable to issue a decision and further assessment/clarification is required for a PICBA claim?

1) Close Auto Alert 1 (New Claim) task.

2) Click on the "Task" tab on the General Screen and transfer the other open tasks that you can also action (to prevent other team members transferring additional tasks for the same claim). Eg there is also a Contact Party and Alert Mail task open on the claim.

What if you need to clarify the diagnosis or accident details with the client or Provider?

- 1) Make contact with the client or Provider and if agreement has been made to amend or update the diagnosis and accept the claim. Record the conversation in the "Contacts" tab.
- 2) Go to Activity 4.0 Issue Decision.

What if you need to clarify the diagnosis or accident details with the client and/or Provider but have been unable to make contact?

- 1) Create and update a "Follow Up Provider" and/or "Follow up Claimant Information request" task and move the task date/s to the following working day and transfer the task/s to the Registration Centre Low Complex Dunedin queue. Record the attempt in the "Contacts" tab.
- 2) Update the 'Confirm Cover Decision' task with the correct cover decision due date of the claim (taken from the General Screen). Transfer the task back to the Registration Centre Low Complex Dunedin queue.

What if a full assessment and medical notes are required?

- 1) Do an initial assessment and update the 'Confirm Cover Decision' task confirming you have:
- Checked the ACC45 Y
- Checked for any duplicates Y
- Checked MFP/Pathway Y
- Checked Claim history Y
- Checked Party level documents / contacts Y
- 2) Then follow the Assess Claim for Cover :: PICBA process
- If requesting medical notes create and update a "Follow Up Provider" task. Move the task date out by five working days and transfer the task to the Registration Centre Low Complex Dunedin queue.

When requesting notes make sure to put the return email address as coverassessment@acc.co.nz.

- If you have requested information from a client (eg questionnaire, photos etc) create and update a "Follow up Claimant Information Request" task. Move the task date out by five working days and transfer the task to the Registration Centre Low Complex Dunedin queue.
- 3) Update the 'Confirm Cover Decision' task to the cover decision due date of the claim (as noted on the General Screen). Transfer the task back to the Registration Centre Low Complex Dunedin queue.

PROC	SS Assess Claim for C	over ::
	PICBA	

3.1 Review and action task

Cover Assessor

a Open the claim by clicking on the claim number in the task

NOTE What if the task is for an 'Alert you have Mail'?

1) Go to 'Tasks' at claim level and check for an associated 'Follow Up Provider' task.

Transfer the other open tasks that you can also action (to prevent other team members grabbing

action (to prevent other team members grabbing additional tasks for the same claim). Eg there is also an ACC18 and Contact Party task open on the claim.

- 2) Check the original request to confirm you have received all the information requested. If there is information missing, contact the Provider. Update the Contacts on the claim. Reset the 'Follow Up Provider' task to show what you are waiting for, move the target date for a further five working days and transfer back to the Registration Centre Low Complex Dunedin queue. Update the 'Confirm Cover Decision' task with activity carried out.
- If you can issue a decision go to Activity 4.0 Issue Decision.
- If you need to seek Internal Guidance follow the Seek Internal Guidance Process:

Note - If the initial internal guidance is to seek formal written comment create an ACC6260 on the 'Documents' tab.

- 1) Fill in the relevant details (claims, documents, question for clinical etc)
- 2) Create an 'Organise Internal Referral' task and move the task date out by three days.
- 3) Create a 'Complete Internal Referral' subtask off the 'Organise Internal Referral' task.
- 4) Link the necessary documents to the task and transfer the Complete Internal Referral task to 'Regional Clinical Advice Central queue. If the claim is INCAP Transfer the Organise Internal Referral task to the Registration Centre Low Complex Dunedin queue. Update the Confirm Cover decision task with the action taken.
- Close the 'Alert you have Mail' task and the other tasks that you have actioned.
- Update the 'Confirm Cover Decision' task with activity carried out.

NOTE What if the task is for Follow up Claimant Information Request?

- If the information has not been received (check in the "Documents" tab). Follow up with the client again for the information needed. Note attempt in "Contact's" tab. Update the task move the date to the following working day and transfer back to the Registration Centre Low Complex Dunedin queue.
- If the information has been received and you can issue a decision, go to Activity 4.0 Issue Decision.
- If a decision can't be issued and further medical information is needed request the information and create and update a "Follow Up Provider" task update the date to five working days and transfer to the Registration Centre Low Complex Dunedin queue. Close the Follow Up Claimant Information Request task.
- When requesting notes make sure to put the return email address as cover.assessment@acc.co.nz.
- Update the Confirm Cover Decision tasks with your action.

NOTE What if the task is 'Contact Party'?

- Click on the task tab and transfer the other open tasks that you can also action (to prevent other team members grabbing additional tasks for the same claim). Eg there is also an Alert Mail task open on the claim.
- Check the Contact Party task to see who has called and what the query or need is. Before contacting the client, review the claim history.
- Add a Contact in Eos to record the attempted contact. Update the 'Contact Party' task and move out to the following day. Transfer the task back to the Registration Centre - Low Complex Dunedin queue.
- If contact has been made close the 'Contact Party' task. Ensure that all appropriate actions or tasks that could be completed on the claim have been.

NOTE What if the task is Organise Internal Referral?

- Go to the claim and check the information requested from Clinical is on the claim. This could be under the Documents tab or on the Recovery Support Tab on the General Screen. Review the internal advice provided to determine next steps.
- If recommendation supports you to make a decision go to Activity 4.0 Issue Decision.
- If the request is to obtain further information, follow Requesting Medical Information process.

NOTE What if the task is a 'General' task - User to enter details'

The 'General' task could relate to several different requests from any part of the business. You will need to review the task and the claim history to determine next steps. Action the task and close.

3.2 Review and action Provider related tasks

Cover Assessor

a Open the claim by clicking on the claim number in the task

NOTE What if the task is for a Follow Up Provider task relating to a request for medical notes?

- Go into 'Tasks' and the 'Documents' tab on the claim to see if there is any associated 'Alert: You have Mail' or 'AUTO: You have Mail Medical Notes added' or that the requested documents have been scanned to file. You should also check in the Party Level Documents tab, in case they have been scanned in at the Party level.
- If there are no 'Alert Mail' tasks and the information has not been received, contact the Provider to follow up. Add a contact to the 'Contacts' tab on the claim and set the task out for a further five working days. Return the 'Follow Up Provider' task to the Registration Centre Low Complex Dunedin queue. Update the 'Confirm Cover Decision' task with activity carried out.
- If there is an associated "Alert Mail" task or 'AUTO: You have Mail Medical Notes and all the information you need has been received transfer all the "Alert Mail" tasks into your name and other tasks that you can action (to prevent other team members transferring additional tasks for the same claim), and determine next steps:
- If you can issue a decision go to Activity 4.0 Issue Decision.
- If you need to seek internal guidance go to the Seek Internal Guidance process.
- If further information is required, request the information and update the 'Follow Up Provider' or 'Follow Up Claimant Information Request' task as per templates, move the task out for five working days (provider) or the following day (client) and transfer the task to the Registration Centre Low Complex Dunedin queue.

Note - If the initial internal guidance is to seek formal written comment create an ACC6260 on the 'Documents' tab.

- 1) Fill in the relevant details (claims, documents, question for clinical etc)
- 2) Create an 'Organise Internal Referral' task and move the date out by three working days.
- 3) Create a 'Complete Internal Referral' as a subtask off the Organise Internal Referral task.
- 4) Link all the necessary documents to the task and transfer the Complete Internal Referral task to 'Regional Clinical Advice Central queue.
- 5) Transfer the Organise Internal Referral task to the Registration Centre Low Complex Dunedin queue.
- 6) Update the Confirm Cover decision task with the action taken.
 - PROCESS Seek Internal Guidance

NOTE What if the task is for Follow Up Provider requesting a quick clarification?

If the information has been received determine whether you can now issue a decision:

- If you can issue a decision go to Activity 4.0 Issue Decision.
- If the information has not been received. Contact the Provider. If you're unable to to make contact, record this as a contact in the 'Contact' tab. Move the task date to the following working day and transfer the task back to the Registration Centre Low Complex Dunedin queue.
- If a decision can't be issued and further information is needed:

For medical notes - create and update a 'Follow Up Provider' task. Move the target date by five working days and transfer the task into Registration Centre - Low Complex Dunedin queue.

 When requesting notes make sure to put the return email address as coverassessment@acc.co.nz.

3.3 Review and action ACC18 related tasks

Cover Assessor

a Open the claim by clicking on the claim number in the task.

NOTE What if it's an ACC18 task, but relates to an actively managed claim in a Recovery Team?

Go to Match Claim to Recovery Team process.

PROCESS Match Claim to Recovery Team

NOTE What if it's an ACC18 task but relates to a claim in an 'Actioned Cases' queue?

- 1) Review the information and determine whether this is for an additional diagnosis request.
- 2) Update the diagnosis on the Injury tab and put to "investigating".
- 3) Review the 'Traffic Light' Tool to establish if the injury is one you're able to issue a decision.
- 4) If you're able to issue a decision go to Activity 4.0 Issue Decision.
- If you're unable to make a decision refer to the Assess Cover for an Additional Injury or Change in Diagnosis process.
- The date of the ACC18 task must be updated to reflect the Cover Decision due date on the diagnosis. This will need to be calculated manually (21 days from the date we received the ACC18 or 60 days if the diagnosis is late lodged). Transfer this task to the Registration Centre Low Complex Dunedin queue.

To manage timeframes create a 'Follow Up Cover' task with the target date as one day prior to the new target date of the ACC18 task - transfer this task to the Registration Centre - Low Complex Dunedin queue.

PROCESS Assess Cover for an Additional Injury or Change in Diagnosis

4.0 Issue Decision

UNASSIGNED

a Accept claim, decline claim, or accept and decline claim.

NOTE What if you can accept cover?
Go to Accept Claim.
PROCESS Accept Claim

NOTE What if you are declining the claim?

Go to 'Decline Claim'.

► PROCESS Decline Claim

Applying the Two-part Test to Determine Cover for Mental Injury Because of Physical Injury v4.0



Summary

Objective

This policy provides Clinical Services and Technical Services staff with guidance when applying the two-part test to determine cover for mental injury because of physical injury claims.

Background

The High Court decision, W v Accident Compensation Corporation [2018] NZHC 937 (W) prescribed the following two-part test to determine cover for mental injury because of physical injury claims:

- 1) Whether 'but for' the physical injury the mental injury would have occurred; and
- 2) Whether the physical injury materially contributed to the mental injury.

Both parts of the test must be met for the client to receive cover.

Owner

Out of scope

Out of scope

Procedure

1.0 Operational Policy

UNASSIGNED

- a Clinical Services will identify complex mental injury because of physical injury' claims where it is difficult to determine the causal link between the physical injury and mental injury.
- b This may include cases where:
 - the assessor suggests an indirect causal link between the physical injury and mental injury; and/or
 - the client cannot recall the physical injury/event, and the cause of the client's mental health condition includes their knowledge of the fact that they suffered a physical injury;
 - a significant period has elapsed since the physical injury and the diagnosis of a mental health condition, raising proximity issues; and/or
 - there is an intervening event.
- c Clinical Services will contact Technical Specialists, who will apply the two-part test.
 - The Two-Part Explanation 20190906.docx
- d If Technical Specialist have trouble applying the two-part test, then they will be able to refer these cases to the Complex Mental Injury Panel.
- e ACC will not apply the 'but for' test to MICPI claims where a traumatic event occurs at the same time as a physical injury and the effects of each cannot be distinguished. In these cases, ACC will only apply the second part of the test i.e. determine whether the physical injuries materially contributed to the mental injury.
- f ACC will not specifically apply the two-part test when determining cover for mental injury types other than mental injury caused by physical injury claims (i.e. sensitive claims, work-related mental injury, and treatment injury mental injury). If a review is lodged for a cover decision for these types of mental injury and the two-part test is an issue, Resolution Services will seek advice from Technical Services.

2.0 Links

UNASSIGNED

W v Accident Compensation Corporation [2018]
NZHC 937

http://www.nzlii.org/nz/cases/NZHC/2018/937.html

Accident Compensation Act 2001, section 26 Personal injury

http://www.legislation.govt.nz/act/public/2001/0049/lat

Panels - Technical Services

Arrange Mental Injury Assessment for Cover v20.0



Summary

Objective

To arrange a Mental Injury Assessment specifically to help determine cover for a claim.

For all other mental health assessments including Mental Injury Assessments or progress reviews for the purposes of ongoing rehabilitation or supports refer to the following processes:

Arrange Psychiatric Services or Arrange Psychological Services processes

Background

Mental Injury Assessments are used to help determine eligibility for cover for:

- Mental injury caused by physical injury (MICPI)
- Work related mental injury (WRMI)
- Treatment Injury Mental Injury (also TIMI)

For cover to be determined for Mental Injury Caused by Sexual Abuse a Supported Assessment is carried out under the Integrated Services for Sensitive Claims (ISSC) refer to the 'Assess Early Planning and Set up Supported Assessment' process for the required steps.

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Determine eligibility for assessment

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Specialist Cover Assessor

- a Review the client's current circumstances and the medical information received or information on the claim.
- **b** Determine whether the client meets the criteria for a Mental Injury Assessment.

What is the eligibility criteria for a Mental Injury Assessment under this process?

The client must meet one of the following criteria:

- Have a covered physical injury and needs an assessment to determine cover for a mental inlurv.
- Have a non-covered physical injury due to a treatment injury and needs an assessment to determine cover for a mental injury.
- Experienced a work-related trauma and an assessment is needed to determine cover for a work-related mental injury.

What do you need to consider when the entitlement request is received and deemed cover exists?

Refer to the Deemed Cover and Entitlements Policy for considerations to determine client entitlement eligibility while in deemed cover period.

Deemed Cover and Entitlements Policy

NOTE What if it is for an assessment to determine cover for a mental injury caused by sexual

> Refer to the Assess Early Planning and Set Up Supported Assessment process.

PROCESS Assess Early Planning & Set up Supported Assessment

c Determine whether the referral should be sent to a Psychologist or a Psychiatrist.

NOTE When should a psychologist carry out the assessment?

A Psychologist is trained in the study of human behaviour and has specialised skilled in talking therapies as a treatment for mental disorders and other psychosocial causes of distress. They are trained in administering psychometric tests. such as personality assessments and other objective, structured measurement tools. A psychologist may be the preferred choice of assessor where psychometric assessment is required. They are also often better able to provide a sophisticated explanation of the development of a client's difficulties (called the 'formulation'), which is often required when it is not clear how the client came to present in a certain way, or it is unclear how the current symptoms are linked to an injury event.

Psychological Services Service Page

NOTE When should a psychiatrist carry out the assessment?

A psychiatrist is a medical doctor who is specialised in the diagnosis and treatment of mental disorders. They are able to prescribe medication and often use this as a primary form of treatment. They are often the preferred assessor in cases where the client has complex co-occuring medical conditions or is taking a large number of medications that need to be taken into account when making a diagnosis or considering treatment. They are sometimes more suited to offering an opinion on severe psychiatric disorders such as schizophrenia or bipolar disorder, which require treatment with medication. They are also able to assess inability to work based on mental injury.

Clinical Psychiatric Service Referral Service Page

What if you are unsure if a Psychologist or a Psychiatrist should carry out the assessment?

Refer to a Psychology Advisor via the hotline using the Seek Internal Guidance process.

PROCESS Seek Internal Guidance

2.0 Contact client

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Specialist Cover Assessor

Contact the client or ATA by their preferred method of communication.

NOTE What if you are unable to contact the client?

- 1) Attempt a maximum of two contacts over two full working days before leaving a voicemail or sending a notification to request client contact.
- 2) If after the second attempt, you are unable to reach the client either:
- if client is receiving supports add a contact to note your attempts. This process ends.
- if the client is not actively receiving supports proceed to Decline Claim, this process ends.

If you're in Partnered and no contact is made with the client after three attempts, you must contact the provider, GP or other verified contact on the claim.

b Confirm you are speaking with the right person by asking ACC's identity check questions.

Identity Check Policy

NOTE What if the client would like you to discuss the assessment with another person, but there is no ATA on record?

Go to Obtain Authority to Act (ATA), then return to this process.

PROCESS Obtain Authority to Act (ATA)

C Check the client has granted ACC the authority to collect medical and other records.

View Client Consent

NOTE What if the client hasn't provided consent?

Go to Obtain Client Authority to Collect Information, then return to this process.

PROCESS Obtain Client Authority to Collect Information

- d Discuss with the client why you are recommending and referring them for this assessment and remind them of their rights and responsibilities.
 - Client Legislative Rights and Responsibilities Policy
- e Explain the assessment will be with either a Psychiatrist or Psychologist and confirm they are happy to be referred.
 - WOTE What if the client does not want to proceed with the assessment?

Advise the client that ACC will have to make a decision based on available information. Continue to assess the claim for cover. End of Process.

NG Principles Decision Making

- Advise the client what information will need to be collected, including medical or clinical notes relating to all mental health records and all relevant GP records predating the injury by two to five years, and that this information will be shared with the selected Provider who will be carrying out the assessment.
- g Check the claim for medical or clinical records.

NOTE When should medical or clinical notes relating to mental health pre-dating the injury by two years be requested?

Request medical or clinical notes relating to mental health pre-dating the injury by two years when the client has no history of mental health concerns.

NOTE When should medical or clinical notes relating to mental health pre-dating the injury by five years be requested?

Request medical or clinical notes relating to mental health pre-dating the injury by five years when the client has a history of mental health concerns.

NOTE What if you need to request medical or clinical records?

Go to Request Clinical Records process
PROCESS Request Clinical Records

h Advise the client the Psychiatrist or Rsychologist will contact them to schedule an appointment.

NOTE What other information should you give to the client?

- Let them know that if they are unable to attend an appointment, they must give 24 hours notice.
- Failing to attend could risk suspension of any entitlements, and a cover decision could be made based on the information.
- They are able to have a support person with them.
- There is no cost to them for the assessment.
- The assessor will send ACC a report, of which a copy will be sent to them.
- i Ask the client if they have a preferred Provider.
- Go to the 'Contracted Suppliers by Geographic Area of Coverage' and search for Psychologist or Clinical Psychiatrists located in the client's geographic area.

Contracted Suppliers by Geographic Area of Coverage

NOTE What if the client has a preferred Vendor and/ or Provider?

Mental Injury assessments can only be completed by contracted Suppliers. Refer to the Contract Suppliers by Geographic Area of Coverage to confirm if the preferred Provider is contracted to ACC. If not, advise the client we will find a contracted supplier and let them know.

NOTE What if the client has particular needs that are to be taken into consideration?

If the client expresses particular needs, eg culture, language or gender preference, you may consider using out of region or non-contracted assessors.

- Client choice of providers Policy
- k In Salesforce, add a contact to record the conversation with the client and if required, verify and update the client's contact details.

NOTE What if you are a Cover Assessor?

In Eos, add a contact to record the conversation with the client and if needed, verify and update the client's contact details.

3.0 Confirm Vendor/Provider

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Specialist Cover Assessor

- a Email five Vendors and Providers (as per the correct Service Code: PSY51 (MICPI), PSY52 (WRMI) or CPSP1 (TIMI)) requesting them to provide available appointments for a mental injury assessment.
- Service Contracts and Contracted Providers MFP spreadsheet

NOTE What if the client has a contracted preferred

Provider?

Only email this Provider for available appointments

NOTE What information should you put in the email?

Refer to the initial query template as outlined below.

Initial Availability Enquiry

Subject line: Mental Injury Assessment Availability - (Add Area) - (Claim number)

Good morning/afternoon,

I have a client based in (ADD DISTRICT) who is in need of Mental Injury Assessment following their injury.

Please advise if you're able to accept the referral and, if so, the earliest availability for the assessment to take place.

ACC will respond and confirm the assessment details once all responses have been received and reviewed.

Kind regards,

b In Salesforce, add and schedule a reminder task for five days, outlining which providers/vendors are still to reply.

NOTE What if you are a Cover Assessor?

Create and schedule a 'Follow-up Provider' task for five days,

- C Acknowledge receipt of Vendor/Provider emails letting them know whether an alternative provider has been found.
- d Contact the client once all Providers/Vendors have replied with availability and advise dates and times of available appointments unless the Provider has specified they will contact the client directly.
- e In Salesforce, add a contact to confirm and record that the Vendor and Provider have confirmed they are happy to take the referral. (In Eos if you are a Cover Assessor).
- Add the selected Vendor/Provider as participants on the claim.

Add a participant

Update the client's Recovery Plan with the agreed intervention.

NOTE What if you don't know how to update the Recovery Plan?

Go to Create or Update Recovery Plan.

PROCESS Create or Update Recovery Plan

NOTE What if you are a Cover Assessor?

No action is needed.

4.0 Request assessment referral

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Specialist Cover Assessor

Create a referral-specific document group and name it Mental Injury Assessment.

What documents do you need to include for a Mental Injury Assessment referral?

- · Recent medical certificate
- · Clinical guidance transcript
- · Relevant clinical records see note below for further information
- Police reports
- Work incident/accident reports
- Signed ACC6300 or ACC6300D. If verbal consent was provided, note this in the eform or completed Psychiatric Assessment Memorandum (Specialist Cover Assessor)
- Psychiatric Assessment Memorandum (Specialist Cover Assessor).

Which clinical records are relevant?

- Information relating to a potential mental injury (ie symptoms of a diagnosable mental health condition)
- · GP records (GP will determine relevance of information being provided to ACC)
- Anything relating to psychological symptoms or treatment (eg symptoms of low mood, depression, anxiety, trauma, stress and other nonspecific symptoms such as headache, fatigue, etc)
- For some proposed mental injuries (eg somatic symptom disorder), all GP records relating to unexplained medical symptoms may be relevant

Redact medical information that has no relevance to the injury.

Manage document groups

Check if there are documents on other claims relevant to the referral.

NOTE What if there are documents on other claims? Create a copy and transfer to the other claim:

- 1) Create a bulk print of documents on the other claim, complete mandatory fields and add a description.
- 2) Open PDF document from email link.
- 3) File the PDF away to the claim you are creating the referral on.
- 4) Repeat these steps if there are documents on other claims.

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg Medical records and reports from claim: 1000XXXXXXXX

Do not create a bulk print on one claim and move to another claim as it will not appear in any file copy requested by the client.

What do you do if Complex Mental Injury NOTE Claim information needs to be sent with a Referral from a Physical Injury Claim?

In Eos, manually transfer the Referral Task generated to the Recovery Administration department with the Sensitive Claims Administrator Role

	NOTE	What if you do not have access to the Sensitive Claim?		Disclosure of Care Indicator Information to Third Parties Policy
		Contact the Recovery Partner for the Sensitive Claim or Assisted Recovery (if not managed) for them to complete the document group with the		e Consider the timing of the task. The task routes to the Recovery Administration team with an SLA of 24 hours.
		relevant information for the referral. Contact can be made by phoning, emailing or tasking the request. If the request is tasked please ensure you provide all relevant information, what is required, why it is required, who the information is to be sent to and confirm that client consent has been obtain and where this is noted.		NOTE What if the request is urgent and needs to be completed that day? 1) Call Recovery Administration. 2) Give the Recovery Administrator who answers the call the claim number. 3) The Recovery Administrator will open the claim in Eos and find the task on the claim. 4) Transfer the task into the Recovery Administrator will prove the task into the Recovery Administrator will be seen and the second of the
С	relevan informa	n privacy checks to ensure that the documents are it to the referral, do not contain any third party ition and do not contain any other information that to be withheld.		istrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.
		S SUPPORTING INFORMATION Inbound and attraction into the state of the	5.0	Review task Recovery Administrator
	NOTE	What if you find information that needs to be redacted?		a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.
		Email the document to Recovery Administration (recoveryadmin@acc.co.nz) or		b Check the task contains sufficient information to proceed.
		(recoveryadmin1@acc.co.nz) for CMI clients) advising instructions to redact as required. Once returned, add to the document group.		NOTE What if you don't have all the information you need? Refer to the Task clarification process outlined in
	□ NG	GCM - Redact information from PDF documents	7/	NG PRINCIPLE Working in the Administration Team.
d	ity', sele	in the Recovery Plan sub-case select 'Add Activect 'NGCM - Manage Referral' task and 'Mental assessment'.		NG PRINCIPLES Working in the Administration
	NOTE	How do you refer a task to Recovery Administration?		NOTE What if it is for an assessment to determine cover for a mental injury caused by sexual abuse?
		Refer to the 'Referring Tasks to Recovery Administration - Principles document below for further guidance.		Refer to the Assess Early Planning and Set Up Supported Assessment process. PROCESS Assess Early Planning & Set up
		ferring Tasks to Recovery Administration Prin- les		Supported Assessment
		eating Manage Referral Tasks - System Steps	6.0	Create and approve purchase order
	NOTE	What information should you include in the task?	0.0	Create and approve purchase order Recovery Administrator
<<		• Geographic location		a In Eos, create a Purchase Order.
		Confirmed Vendor and Provider Note if the client's Mental Injury is the result of		Create QE Purchase Orders
		Work Related or Physical Injury (this needs to be specified to allow Recovery Administration to		Creating purchase orders using general + QE
	~	modify the letter to reflect why the assessment is		NGCM - Psychiatric purchase order details
		Needed State clearly if your client has a Care Indicator Reason for referral and the status of the claim		 Guidelines Psychological services purchase order details
		(Held)		NOTE Purchase order codes
		Note injuries on the claim, including held, declined and accepted injuries (these will be included in the PSY11 letter to the Vendor). Provide the correct Service Codes: If it is under the Psychological Services contract, use service code PSY51 (MICPI) or PSY52 (WRMI). If it is under the Psychiatric Services contract, use service code CPSP1 (Other Injury) or CPSS1 (Complex Mental Injury)		If the referral is under the Psychological Services contract, use service code PSY51 (MICPI) or PSY52 (WRMI). maximum 16 hours/units. If the referral is under the Psychiatric Services contract, use service code CPSP1 (Other Injury) or CPSS1 (Complex Mental Injury) maximum 16 hours/units If the task is unclear refer to the Task clarification process outlined in NG PRINCIPLE Working in the Administration Team
		Note anything else that needs to be included in the PSY11 vendor or client letter		b Search for and select the Vendor provided in the task using the Geographic Location search.
	NOTE	What if the client has a Care Indicator?		Search for a Party
		You need to clearly outline this in the referral. Refer to the 'Disclosure of Care Indicator to third parties' policy below for more information on how		C Approve Purchase Order.

the information is disclosed.

		NOT	Έ	What if the purchase order requires a higher delegation? Save the purchase order. To request authorisation refer to the system steps below.
				quest Authorisation for a Purchase Order - tem Steps
				chase Order - Handy Hints on how to create and POs
7.0				nd send referral documents Administrator
	а	Vend	dor	create the Request Mental Injury Assessment - (PSY11) using 'Add by Doc' on the purchase reen.
	b	men shee	t red et. T	ocs Tab, create the PSY11 Mental Injury Assess- quest client letter and the PSYIS01 information here is no administration template for this form, rification from the task creator if required.
		NOT	Έ	What if the claim is a complex mental injury/ sensitive claim? If the client is being managed as complex mental injury, in the Docs Tab, create the SCU61 - Psy- chiatric Assessment - Cover (client) and the SCU60 - Psychiatric Assessment - Cover (Vendor)
	С			the task and modify the referral letters as per the ion provided.
	d			e documents as 'Completed' and add to the njury Assessment document group.
		NOT	Έ	What if the document group contains an e- form saved as a word document? Convert the e-form to PDF to enable it to be emailed by Eos.
			Cor mei	nvert an Internal Referral e-form to a PDF docu- nt.
			NG Tea	PRINCIPLES Working in the Administration
<	е			dispatch privacy checks using inbound and Out- ocument Checks.
				SUPPORTING INFORMATION Inbound and bound Document Checks
	f	plate and	e. At the ovid	e Provider using the Requests and referrals tem- tach the Mental Injury Assessment referral letter document group to the email. Select the vendor der email address from the list of participants on n.
	<			CM - FINAL Emailing from Eos using a Template vstem Steps
		ЙОТ	Έ	What if the provider has requested the documents are sent by courier? Go to Prepare and Send Client Information by Courier process. PROCESS Prepare and Send Client Information by Courier
	g	the 'l	Doc	e Mental Injury Assessment client letter located in uments' tab to the client by their preferred of communication.
	h	In Sa	ales	force, close the assigned referral task.

Assess Claim for Cover :: Late Lodged v16.0



Summary

Objective

To review late lodged 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 etc.).

Background

The Cover Decision Service has identified that the claim was lodged more than 12 months after the date of accident. Eos sends a Confirm Cover Decision task for someone to make a manual cover decision. This task will include Late Lodged and Cover Decision Required information requirements. It may also include 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 is Invalid, Client Address Matches Previous Home Address.

Late lodged claims are considered complex. This means we must make a cover decision (or a decision to extend the time-frame) within two months of the claim being lodged.

Owner

Out of scope

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, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Open the Confirm Cover Decision task.

Do a task with information requirements

b Review the outstanding information requirement(s) to identify what aspects of the claim need to be resolved. If you need to contact the client or provider at any stage in this process, then ensure you resolve as many outstanding requirements in a single contact as possible.

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
- · If the claim type is Sensitive or Fatal
- · If the client is deceased
- If the client is under 16 years old
- If the client has a Safe Contact on their party record
- If the Stop Notification attribute on the client party record is set to Yes
- If the claim is for a serious injury (determined by the injury diagnosis code)
- If there is an outstanding Case Alias Check Required information requirement
- If the client has an invalid mobile number 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 I'm 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 the

Resolve Provider Competency process below to do this (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

3.0 Confirm claim is not a duplicate

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check the accident date is on or after 1 January 1982.

NOTE What if the accident date is prior to 1 January 1982?

Eos can't complete the automatic duplicate claim checks for claims with an accident date prior to 1982, as the records in Eos don't go back that far. A duplicate claim check must be completed before continuing with this process when the accident date is prior to 1982.

Search the static data store of pre-1982 claims via the InFact reporting portal (using the 4.02 Pre 1982 Report) to see if there are any existing claims for the injury/accident.

- If there are no existing claims for a similar injury and date, then go to step 2.0 to continue this process.
- If there's an existing claim that's similar to this new claim but the injuries aren't an exact match, then assess this claim and make a cover decision for it before deciding whether it's a duplicate or not. Go to step 2.0 to continue this process.
- If there's an existing claim that's an exact match of this new claim, then email the report to the Registration Inbox with a request for them to register the pre-1982 claim and link this new claim as a duplicate. This process ends.

NOTE Duplicate claim process

If you identify claim is a duplicate claim follow 'Duplicate Claim Process"

PROCESS Identify and Link Duplicate
Claims :: Standard

4.0 Confirm eligibility status

Cover Assessor, 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 I've completed the information requirement(s) 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 5.0 to complete the information requirement(s) and then decline the claim.

5.0 Assess claim

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Review all available information on the claim and decide what additional information you need to make a cover decision. Use the policies below to help determine this. At a minimum you'll need to contact the client to ask for more information on the claim.

Which Act to use Policy

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

b Once you've determined what additional information is needed, contact the client to ask for more information on the injury. The purpose is to find evidence from the time of the original accident to support that there was an injury. Ask the client if they had treatment at the time of the injury and which provider they saw, and whether they saw anyone else in regards to the injury such as specialists, police, etc. Go to the Contact Client or Provider for Information process below to do this.

NOTE What if the client can't provide the requested information?

The claim should be assessed based on the information already provided. If the injury is for a foreign body (e.g. glass in foot) or a fracture then explain to the client that these injuries could likely be easily identified in an x-ray and they may wish to provide this to help with the cover decision.

client, the lift your non-DH Records web link link lift your DHB, go (Policy), Boards Records Correcord Clir	seed additional information after speaking with the nen: need to request medical or clinical records for a B provider, go to the Request Medical or Clinical s (Policy) and Clinical Notes and Medical Records is below. need to request medical or clinical records from a to the Request Medical or Clinical Records. Requesting Clinical Records from District Health and Contacts for DHB web links below. questing clinical records from District Health and Contacts for DHB web links below. questing clinical records from District Health ands ntacts for requesting District Health Board clinical ords nical Notes and Medical Records What if the provider or third party can't pro-	6.0	Cover Assignator, R. a Update informatic Cover A Comple Comple Could Comple	sessor, Recovery Assistant, Recovery Coorecovery Partner the Late Lodged and Cover Decision Required tion requirements to Complete. Also update the assessment Required information requirement to the if this is present on the task. Implete information requirement for there are any outstanding information requirements or missing information. 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)?
NOTE	vide the requested information? The claim should be declined due to a lack of information. Go to step 5.0 to complete the information requirement(s) and then decline the claim.		NOTE	These should be completed before continuing with this process. Go to the Update Clilent Address process below to do this. PROCESS Update Client Address What if there's an outstanding Phone Number
NOTE	What if the information I've requested can't be provided before the cover decision due date? Identify whether you can extend the cover decision timeframe. Go to the Timeframes to determine cover policy and Extend cover decision timeframes process below to do this. PROCESS Extend Cover Decision Timeframe		NOTE	Verification information requirement? This should be completed before continuing with this process. Go to the Update Client Phone Number process below to do this. PROCESS Update Client Phone Number What if there's an outstanding Vendor Status Removed or Facility Status Removed information requirement?
Tim d Review enough	reframes to determine cover (Policy) reframes to determine cover Policy all information received and determine if there's evidence to support that an injury occurred, and		C Chack it	This should be completed before continuing with this process. Go to the Resolve Provider, Vendor or Facility Status Issue process below to do thi. PROCESS Resolve Provider, Vendor or Facility Status Issue f there's an outstanding Case Alias Check Re-
NOTE	What if you are unsure if you can make a decision based on the information available? Talk to you Team Leader first, then refer to the Recovery Support Decision Tree to help with whether to seek internal guidance. PROCESS Seek Internal Guidance covery Support Decision Tree		quired i	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 process below to do this. Note: A claim can only be investigated as a
NOTE	How to request information from NZ immigration (Customs/PAX) When requesting information around a client's international movements from NZ immigration - Please include a copy of the ACC45 with the request and wording request: "I am currently considering a request for ACC		NOTE	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 What if I identified a potential duplicate claim
	cover and I need to confirm (x travel dates) for the following person: (client's details). I've attached a copy of the ACC45 form for this claim, 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."		NOTE	when searching the Pre-1982 Report in step 2.0? Now that you've determined what the cover decision should be for this claim, you can decide whether it is a duplicate of the claim lodged prior to 1 January 1982. Go to the Identify and Link Duplicate Claims process below to do this. PROCESS Identify and Link Duplicate Claims:: Standard
PROCESS	Contact Client or Provider for Information at Lodgement Cover Assessor, Senior Cover Assessor		PROCESS	Accept Claim Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Coordinator - Supported, Senior Cover Assessor

Assess Cover for an Additional Injury or Change in Diagnosis v250



Summary

Objective

The objectives of the process are

- to assess the 'new injury' against cover criteria, so that the client can request supports.
- · to action information about the 'new injury', so that ACC has accurate information about the client's injuries.
- to re-assess client's needs, so that the recovery pathway can be managed appropriately.

Background

Providers usually change or add a diagnosis if they made a mistake on the original claim form or have completed further diagnostics and assessments from which they identified new symptoms. The additional or changed diagnosis is referred to as the 'new diagnosis' or the 'new injury' in the context of this process, while the diagnosis provided on ACC45 is referred to as 'original diagnosis' or 'original injury'.

If the 'new injury' is different comparing to the 'original injury'. we will assess cover for the 'new injury'. This is because clients might want to request entitlement(s) and support(s) to help recover from their injury, but ACC can only approve entitlements and supports for the injuries that have been granted cover. The Accident Compensation Act 2001 allows providers (on behalf of clients) and clients to submit:

- · a stand-alone request (claim) for cover
- a request (claim) for cover and treatment (or other supports) at the same time

The 'new injury' can be encountered at any stage of the recovery pathway. The following teams are responsible for assessing the 'new injury' for cover:

- · Cover Assessment teams: claims that are not actively managed, ie claims are in Actioned Cases department.
- · Assisted, Supported and Partnered Recovery: if there is actively managed claims within these teams
- · Treatment & Support Assessment; when there is a request for cover and treatment at the same time.

Out of scope Owner Expert

Out of scope

Procedure

1.0 Receive and assess the request

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

- a Review the information for an additional injury or change in diagnosis. This can be via any of the following documents:
 - an ACC18 Medical Certificate.
 - an ACC554 Medical Certificate with permanent impairment.
 - an ACC125 additional information on diagnosis.
 - · A request from the client's treating provider.
 - an ACC2152 Treatment Injury Claim.
 - ACC32 Treatment Extension Request.

NOTE What if you receive a request via MyACC task NGCM - Request Change in Claim Infor-

Contact the client and advise that they need their treating provider to formally lodge a request.

NOTE What if you are unsure if you have a request for additional cover?

If the request is within the timeframes for assessing cover, clarify with the lodging provider if there is a request for an additional injury or change in diagnosis.

If the request is not within the timeframes for assessing cover, refer to Technical Services for guidance following the Seek Internal Guidance process.

PROCESS Seek Internal Guidance

NOTE What if new medical information is received and excluded from above list?

We consider all new medical information received on a claim. ie Clinical notes, Specialist reports, MRII's/Xrays). This information does not always constitute an additional injury or change in diagnosis cover request unless there is an explicit request from the treating provider.

If that information would change the current diagnosis (but is not explicitly requested) then we may seek a change or request via their treating provider who would complete an ACC18 or ACC32 and submit to ACC for consideration.

What do you need to consider when the entitlement request is received and deemed cover exists?

Refer to the Deemed Cover and Entitlements Policy for considerations to determine client entitlement eligibility while in deemed cover period.

Deemed Cover and Entitlements Policy

NOTE What if the client, provider, or advocate has called and advised ACC verbally of the re-

Inform the party that the request needs to be in writing, advise them to go to the ACC website for more information.

- **b** Check you have all of the minimum required information on the request:
 - the injury diagnosis (code and description).
 - the body site of the injury (if applicable).
 - the date of accident or event (in which the person was iniured).
 - short description of why adding or changing a diag-

NOTE What if information is missing?

Contact the provider to clarify if this is a request for an additional diagnosis or change in diagnosis and obtain the missing information.

c Confirm the client has an accepted claim.

NOTE What if the request is for a new event? A new claim must be lodged.	Non-complicated claim definition
 ensure it's appropriate to lodge a new claim without the client seeing an ACC registered provider call the client and get verbal authority to reg- 	2.0 Determine cover decision Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner
ister a new claim. • complete the Referral for New Claim Lodge- ment form. In the section 'Transfer Claim To', write your name and team details. If this claim a WRGP injury, write - Work related Gradual	1001.
Process Queue • email the completed form to Hamilton.Registration@acc.co.nz	TOOL - Add or change diagnosis decision traffic light NOTE What if there is enough information available
Referral for New Claim Lodgement	to make a decision? In Eos add the additional diagnosis into the Med-
NOTE What if the request is for a possible Work R lated Gradual Process injury? Contact the Work Related Gradual Process tea on huntline 87815 to discuss and ensure it is appropriate to lodge a new claim and to help manage expectations	ical tab and set the Outcome Status to 'Accept or Decline', refer to the Add an Injury Code system
NOTE What if the claim is for a physical injury and	NOTE What if there is not enough information avail-
has cover status of 'held'? Refer to Assess Claim for Cover :: with variatio process. PROCESS Assess Claim for Cover :: PICBA	able to make a decision? In Eos add the additional diagnosis into the Medical tab and set Outcome Status to 'Investigating'. Go to step 2.0c in Extend Cover Decision Time-
NOTE What if this is for a Treatment Injury? All Treatment Injury claims are assessed via a Treatment Injury Cover assessor. In Eos, creat a General Task with the additional diagnosis, s the priority to 'High' and transfer the task to the TIC Administration queue.	and continue. PROCESS Extend Cover Decision Time- frame
NOTE What if it's a request for cover for Mental	CVR30 Time Extension - advise - claimant
Injury caused by Physical Injury? Refer to Make Cover Decisions for Mental Injury Caused by Physical Injury process. PROCESS Make Cover Decisions for Mental Injury Caused by Physical Injury What if it's a request for cover for a work related mental injury?	to determine a cover decision and requires ongoing assessing? If ACC fails to meet the agreed timeframes on a cover decision, a client is deemed to have cover
Refer to Make Cover Decision for Work-Relate Mental Injury Claims process. PROCESS Make Cover Decisions for Work-Related Mental Injury Claims NOTE What if the request is for a sensitive claim and is in Assisted Recovery? Transition the claim to Partnered Recovery, ref to Transition Claim process. PROCESS Transition Claim	Ensure you take the following steps: 1. contact the client to advise them that they have deemed cover for the diagnosis 2. in Salesforce add a contact to document your rationale for the decision (in Eos if you are a Cover Assessor or Lodgment Administrator) 3. generate CVR75 Deemed cover - client letter
NOTE What if the request is for a sensitive claim and is in Partnered Recovery? Refer to Make Cover Decision for Mental Injury Caused by Sexual Abuse process.	CVR75 Deemed Cover - client letter
PROCESS Make Cover Decision for Men Injury Caused by Sexual Abus	
d Ensure that you've read and understood the Timeframe to Determine Cover Policy below. We must issue an extension decision advising the clien of this before the current time frame expires. For more information please refer to the Complicated claim and Non-complicated claim Business Rules.	NOTE What if you are a recovery team member? 1. edit the description of the task with the diagnosis (name of diagnosis) and the date the cover decision is due. 2.change the target date of the task to one
Timeframes to determine cover Policy	month before the due date. 3. change the priority to 'High'.
Complicated claim definition	

NOTE What if you are a Cover Assessor or Lodgement Administrator? Edit the task that you received with the following: 1.additional diagnosis name. 2.decision due on date. 3.set the priority to 'High'. 4.set the target date to 3 working days before the decision due date. Determine if you need to request medical notes. Refer to the Request Clinical Records process for guidance. NOTE What are examples of additional medical notes? Lodgment notes, imaging, specialist records, etc. PROCESS Request Clinical Records NOTE What if you cannot make a decision in the legislative timeframe? You have to make a decision with the information available, you can continue to assess or investinue. tigate as more information is received. NOTE How to request information from NZ immigration (Customs/PAX) When requesting information around a client's international movements from NZ immigration movementchecks@customs.govt.nz - Also referred to as Customs or PAX movements -Please include a copy of the ACC45 with the re-Policy quest and wording request: "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 copy of the ACC45 form for this claim, in which the client authorises ACC to collect information to determine what support ACC can provide. decision letter. 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." What if the claim is in Enabled Recovery? NOTE Transition the claim to Assisted Recovery, refer injury? to Transition Claim process below. PROCESS Transition Claim d In Salesforce, in the Recovery Plan update Life Area: Health: Request for new diagnosis [name of diagnosis] received through [source] on [the date received]. Cover decision is due on [date]. NOTE. What if you are a Cover Assessor or Lodgement Administrator? NOTE This is not required as you don't have access to Salesforce. e Review the clinical notes once received for any additional information needed to make a decision. Determine if cover for the additional diagnosis can be accepted or declined using the Add or change diagnosis decision traffic light tool. TOOL - Add or change diagnosis decision traffic light NOTE What if you are unsure whether you can accept or decline the additional diagnosis or

change in diagnosis?

process

Seek guidance via the Seek Internal Guidance

PROCESS Seek Internal Guidance

What if you fail to make a decision in the legislative timeframes?

If ACC fails to meet the agreed timeframes on a cover decision, a client is deemed to have cover for their injury. Refer to Deemed Cover Decisions When Timeframes Not Met Policy.

For non-complicated claims - if approaching the 4 month timeframe:

 You must issue a decision with the information vou have.

For complicated claims - if approaching the 4 month timeframe:

- · You will need to request a further timeframe extension from the client, using the CVR31 Time Extension request - client letter.
- · Go to step 2.1a in Extend Cover Decision Timeframe process and follow all the steps.
- Once completed return to this process and con-

Note that prior to the end of the additional 5 months you must make a decision with the information you have.

PROCESS Extend Cover Decision Timeframe

Deemed cover decisions when timeframes not met

CVR31 Time Extension - request - claimant

3.0 Issue cover decision

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

- In Eos, in the Medical tab update the diagnosis status to 'Accept or Decline' and then generate the appropriate
 - CVR70 Cover approve add injury claimant
 - CVR999 Cover decline decision client

NOTE What if the claim is for a complex mental

Generate the appropriate decision letter.

- MIS12 Approve Mental Injury Client.
- CVR999 Cover Decline decision client.
- SCU999 SCU Cover decision PO client.
- MIS12 Approve Mental Injury Client.docx CVR999 Cover decline decision - client
- SCU999 SCU Cover decision PO client

What if the claim is for a Work Related Personal injury (WRPI)?

This is a new cover decision for the liable employer who needs to be notified with review rights (Section 64(2)). An additional letter CVR48 Claim approve - work injury - Employer must be generated.

- CVR48 Claim approve work injury employer
- **b** In Salesforce, in the Recovery Plan, update Life Area: Health: Diagnosis [name] - accepted or declined.

NOTE What if you are a Cover Assessor or Lodgement Administrator?

This is not required as you don't have access to Salesforce.

c In Eos, close the 'NGCM - Cover Decision Required' task.

NOTE What if you are a Cover Assessor or Lodgement Administrator?

In Eos, close the appropriate task you have been working on.

d Go to Issue Recovery Decision process for guidance on recording and communicating the decision with the client.



Issue Recovery Decision Recovery Assistant, Recovery Coordinator, Recovery Partner

Claim Lodgement v13.0



_		Claim lodgement methods
Su	ımmary	Claim lodgement method types
Obi	jective	Client lodgement methods
Cla	iims can be submitted on any of the ACC-approved ACC45	Authorised representative lodgement methods
	ry claim form versions, electronic methods or the Accident urance Treatment Certificate (AITC).	One method of lodgement
		Treatment provider lodgement methods
Ow	ner Out of scope	
Fyr	pert Out of scope	Accident Information Definition
-^1	pert	b For all non-work injuries, or work injuries received after 1 July 2000 use:
Pr	ocedure	• the ACC45 ACC injury claim form (ACC45).
1.0	Lodging a claim	For work injuries received between 1 July 1999 and 30
	a When a claim is lodged, it is important to note that:	June 2000 use: • an ACC45 or AITC.
	 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 in- surer, cover and payment of statutory entitlements	4.0 Collecting claim information at registration
	mandatory information is required for each claim.	Snapshot of registration
	b For more details, see the related business rules below.	Storage of claim information
	Claim lodged using claim form	Claim information for a claim
	Registration of a claim	Inbound documentation
	ACC issued claim number) ~
	Claim number assignment	5.0 Claim types
	Client consent for claim lodgement	 a) A claim type is used to determine the allocation of a claim for a cover decision and claim management (if accepted).
	Treatment provider lodging on behalf of a client	Assigning a claim type
	Claim lodgement: accredited employer claim	Mandatory claim information for claim type identi-
	Claim lodgement: non accredited employer claims	fication
		Who can assign a claim type
2.0	Client & claim records	b Claim types are defined using the following rules.
	a When a claim is lodged the rules about client records and	Complex claim type definition
	claim records listed below must be followed.	Non-complex claim type definition
	Client record	Simple dental claim type definition
	Unique claim records	Assigning dental complex claim type
	One claim per claim record	Fatal complex claim type definition
	One client per client record	Hearing loss complex claim type definition
	One client per claim	Mental injury complex claim type definition
	Duplicate clients	Sensitive complex claim type definition
	Add employer when employer can be identified	Treatment injury complex claim type definition
	Add a default employer when the employer cannot be identified	Work-related gradual process complex claim type definition
	Matching client record to a claim record when no NHI number – system and manual lodgement	Work-related mental injury complex claim type definition
	Matching client record to a claim record when NHI number – manual lodgement	Claim type to be assigned if multiple complex claim types identified
	Matching client record to a claim record when verified NHI number – system lodgement	71
	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.

Consequential Injury Claims Policy v20.0



Summary

Objective

Use this guidance to determine whether a person has suffered a consequential injury, and if so, how to determine the date of injury. A consequential injury is an injury that occurs as a result of a previous injury, e.g. gradual process, disease or infection due to a covered injury or due to treatment for a covered injury.

- 1) Is there a new injury?
- 2) Is the injury a consequential injury?
- 3) The difference between a consequential injury and treatment injury
- 4) Treatment Injury delegation
- 5) Branch delegation
- 6) Identifying a consequential injury caused by treatment
- 7) Determining the date of injury for the consequential injury
- 8) Consequential claims under previous Acts
- 9) Forwarding consequential injury claims
- 10) Fund code
- 11) Links to legislation and appeal decision

Background

In the October 2012 decision of Accident Compensation Corporation v Kingi [2012] NZACC 351, the Court found that the appellant was eligible for weekly compensation because, while he was not an earner at the date of the original personal injury (a lower leg fracture), he was an earner at the time he had suffered a consequential injury (osteoarthritis).

Previous to this decision, ACC's approach to consequential injuries was that the date of injury for a consequential injury was deemed to be the date of the original personal injury.

Following the Kingi decision, some guidelines were established for determining consequential injuries.

Out of scope Owner. Expert

Out of scope

Policy

1.0 Is there a new injury?

- a To determine whether there is a consequential injury we need to determine whether there is a new injury.
- b If the condition is:
 - · caused by a separate and identifiable accident; or
 - an aggravation of an already covered injury; or
 - · an additional injury caused directly by the accident or treatment (for Treatment Injury claims) and not previously diagnosed
 - ...then it is not a consequential injury and Kingi does not apply.

2.0 Is the injury a consequential injury?

- a Does one of the provisions under section 20(2) apply?
 - 20(2)(d) caused by treatment for a covered injury
 - 20(2)(g) caused by a gradual process, disease, or infection arising from a covered injury
 - 20(2)(h) caused by a gradual process, disease, or infection resulting from treatment of a covered injury.

3.0 The difference between a consequential injury and treatment injury

- a The key point in the difference between a treatment injury and a consequential injury is understanding what the treatment is provided for, that gives rise to the claimed new injury. The type of injury will determine who has the delegation to consider cover.
 - If the treatment is for an underlying condition and the person suffers new injury from the treatment provided by a registered health professional, it is considered under the treatment injury provisions (section 32 of the Accident Compensation Act 2001)
 - If the treatment is for a covered injury and the person suffers new injury from the treatment, it is considered under the consequential injury criteria (section 20(2)(d) & (h)) - Treatment Injury delegation to determine cover
 - If the person has a covered injury and that injury through gradual process, disease or infection develops into another injury, this is a consequential injury that the branch has delegation to determine cover [as there is no intervening treatment that gives rise to the additional injury] (section 20(2)(g)).

4.0 Treatment Injury delegation

- a Treatment Injury determine cover if the treatment is for:
 - · an underlying condition and the person suffers new injury from the treatment provided by a registered health professional, it is considered under the treatment injury provisions (section 32 of the Accident Compensation Act 2001), or
 - a covered injury and the person suffers new injury from the treatment, it is considered under the consequential injury criteria, see section 20(2)(d),(h).

5.0 Delegations

a If the person has a covered injury and that injury through gradual process, disease or infection develops into another injury, this is a consequential injury that the Recovery Teams and Cover Assessment has delegation to determine cover [as there is no intervening treatment that gives rise to the additional injury], section 20(2)(g).

6.0 Identifying a consequential injury caused by treatment

- a A consequential injury caused by treatment is identified by any of the following:
 - text on the ACC45 ACC Injury claim form (ACC45) stating the client has an existing physical injury claim, and while receiving treatment for this injury, incurred a further injury
 - the key words 'treatment', 'medical', 'hospital', 'surgery', 'physiotherapy', 'chiropractor' or 'doctor' appearing on the ACC45
 - a tick in the 'Is this claim for treatment injury?' box on the ACC45 or, for older ACC45s, the 'Medical misadventure' box
 - · discussion with the client and/or provider.

7.0 Determining the date of injury for the consequential injury

- **a** To determine the appropriate date of injury for the consequential injury the following criteria can be considered:
 - The date of injury for the consequential injury will depend on the medical evidence and other relevant assessments, subject to approval at Team Leader level in consultation with a Medical Advisor or a Technical Specialist.
 - If the date of the consequential injury differs from the date of the original injury then a new claim can be created if there is a material reason to do so e.g. if a client requests this or it is to their advantage.
 - For the purposes of determining the appropriate injury date for a consequential injury, it was agreed that the provisions of sections 36 to 38 of the Accident Compensation Act 2001 can be used as guidelines for determining the date of injury for consequential injury claims (in conjunction with the medical and other information available), that is:
 - what is the date the client first sought or received treatment for the injury or the symptoms of the injury?
 - what is the date that the person first became unable to work because of their injury?
- **b** We may also consider when the consequential injury was first diagnosed.
- of If you need to set up a new consequential injury claim with a separate date of injury, instead of requiring the lodgement of a new ACC45, ACC staff can email the below form through to the Registration team.

8.0 Consequential claims under previous Acts

- a The guidelines for consequential injuries apply to the Accident Compensation Act 2001, and could also apply to the Accident Rehabilitation and Compensation Insurance Act 1992 and the Accident Insurance Act 1998.
- b Under the 1972 and 1982 Acts, the definition of personal injury by accident includes "the physical and mental consequences of any such injury or of the accident". This suggests there is no need for a consequential injury claim, as any consequential injury would already be eligible for cover under this definition.

- c For a consistent approach, the Kingi principles will also apply to 1972/1982 Act claims, and we will apply current policy to these scenarios. That is, the request for a new claim will need to:
 - · meet the criteria for a consequential injury, and
 - be to the client's advantage

9.0 Forwarding consequential injury claims

- a If you determine that a new consequential injury claim with a separate date of injury needs to be set up, then instead of requiring a new ACC45 to be lodged, you can email the below form through to the Registration team.
 - Referral for New Claim Lodgement
- b All consequential injuries caused by treatment, whether the original injury claim is lodged or accepted, are sent to one of the following for processing:
 - the Treatment Injury Administration EOS queue, for non-accredited employer claims
 - the registered accredited employer, for accredited employer claims.

10.0 Fund code

- a You must make sure the correct fund code is allocated to
 - Fund Code Policies

11.0 Links to legislation and appeal decision

Accident Compensation Corporation	v Kingi	[2012]
NZACC 351 (26 October 2012)		

http://www.nzlii.org/nz/cases/NZACC/2012/351.html

- Accident Compensation Act 2001, section 20 Cover for personal injury suffered in New Zealand (except mental injury caused by certain criminal acts [or work-related mental injury])
 - http://www.legislation.govt.nz/act/public/2001/0049/lat
- Accident Compensation Act 2001, section 28 Work-related personal injury
 http://www.legislation.govt.nz/act/public/2001/0049/lat
 - Accident Compensation Act 2001, section 36 Date on which person is to be regarded as suffering mental injury
 - http://www.legislation.govt.nz/act/public/2001/0049/lat
- Accident Compensation Act 2001, section 37 Date on which person is to be regarded as suffering personal injury caused by work-related gradual process, disease, or infection
 - http://www.legislation.govt.nz/act/public/2001/0049/lat
- Accident Compensation Act 2001, section 38 Date on which person is to be regarded as suffering treatment injury
 - http://www.legislation.govt.nz/act/public/2001/0049/lat

Conversion Probability Threshold v7.0



Summary

Objective

Conversion Probability measures the likelihood a client will need weekly compensation within the first 28 days of lodging their claim. It's measured as a percentage. For example, if a claim has a conversion probability of 35%, it means there's a 35% chance that the client will need weekly compensation within the first 28 days of lodging their claim.

When working out the conversion probability, we also consider a claim's duration rating. Duration rating predicts how long a client will need weekly compensation for. Duration rating is rated on a scale from 1 to 10, where 1 represents the 10% of claims with the shortest time on weekly compensation and 10 represents the 10% of claims with the longest time on weekly compensation

Eos automatically transitions earner claims based on an individual claim's conversion probability and duration rating.

Depending on whether claims meet or exceed the set conversion probability threshold, claims are either:

- · transitioned to Registration Actioned Cases
- · assessed by the Service Needs Assessment (SNA) team before being allocated
- allocated directly to a Short Term Claims Centre (STCC) or branch for case management.

Current policy sets the conversion probability threshold at 30% for all duration ratings.

Claims with a conversion probability that:

- is less than the 30% threshold are transitioned to Registration
- Actioned Cases
- · meet or exceed the 30% threshold are transitioned to either:
- the SNA team for assessment
- an STCC or branch for case management.

Owner Out of scope Expert Out of scope	
Policy	

1.0 Conversion probability thresholds for each duration rating

ACC can choose to vary the conversion probability threshold for each duration rating. The attached table details the current thresholds for transitioning earner claims immediately after registration. These thresholds may change over time.

Conversion probability thresholds.PNG

2.0 Related business rules

Determination of the conversion probability
Streaming earner claims to SNA when conversion probability is greater than or equal to the threshold
Streaming earner claims to SNA when conversion probability is less than the threshold

Cover criteria for personal injury v9.0



	Cover criteria for dentures and prostheses https://go.promapp.com/accnz/Process/f02eb0ef-575
	k - the death of the client
	Cover criteria for accidental death claim https://go.promapp.com/accnz/Process/fb268b6b-089
	 a pregnancy as the result of rape or treatment injury (or medical misadventure for claims prior to 1 July 2005)
	Pregnancy as a personal injury https://go.promapp.com/accnz/Process/5ce6add6-6de
	m See the AC Act 2001, Section 26, subsections (2) to (4).
	AC Act 2001, Section 26, subsections (2) to (4) https://www.westlaw.co.nz/maf/wlnz/app/authentication
2.0	Categories of personal injury excluded from cover
	a A personal injury is excluded from cover if it is:
	caused wholly or substantially by the ageing process an injury to teeth or dentures caused by the natural use of the teeth
	caused by gradual process, disease or infection, unless it is:
)	- work related
ı (- caused by treatment - a consequence of a covered personal injury - a consequence of treatment given to the client for an
	covered injury.
	a pregnancy that:
	 results from failed contraception results from failure of treatment to a third party, eg a
	failed vasectomy - is an unwanted pregnancy.
С	See the AC Act 2001, Sections 20(2)(e) to (h), subsec-
	tions (2) to (4).
	AC Act 2001, Sections 20(2)(e) to (h), subsections
3;	(2) to (4). https://www.westlaw.co.nz/maf/wlnz/app/document?&
	Pregnancy as a personal injury https://go.promapp.com/accnz/Process/5ce6add6-6de
f	
31	
91	
	2.0 2.0

3.0 Natural use of teeth

- **a** We do not cover injuries caused by the natural use of teeth. AC Act 2001, Section 26, subsection (4b) stated:
 - personal injury does not include "...personal injury to teeth or dentures caused by the natural use of those teeth or dentures".

There have been several cases heard by the Court in relation to this issue including Partner HC180/1993, Moulder [34/97], Brumby 87/97, McCardle [74/06] and [206/06], Scaife [114/12] and Mares [292/14].

The case law is clear that where the applicant is eating food, the courts have routinely held that where there is something hard contained within that food, then damage to teeth from chewing on that hard food is excluded from cover. This is because chewing of food is 'normal use of the teeth' and is excluded from cover by section 26(4)(b).

This means the act of breaking/injuring a tooth whilst eating is declined – regardless of whether it's a piece of glass/metal/shot or gristle/olive pit/nutshell/bone.

See Natural use of teeth - historical background for more information regarding legislative changes.



Natural use of teeth - historical background.docx

Cover Criteria for Physical Injury v12.0

ace

Summary Objective

Use this guidance to determine cover for a physical injury.

- 1) Rules
- 2) Poisoning
- 3) Choking

Owner

Out of scope

Expert

Out of scope

Policy

1.0 Rules

- a The definition of 'personal injury' provided by the Accident Compensation Act 2001 includes 'physical injury'. A physical injury is sustained where there is evidence of actual damage to the body. This entry provides examples and details of physical injuries.
- b The type of physical injury must be diagnosed for us to consider a claim for cover. The presence of pain is not enough to establish that there's a physical injury.

Physical injuries can include the following:

- · wounds, lacerations, contusions, etc
- hurne
- sprains and strains
- work-related gradual process injuries, eg tendonitis, occupational noise-induced hearing loss etc
- · work-related infections or diseases
- · fractures, amputations or dislocations
- blindness
- poisoning*
- unconsciousness or loss of consciousness
- a foreign body in the eye. For orifices other than the eye, the presence of a foreign body does not automatically mean a physical injury has been sustained.
- C If you're unsure about any diagnosis, consult a Medical Advisor.

2.0 Poisoning*

- a Adults who suffer a physical injury from poisoning must meet the criteria for inhalation and oral ingestion before we'll accept their claim for cover.
 - Cover criteria for inhalation or oral ingestion Policy
- **b** It's often difficult to determine if a child has sustained a physical injury from poisoning. If a child has a poisoning event, determine cover on a case-by-case basis.

We consider that a physical injury has occurred when the information on the claim file shows:

- the child has ingested a substance that is, or is believed to be, potentially toxic or corrosive
- the child has received some form of active treatment or intervention from a medical practitioner.

Always seek advice from a Medical Advisor before declining a claim for child poisoning.

3.0 Choking

- a If a person presents following a choking occurrence, we will consider whether they have sustained a physical injury e.g. damage to the throat. The claim must meet the criteria for inhalation and oral ingestion and the injury must also be identified before we can accept it for cover.
 - Cover criteria for inhalation or oral ingestion Policy

Cover criteria for pre-existing conditions Policy v10.0



Summary

Objective

If a client has a pre-existing condition and suffers a personal injury, the personal injury may be covered but the pre-existing condition will not. However, if the pre-existing condition has previously been accepted for cover, the worsened condition may be covered under the existing claim.

The AC Act 2001, Section 26(4) states that personal injury does not include personal injury caused wholly or substantially by the ageing process.

Out of scope Owner Out of scope **Expert**

Policy

1.0 Taking a person as they are

a If a person with a pre-existing condition has an accident, they may sustain more serious results from the accident than a healthy person. They have a right to compensation for the more serious results. See Examples of preexisting conditions.

You may sometimes hear this referred to as the "eggshell" skull principle" or the "thin skull rule". It means that we consider all claims for cover on their own merits, without giving weight to any pre-existing conditions.

2.0 Aggravation or acceleration of pre-existing damage

a We will not cover the aggravation or acceleration of preexisting damage that is a natural step in the process of deterioration, without evidence of a fresh injury.

3.0 Obtaining medical information

- a When obtaining medical information you must:
 - · establish the cause of injury, to determine whether the injury is the result of an accident
 - · get a description of any significant pre-existing condition.

You should collect the following information to get a full picture of a client's condition:

- · full diagnosis of the condition claimed for
- likely prognosis of the condition
- · description of any significant pre-existing medical condition that may have caused or contributed to the injuries claimed for
- details of any other medical practitioner consulted about either the injuries or a pre-existing medical condition that may be related to the injuries claimed for
- copies of any medical reports, x-rays or clinical test results that may be related to the injuries claimed for
- information about any unusual features of the injuries.

If you contact medical practitioners by phone, make sure you get a written response from them as well.

4.0 Adjacent Segment Disease

- a Adjacent Segment Disease (ASD) is a term describing pathology that has become symptomatic following a spinal fusion. When a person has one or more levels of their spine fused surgically to treat disc pathology caused by a covered back injury, the adjacent disc level above or below the fused segment may be subject to extra load and stress because those levels are now the lowest remaining mobile segments.
- Only spinal fusion surgery has the potential to cause adjacent segment disease. The way in which disc prolapses contribute to ASD is not scientifically well established

Cover for ASD is not available if a fusion accelerates the progression of pre-existing degeneration at an adjacent level.

ASD arising from non-ACC funded fusions would not be covered unless the disease met the criteria for a treatment injury.

The fact that ACC has funded an earlier fusion which, in turn, is alleged to have caused ASD is not enough in itself to determine causation.

5.0 Examples of pre-existing conditions

a Example 1

Paul is being treated for cancer. While undergoing a course of radiotherapy, he falls and fractures his knee. His claim will be accepted for cover for the knee fracture, but not for the pre-existing cancer.

Paul's entitlements are limited to the separate consequences of the knee fracture. For instance, ACC may contribute towards the cost of treatment of the fracture by an orthopaedic surgeon, but not towards any cost of further radiotherapy.

b Example 2

Ann is aged 85 years and lives in a rest home. She falls and fractures the neck of her femur.

The fracture heals but Ann does not become as mobile again. A year later, when the fracture is healed, she contracts pneumonia and dies. Because there is no direct causal link between the fracture and Ann's death, ACC is not responsible for any costs arising from the pneumonia and death.

c Example 3

Carl is aged 85 years and lives in a rest home. He falls and fractures the neck of his femur.

Because of the fracture, Carl is immobilised in bed and cannot even sit up. Within a few weeks, he has congestion in his lungs because of his immobility. Carl contracts pneumonia and dies.

The claim for cover will be accepted for Carl's death, because there is a clear chain of causation. The fall caused the fracture, which caused the immobilisation, causing the congestion in the lungs. The congestion led to pneumonia, which caused Carl's death.

d Example 4

Scott, aged 52, has an osteoarthritic hip joint. He is still reasonably mobile, but it is anticipated that, at some time, he will need a replacement joint.

While swinging his golf club one day, Scott twists his hip joint. His claim will be accepted for cover for the twisting, but not for the underlying osteoarthritis.

e Example 5

Cath has suffered from the effects of Scheuermann's disease (an osteochondritis of the spine) since her teenage years. This will gradually deteriorate so she will not be able to flex part of her spine.

When lifting a bolt of material, Cath severely strains her back muscles. Her claim for the muscle strain will be accepted for cover, and she can receive appropriate entitlements while the strain heals. But as soon as the deteriorating osteochondritis becomes the substantial cause of Cath's back problems she will lose her entitlements.

f Example 6

Brent is an active diabetic who slips while cutting firewood and a splinter pierces his foot. The injury, because of his pre-existing poor circulation, leads to gangrene in a part of the foot. This has to be excised in two separate operations.

Brent's claim will be accepted for cover for the splinter incident and his entitlements extend to the two separate operations. However, ACC has no responsibility for other measures that are required, for example a vein transposition, which is a prophylactic measure undertaken to improve the blood circulation to what remains of Brent's foot.

q Example 7

Brenda has always been inclined to minor depression, but did not need any treatment other than rest. She sustains serious chest injuries and other abrasions in a motor vehicle accident. As a result of these physical injuries Brenda suffers a post-traumatic stress disorder (PTŚĎ).

The PTSD needs medical treatment, which prevents Brenda from working for a time ACC will accept the claim for cover for the PTSD and for her physical injuries.

Criteria for Work-related Personal Injury 'Place of Work'



Summary

Objective

Use this information to help you determine whether a client is at a place of employment, and assign the correct fund code.

- 1) Work-related personal injury criteria
- 2) Complex cases
- 3) Employee carparks and work-related injuries
- 4) Questions to consider to help you determine WRPI
- 5) Examples to help you determine WRPI when the client is taking a temporary break from work
- 6) Additional examples to help you determine WRPI
- 7) Feel free to provide examples of cases you've encountered
- 8) Link to legislation.

Owner Out of scope

Expert Out of scope

Procedure

1.0 Work-related personal injury - criteria

- a Section 28 of the Accident Compensation Act 2001 provides the criteria used to determine a work-related personal injury (WRPI). An injury is clearly a WRPI when the injury occurs:
 - at the physical place of employment, while the employee is there for the purposes of work, during normal work hours (this includes a place that moves or a place that the client moves through)
 - while the employee is taking a break from work and remains on the work premises.
- **b** The following 'guiding principle' will help you determine whether an injury is a WRPI.

NOTE Guiding principle

An injury is a WRPI if the person is injured at a specific place while performing either:

- an employment activity
- some activity reasonably connected with their employment.

2.0 Complex cases

- a In some cases, you may find it difficult to determine whether an injury has occurred at work, for example:
 - employees who work in 'non-traditional' workplaces, ie clients who work from home or on assignment
 - clients who work in a traditional place of work, but are out of town on business, en route to another workplace, or away from their usual place of work.
- b When deciding whether cases like these fit the WRPI criteria, you must:
 - determine the specific place the injury happened
 - · determine the purpose for being in that place
 - · apply the guiding principle.

-	-	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_	_

non traditional work place decision flowchart.gif

3.0 Employee carparks and work-related injuries

- a Several factors need to be considered when considering whether a carpark is considered as a place of employment if we are to understand if a work-related personal injury (WRPI) has occurred, or not
- When can a car park be considered as a place of employment?
 In general, the carpark must be attached to the building where they work, be for employees only and have restricted access to the public. There would need to be internal access to the building from the car park. For further detail see business rule
- c When can we consider a person has had a WRPI in that car park?

 If the person was in that carpark for the purpose of employment, then we would consider any personal injury caused by accident to be work-related.
- d Start and end of Shift

 If the person is in that carpark as they start or end their shift for the day and they have a personal injury caused by accident, this will be considered a WRPI (see Section 4)
- Was the person there for the purpose of employment?
 - à. Purpose for an injury to be work-related, an employèe needs to be at the place of the injury for the purposes of employment.

Key considerations:

- Why was the employee in the carpark at the time of the accident?
- Was it for the purpose of employment? And

Was the person at a place of employment

b. Place of employment – for an injury to be work-related, the injury should occur at the employee's place of employment.

Key considerations include:

- · Where did the accident occur?
- Did it occur in an employee workplace carpark provided by the employer? (see "Employee carpark" business rule for start and end of shift).
- f During their shift

Once they have begun their shift and they are in any place for the purpose of employment and they have a personal injury caused by accident, this will be considered a WRPI

- g If you are satisfied that the person was in a carpark (that meets the business rule as place of employment for carparks) for the purposes of employment, and that the person had a personal injury caused by accident then we can consider it a work-related personal injury
 - When a carpark is a place of employment at the start of a shift of an employee
 - When a carpark is a place of employment at the end of a shift of an employee

4.0 Questions to consider to help you determine WRPI

a Was the person at the location primarily for the purposes of employment?

NOTE Example:

A teacher is injured while marking students' assignments when travelling home from work on the train. Although they're performing a work task, the primary purpose for the teacher to be on the train is to travel home from work.

b What activity was the person doing at the time of injury? Were they doing a leisure activity that's reasonably associated with their employment?

NOTE Example:

An employee goes out for drinks with friends while out of town for work and suffers an injury while at a pub. The employee is engaged in a leisure activity not reasonably associated with their employment.

c Was the activity reasonably part of the person's day to day lifestyle, irrespective of their employment?

NOTE Example:

An employee is staying in a hotel while out of town for work and is injured while having a shower. The employee is engaged in an activity which is reasonably part of their day-to-day lifestyle, irrespective of employment.

d What were the specific requirements of the person's employment? Was it necessary for the person to be at that particular place for employment purposes?

NOTE Example

A cook is injured in the bunkroom of a factory boat while off duty. The nature of the cook's employment requires them to remain on the boat during off duty hours. This significantly impacts their ability to carry out normal day to day or leisure activities.

Does the client have no option but to remain at the work environment when not working because of the nature of their employment?

NOTE Example:

Due to bad weather, a client falls out of their bunk-bed at night while off-duty on a fishing trawler. The client injures their elbow. This injury will be covered as a WRPI.

Considering the restriction on personal freedom caused by the requirement to remain on the work-site (ie employees cannot leave between shifts) all activities performed on the work-site are reasonably connected with employment.

When the nature of employment means that employees have no option but to remain at the work environment when not working, these injuries would be classified as WRPI.

f Was the client working from home, and their primary purpose for being at home is to complete work tasks?

NOTE Example:

A client usually works from home on Fridays. They burn themselves while making a cup of tea on a break. This injury will be covered as a WRPI

Any injury sustained in a situation where an employee is working from home, and their primary purpose for being at home is to complete work tasks is a WRPI.

The client was at home for the primary purpose of completing work tasks, ie they had an ongoing arrangement with their employer to work from home on certain days. This contrasts with cases where employees stay home primarily for a reason other than work (even though work tasks might be completed while at home), eg due to their child being sick (non-WRPI).

g Was the client injured away from the immediate workplace, but in a place that is strongly associated with the employer?

NOTE Example

A client has finished work for the day and is walking to their car in the employee carpark located across the road from their workplace.

While walking through the carpark, they trip and injure themselves.

The carpark is owned by the employer and the client has a carpark pass to use the spaces. The carpark is intended for employees only and has prominent signage stating that cars without passes displayed will be towed, but there are no physical barriers to prevent members of the public parking in the space.

Even though the client was leaving work at the end of the day, the carpark is likely to be considered as an extension of the place of employment due to the level of control the employer exerts over the space. This injury will be covered as a WRPI.

5.0 Examples to help you determine WRPI when the client is taking a temporary break from work

NOTE Example:

An office manager is playing indoor cricket during their lunch break at an area of their workplace set aside for employee leisure activities. The manager slips and sprains their shoulder while diving for a catch.

- The client was on their lunch break from work and would have resumed work after the temporary break
- The injury occurred at their place of employment

The injury occurred while the client was on their lunch break at their place of employment. It is a WRPI.

NOTE Example:

A client is working from home and their primary purpose for being at home is to complete work tasks (as opposed to a client is working from home, but the primary reason they are at home is other than work, for example, looking after their sick child).

They spill hot tea on themselves while in the kitchen taking a break from work.

- The injury occurred at their place of employment, which is their home
- The client was on a tea break and would have resumed work after the temporary break

The injury occurred while the client was on their break at their place of employment. It is a WRPI.

NOTE Example:

A salesperson is having lunch at a hotel where they are attending a training course, arranged and paid for by their employer. They suffer burns when a tea urn tips over.

- The client was on a lunch break from their work and would have resumed the course after the temporary break.
- The injury occurred at a place of employment. The client was at the hotel in order to attend training for the purposes of their employment. The hotel is a place to which the person has access because of their employment.

While the injury did not occur at the claimant's usual place of employment, it occurred during their lunch break, at a place the person has access to because of their employment. It is a WRPI.

NOTE Example:

A ski technician injures herself during a paid break whilst snowboarding.

- · The client was on a paid break
- The injury did not occur at their place of employment – the courts have held that the whole mountain or ski field cannot be considered their workplace.
- The client was participating in a leisure activity which is not reasonably associated with her specific work repairing skis and snowboards.

The injury did not occur at the place of employment and was not a task associated with his employment. It is not a WRPI.

6.0 Additional examples to help you determine WRPI

NOTE Example One:

An executive of an advertising company is overseas for business, pitching a new campaign. As part of their employment they're required to take clients out to meals. On one of these occasions, while in the dining room of the hotel, the executive suffers burns when a waiter spills coffee on their lap.

- The specific place of injury is the hotel dining room.
- The primary reason for being in the hotel dining room is to attend an employment-related dinner.
- Having dinner is reasonably part of the executive's day to day lifestyle, irrespective of employment
- It's a necessary part of the executive's job to attend the dinner in the hotel dining room.

On balance, the executive is in the hotel dining room primarily for the purpose of performing an employment activity or some activity reasonably connected with employment. This supports the decision that the injury is a WRPI.

NOTE Example Two:

A sales representative in Auckland on business leaves work for the day and stops at a nearby supermarket on the way back to their hotel. While shopping they trip and break their leg.

- The specific injury location is the supermarket.
- The primary reason for the client to be in the supermarket is not employment-related. It's to buy dinner.
- Buying dinner is reasonably part of their day to day lifestyle, irrespective of employment.

On balance, the client isn't in the supermarket primarily for the purposes of performing an employment activity or some activity reasonably connected with employment. This supports the decision that the injury is not a work-related personal injury (WRPI).

NOTE Example Three:

An office worker is injured, at their work place, on the way to get their jacket from the coat stand after finishing work for the day.

- The specific place is the hallway near the coat stand at the claimant's work place.
- The reason for being at that place is to collect their coat. Although the claimant has finished work for the day, part of their employment activities includes necessary activities associated with arriving and leaving their work place.

Note: it is generally not relevant that the public also have access to the work place.

The injury occurred while the claimant was at their place of employment for the purposes of employment. It is a WRPI.

NOTE Example Four:

After finishing work for the day, an employee leaves their work premises and is injured on the footpath on the way to catch a bus home.

- The specific place is the footpath.
- The reason for being on the footpath is to travel home after finishing work and leaving the work place. The footpath is occupied for the purposes of travelling home from work, rather than for the purposes of their employment.

The injury occurs while the claimant is at a place for purposes unrelated to their employment. It is not a WRPI.

7.0 Feel free to provide examples of cases you've encountered

- a There will still be grey areas where it is difficult to determine whether a WRPI occurred each claim will need to be determined on a case-by-case basis taking into consideration the specific facts of the case.
- b Feel free to provide examples (via [Give Feedback] function on this page) of complex cases where you've found it difficult to determine WRPI. These examples can be included here to help others.

8.0 Link to legislation

Accident Compensation Act 2001, Section 28: Work-related personal injury http://legislation.govt.nz/act/public/2001/0049/153.0/D

Decline Claim v14.0



Upload an Incomplete Electronic Document Summary CVR999 Cover decline decision - client **Objective** NOTE What if the client's preferred method of To advise a client that we've declined their claim. communication is by email? Follow 'Send an email with an Eos document' system steps. A staff member has investigated a claim and determined that they must decline it. They can decline the claim for two reasons: Send an email with an Eos document (Eos Online - There is insufficient information to make a cover decision, or Help) - The claim does not meet criteria for cover. NOTE What if the client's address is not valid? Out of scope · If the address is verified but not valid, it is okay Owner to send a letter to the client. Out of scope **Expert** · If the address is not verified and not valid, add a note in the contact for the document stating: 'Letter not sent to client as address is invalid.' **Procedure** Send a copy of the decline letter to the provider 1.0 Check registration status only. **Lodgement Administrator** NOTE What if the client's preferred method of a Ensure the claim's registration status is complete. communication is by post or email is not verified? NOTE What if it's not complete? 1) In Eos, go to 'Recovery Plan' sub-case and Go to the Decline Claim Due to Incomplete add activity 'NGCM Send Letter'. Registration process. 2) In the task description, list the title of the letter, information sheets and other relevant attachments that need to be printed out and included **CONDITIONAL Decline Claim Due to Incomplete** with the letter. Registration 3) Review "When to use 'high' priority indicator **Lodgement Administrator** on the tasks sent to Recovery Administration" rules to determine priority of the task. If you scenario meets the rules, change the priority indicator to 'high'. 2.0 Communicate cover decision 4) Close task Cover Assessor, Recovery Administrator, Recovery This is the same as 3.0 g Note in 'Issue Cover **Team Member** Decision (Treatment Injury)' process. Ensure that all the available information has been consi-NOTE What if the client's address is not verified? dered. FOR CLAIMS ASSESSMENT **b** Call the client to explain the decision. Go to the Contact - If the address is verified but not valid, it is okay Client or Provider for Information process below to do to send a letter to the client. However, if speaking with the client as part of the assessment NOTE What if the claim is for a wilfully-self inflicted process, please ensure the address details are (WSI) injury? verified. Don't call the client to decline the claim, as this - If the address is not verified and not valid, add may cause further distress for them. Go to the a note in the contact for the document stating: next step in the process. 'Letter not sent to client as address is invalid.' Send a copy of the accept cover letter to the pro-NOTE What if there's an Assistance Required task vider who lodged the claim instead. on the claim? NOTE What if the client address is not verified -Explain to the client that we're unable to provide FOR RECOVERY TEAM MEMBERS assistance for a claim that isn't covered. -If an address is verified the letter can be sent NOTE What if the client provides new information regardless of whether the address is valid or about the claim? invalid · If the information is relevant to their claim, post--If an address is not verified the letter cannot be pone making the cover decision. Considered sent regardless of whether the address is valid how the new information will affect your decision. or invalid. Add a note in the contact for the docu-Go to 'Assess Claim for Cover' process. This ment stating: 'Letter not sent to client as address process ends. is invalid.' Send a copy of the accept cover letter to the provider who lodged the claim instead. • If the information is not relevant to their claim, When to use 'high' priority indicator on the tasks sent explain this to the client. Continue with this to Recovery Administration process. PROCESS Assess Claim for Cover :: d Add the Working Together information sheet to the **PICBA** client's letter.

NOTE A copy must also be printed and sent to the

c In Eos, generate the CVR999 cover decline cover letter.

Lodging Provider.

NOTE What if you are declining a claim for hernia?

If a hernia decline, add the ACC7913 Primary abdominal wall hernias, including groin hernias.

ACC255 Korero mai - Working together

		٢		C7913 Primary Abdominal Wall Hernias, Including in Hernias - A Guide to ACC Cover.pdf
	е	are	only	check outbound documentation to ensure you sending information to the client and provider elevant to this claim.
		NO	TE	Do I have to complete the privacy check myself?
				In some business units a separate team will complete this privacy check. Ask your Team Leader if this is the case for your team. If there is not a separate team responsible for privacy checking you will need to complete the check yourself.
				SUPPORTING INFORMATION Inbound and bound Document Checks
-	PR	oci	ESS	Contact Client or Provider for Infor-
				mation at Lodgement Cover Assessor, Lodgement Admin- istrator, Senior Cover Assessor
3315			-8-2	
3.0				over status and transfer claim essor, Recovery Team Member
	a	clin	e' an	n 'General' tab, change the Cover Status to 'Dedupdate the Cover Status Reason. Review 'Dever status reasons and rationale' guide to deterect cover status reason to use.
			Upo	date Cover Status
		NO	TE	Do not change the outcome status of the diagnosis (in medical tab) from "provisional" to "declined" when the whole claim is declined. This should only be changed to declined in an 'Accept/Decline' situations. An 'Accept/Decline' is when the whole claim cover status is accepted, but a single injury code/diagnosis is being declined.
		NO	TE	What if it's a change in or additional diagnosis?
6	1	1		Do not change the cover status to 'Decline'. In Eos, in the 'Medical' tab, set the Outcome Status of the new diagnosis to 'Declined'.
1	b	you	r cov	in the 'Contacts' tab, add a contact explaining yer decision rationale. Review 'Decline cover easons and rationale' guide on what to include in onale.
1		D	Add	a client contact
-1	X	ð	Dec	cline cover status reasons and rationale
)	c	V-1		the relevant Information Required actions have mpleted.
	d		se then tas	e Confirm Cover Decision task and any other sks.
		NO	TE	What if it's a change in or additional diagnosis? Close 'Follow-up' cover task.
		-	Clo	se a Task
	е	Tra	nsfer	the declined claim to your department's actioned

NOTE	What if I'm declining the claim due to time- frames, and I'm waiting for information to arrive that will help me to make a cover deci- sion?
	Leave the claim in your queue instead of transferring it to actioned cases.
Tra	ansfer a Task to a Department
☐ Mo	ove claim to actioned cases (Eos Online Help)

cases queue.

Definition of Accident Policy v10.0



Summary

Objective

Use this guidance to understand how we define accident at ACC.

- 1) Definition of an accident
- 2) Definition of accident until 30 June 2005
- 3) Exclusions
- 4) Processing claims
- 5) Link to Regulations

Owner

Out of scope

Expert

Out of scope

Policy

1.0 Definition of an accident

- a For an occurrence to be classified as an accident under the Accident Compensation Act 2001, Section 25 it must:
 - be a specific event, or series of events, that involves one of the following:
 - the application of a force, including gravity, or resistance external to the body
 - the sudden movement of the body to avoid a force, including gravity, or resistance external to the body
 - a twisting movement of the body
 - involve the inhalation of any solid, liquid, gas or foreign object on a specific occasion, but not including inhalation of a virus, bacterium, protozoa or fungus, unless the inhalation results from a criminal act by another person
 - involve the ingestion of any solid, liquid, gas or foreign object on a specific occasion, but not including ingestion of a virus, bacterium or protozoa, unless the ingestion results from a criminal act by another person
 - be a burn or exposure to radiation or rays of any kind on a specific occasion, except exposure to the elements
 - involve exposure to the elements, or to extremes of temperature or environment, within a defined period of time not exceeding one month, which results in death or inability to work for a period exceeding one month
 - involve the absorption of any chemical through the skin within a defined period of time not exceeding one month.
- b Just because a personal injury has occurred, don't presume that it was caused by an accident.
- c Links to related policy:

	Cover	criteria	tor	ınhala	ation o	or oral	ingestic	on Pol	ІСУ
Γ4	_						.		

Cover criteria for burn or exposure Policy

Cover criteria for exposure to the elements

Cover criteria for absorption Policy

2.0 Definition of accident until 30 June 2005

a The definition of accident prior to 30 June 2005 is the same for all of the above occurrences, with the exception of ingestion.

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3.0 Exclusions

- a All of the occurrences listed above are not considered accidents if the occurrence is also treatment given:
 - by or at the direction of a registered health professional (see Cover criteria for treatment injury)
 - outside New Zealand, by or at the direction of a person who has qualifications equivalent to those of a registered health professional in New Zealand (see Cover criteria for treatment injury)
- b Certain other occurrences will not meet the definition of accident, unless the accident is work-related. These are:
 - any ectoparasitic infestation
 - contraction of any disease carried by an arthropod.

Refer to Cover Criteria for Ectoparasitic Infestation Policy.

c Links to related policy:

Cover criteria for ectoparasitic infestation Policy

Cover Criteria for Treatment Injury Policy

4.0 Processing claims

- a The cause of the injury must be clearly identified on the claim form.
- b We can cover injuries caused by a series of events, provided that the treatment provider verifies that the injury can be attributed to this rather than to some other cause, eg the aging process, disease. See Examples of accidents (below).
- **c** If there is any doubt that the injury was or could be caused by the described incident, then request a further medical opinion.

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5.0 Link to Regulations

NOTE The Accident Compensation (Definitions) Regulations 2019

An amendment to the Accident Compensation Act 2001 moved the definitions of 'registered health professional' and 'treatment provider' from the Act to regulations. The Accident Compensation (Definitions) Regulations 2019 took effect on 01/10/2019.

Accident Compensation (Definitions) Regulations 2019

http://www.legislation.govt.nz/regulation/public/2019/0

Extend Cover Decision Timeframe viso



Summary

Objective

To extend the date a cover decision is due and inform the client of this extension.

Background

A staff member investigating a held claim has identified that there isn't enough information to make a cover decision. They have requested additional information from internal and/or external parties, but will not receive this information before the cover decision due date. To prevent a deemed cover decision, they must extend the cover decision due date.

Out of scope Owner Out of scope Expert

Procedure

1.0 Confirm extension is allowed

Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner, **Recovery Team Member**

- a Ensure that you've read and understood the Timeframes to Determine Cover policy below. You must not extend the cover decision timeframe if you have enough information to make a cover decision, and can only extend the cover decision timeframe if you've made a genuine attempt to investigate the claim within the original timeframe.
 - Timeframes to determine cover Policy
- b If you're completing the first timeframe extension for any claim, or an additional extension for a non-complicated claim, go to step 2101 If you're completing the second timeframe extension for a

complicated claim, go to step 2.1.

2.0 Advise client of the extension

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

NOTE What if it is related to an ISSC Held Claim?

If the claim is Held, refer to sction 1.0 (d) of the Assess Early Plannig & Set up Supported Assessment page check for receipt of the ACC6242 Early Planning: client confirmation and check for the following:

- It is for the right client
- · client has agreed to one of the 3 options for an extension
- · client has signed and dated the document
- PROCESS Assess Early Planning & Set up Supported Assessment
- a In Eos, in General tab, extend the 'Cover Decision Due Date' by clicking on the edit button of 'Reassessment and Accredited Employer Details' section. Enter the new cover decision due date in the date field.
 - Extend cover decision due date

NOTE What if it is a change for an additional diagnosis?

- in Eos, in 'NGCM Cover Decision Required' task, edit the cover decision due date.
- · for previously actioned cases: in Eos, in 'Follow-up cover' task, edit the cover decision due date and set the target date to one week prior to the cover decision due date.

The timeframe for extension needs to be calculated from the date the request for the additional diagnosis was received, eg ACC18 received on claim.

NOTE How long can you extend the due date for?

For non-complicated claims, the maximum extension is four months from the date of lodgement. EOS does not currently allow you to extend by four months, as it may go beyond EOS's maximum allowable extension of 120 days. To allow for this you will need to extend 2-3 days less than the four months.

For complicated claims, the maximum initial extension is four months from the date of lodge-

For additional injuries make sure the extension date is calculated from the date ACC received the request for the additional diagnosis.

- **b** Enter the reason for extension.
- c Call the client with follow up confirmation via their preferred method of written contact using the template below to advise of the extension. Use the 'Contact Client or Provider for Information at Lodgement' process to complete this step. If appropriate for your client send the CVR30 time extension letter, for example where:
 - the client cannot be contacted,
 - additional information is needed to be included or
 - there is a need for clear, documented information in relation to the extension to avoid any potential miscommunications for example for treatment injury claims or if the relationship between ACC and the client is strained and there has been issues regarding communication in the past

NOTE Email template for Injury/diagnosis ACC is investigating

RE: Injury/diagnosis ACC is investigating

From ACC: We're still working on getting (information) from your (source of information). This information is important to help us assess your claim. We'll be in touch as soon as possible and advise that we are required to make a decision by XXX (date). If you have any questions, please call us on 0800 XXXXX

NOTE What do you need to explain during the conversation?

- let the client know that we need to extend the cover decision timeframe
- explain what information we're waiting on that's led to the extension - e.g medical notes from Dr xxxx
- record conversation in EOS contacts noting reason for the extension, client's comments (if any) and the new timeframe, use the following template to record in Eos:
- -Date /time of conversation:
- -Date of cover timeframe extension:
- -Additional agreements/issues

PROCESS Contact Client or Provider for Information at Lodgement

NOTE What time extension reason do you need for an additional diagnosis?

- let the client know that we need to extend the cover decision timeframe
- explain what information we're waiting on that's led to the extension - e.g medical notes from Dr xxxx
- record conversation in EOS contacts noting reason for the extension, client's comments (if any) and the new timeframe, use the following template to record in Eos:
- -Date /time of conversation:
- -Date of cover timeframe extension:
- -Additional agreements/issues

You will need to calculate the extension date from the time the additional request was received, and then enter this date.

NOTE What time extension do you need to apply?

The date should reflect the same date recorded in Eos. Remove the [4 months from lodgement] and replace with the expiry date of the extension.

If it is for an additional diagnosis request, the date needs to be calculated from the date ACC received the request for the additional diagnosis. eg ACC18 received by ACC

What if I haven't been able to contact the client by phone or e-text?

Email or post the appropriate extension letter below to the client to let them know about the extension. This must be sent in advance of the due date on the claim so the client receives it before the cover decision was originally due.

For additional diagnosis:

You will also need to modify the CVR30 letter with the information below (updating the subject of the letter from "...your claim" to "....your additional diagnosis":

ACC has already covered [primary injury diagnosis]. ACC received a request for an additional diagnosis on [Enter the dates the additional diagnosis request was received] for the following:

- Additional DX
- Additional DX

Choose the appropriate option on the CVR30 letter that reflects the reason for the extension. You also need to calculate the extension date from the time the additional request was received, and then enter this date into the letter. Make sure any reference to 'your claim' is removed and replaced by additional diagnosis.

TI30 Time extension advise

CVR30 Time Extension - advise - claimant

- Upload an Incomplete Electronic Document
- d Send the written notification via the client's preferred method of contact.

NOTE What if the client's preferred method of contact is via post or email is not verified? (if using Recovery Administration only)

- in Eos, generate a 'NGCM Send letter task' to Recovery Administration.
- · set the priority of the task to 'high'.
- in the task, include the title of the letter that needs to be posted.
- e Update the 'NGCM Cover Decision Required', add in the description note that the written confirmation of the extension has been sent and set the target date to 7 days prior to the cover decision due date.

NOTE What if you do not obtain the information needed to make a decision within the extended timeframe?

You will have to make a decision based on the information you have, this will most often mean that you will have to decline cover before the due date, Once the required information is received a new cover decision can be issued (if it indicates that cover should be accepted).

2.1 Request permission to extend the timeframe Cover Assessor, Recovery Assistant, Recovery Coor-

dinator, Recovery Partner, Recovery Team Member

- a You must get the client's permission to extend a cover decision timeframe beyond the initial 4 month extension timeframe on a complicated claim.
- b Contact the client to seek their permission to extend the timeframe. Record details of the conversation and the client's agreement to the extension in contacts on the claim.

NOTE Template for recording conversation

- -Date /time of conversation:
- -Date of requested cover timeframe extension:
- -Date of agreed extension:
- -Client comments (particularly if date of requested extension is not agreed to):
- -Additional agreements/issues

NOTE How long can you extend the due date for?

This depends on the claim and the situation. Claims that require external clinical advice such as mental injury and treatment injury are best to be extended to the maximum timeframe of 9 months. If the claim is waiting for internal clinical advice and you're confident we will receive this information soon, you can choose a shorter timeframe. For more information go to 'Timeframes to determine cover Policy'.

NOTE What if you are unable to contact the client?

- If you are unable to reach the client on your first attempt, leave voicemail message and send a call back notification if appropriate. Create a Contact Action to contact the client again in 3 days' time (unless urgent). Note in the task description that this is the first attempt to contact the client. If you are in Assisted Recovery also provide decision rationale in the task description field.
- 2nd attempt in 3 days if unsuccessful send the CVR31 Time Extension Request – Claimant letter. If you are unsure about sending the letter, contact a Practice Mentor to discuss.

		Tim	neframes to determine cover Policy
	NOT	Ē	When should you generate and send the CVR31 letter? The CVR31 letter will only need to be sent if after the discussion with the client they request the
			letter, the is detailed information required to be sent, there is a possibility of miscommunication, or you cannot contact the client after 2 attempts. The letter must be sent at least 10 working days prior to the cover decision due date on the claim. This gives the client time to consider the request and return a signed copy of the letter before the timeframe expires.
		CV	R31 Time Extension - request - claimant
		Upl	oad an Incomplete Electronic Document
С	has	agre	ritten notification of the extension noting the client eed to the extension via the client's preferred of contact.
	NOT	ΓE	Email template for Injury/diagnosis ACC is investigating
			RE: Injury/diagnosis ACC is investigating From ACC: As discussed with me on XXXX you have agreed to a further extension to making a decision. We're still working on getting (information) from your (source of information). This information is important to help us assess your claim. We'll be in touch as soon as possible and advise that we are required to make a decision by XXXXXX. If you have any questions, please call us on 0800 XXXXXX
	NOT	ſΈ	What if the client's preferred method of contact is via post or email is not verified? (if using Recovery Administration only) • in Eos, generate a NGCM - Send letter task to Recovery Administration. • in the task, include the title of the letter that
			needs to be posted. en to use 'high' priority indicator on the tasks sent Recovery Administration
d	Rec	eive	e a signed copy of the letter from the client agree- te extension.
	NO1	Ē	What if a client doesn't agree to the second timeframe extension?
	V		You're required to issue a cover decision at this
> //		>\ 	point. As there isn't enough information to make this decision, you need to decline the claim. Go to 'Decline Claim' process. This process ends. PROCESS Decline Claim
e			in General tab, extend the 'Cover Decision Due and enter the reason for extension.
) `		Ext	end cover decision due date
	NO1	Έ	What if it is a change in or additional diagnosis?
			 for managed claims: in Eos, in 'NGCM - Cover Decision Required' task, edit the cover decision due date. for actioned cases: in Eos, in 'Follow-up cover'
			task, edit the cover decision due date and set the target date to one week prior to the cover deci-

f In Eos, generate 'Follow-up cover' task, add in the description [Check if additional information has arrived, second extension issued. Any additional notes if applicable], set the target date to 7 days prior to the cover decision due date and set the priority as 'High'.

PROCESS

Contact Client or Provider for Information at Lodgement

Cover Assessor, Specialist Cover Assessor

3.0 Re-calculate auto reminder task dates

a When the cover decision due date is extended, Eos automatically re-calculates the reminder task due dates on the automatically generated tasks only, for any manual task created you will have to manage timeframes.

Issue Recovery Decision v29.0



Summary

Objective

To record recovery decisions that we've made on a claim, so that in the future these decisions can be easily located by the business.

Background

When documenting our decisions, we need to show a clear rationale and include key details. This is particularly important for decisions where we have not been able to approve a request.

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Advise Client of a decision

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check the client's preferred communication channel (SMS, email, etc), and if the client has a safe contact.

NOTE What if the decision is to Decline cover for a Complex Mental Injury claim?

Contact the Lead Provider to discuss the decision and determine the best way to deliver the decision (consider if there are any safety issues).

Complex Mental Injury Decline and Disengagement
Best Practice Guide

NOTE Does the provider need to receive a decision letter?

Notifying the provider-varies depending on the decision of support that is affected. If a support is being changed the provider is notified when the purchase order is updated. Other circumstances when a provider needs to be notified are addressed in the relevant process. Including but not limited to 'Stop Supports' and 'Maintain Supports'.

PROCESS Stop Supports

NOTE What if the client has already been contacted?

Go to Activity 2.0 Record details from discussion with the client.

b Contact the client. Confirm you are speaking with the right person by asking ACC's identity check questions. For CMI claims, refer to the policy below.

Identity Check Policy

Contacting sensitive claims clients Policy

NOTE What if you are unable to contact the client?

- If you are unable to reach the client on your first attempt, leave voicemail message and send a call back notification if appropriate. Create a Contact Action on the Recovery Plan to contact the client again in 3 days' time (unless urgent). Note in the task description that this is the first attempt to contact the client. If you are in Assisted Recovery also provide decision rationale in the task description field.
- 2nd attempt in 3 days: leave voicemail message and send another call back notification if appropriate. Consider contacting other stakeholders for an update and to confirm client contact details. Push out the task for another 5 days.
- 3rd attempt in 5 days: send the decision letter. If you are unsure about sending the decision letter, contact a Practice Mentor to discuss.

Create a Notification - System Steps

Recovery Plan - Create Contact Actions - System Steps

NOTE What if the client requests the Recovery Team Member to discuss the treatment request with another person?

Refer to the process below

PROCESS Obtain Authority to Act (ATA)

Discuss the decision with the client and if required ensure you have the client's agreement.

2.0 Record details from discussion with client

Recovery Assistant, Recovery Coordinator, Recovery Partner

- **a** In Salesforce, if relevant record the details of the discussion with the client on the claim.
 - NG Principles Decision Making
- **b** Create a new contact. Record the following in the description field:
 - Decision type [APPROVED/ADVERSE/DECLINED/ PARTIALLY APPROVED] DECISION
 - Provide in detail what was requested [eg. 6 hours home help per week over next 4 weeks]
 - · Who made the request and when
 - · The final decision
 - Who was consulted [eg. Recovery Support hotline guidance from Practice Mentor received 10/03/19]
 - Rationale for the final decision [(e.g. Partially approved home help of 2 hours per week to support Helen with cleaning bathroom, laundry, making beds and vacuuming. Did not approve 6 hours per week as agreed with PM that it is likely the agency could achieve the necessary support tasks within 2 hours]

3.0 Inform client of decision

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Create and complete the relevant decision letter.

NOTE: The letter you use will depend on the decision to be made. What is important is that we add the below comment to the decision letter that we use to refer back to the decision that is being revoked.

= this letter revokes and replaces the previous letter of ../....

NOTE What if there is a decision to Revoke an injury and replace with a new injury?

Follow the Revoking Cover process below PROCESS Revoking Cover

NOTE Does your client require ongoing financial assistance or support outside of the scope or remit of ACC supports?

Refer to ACC Partnering with MSD Flowchart and ACC Partnering with MSD which outlines the supports provided by MSD that may be helpful for our clients. Copy and paste the below statement and the relevant MSD links from the flow chart document into your concluding communications with your client ie the decision letter and any final email communications.

"If you require ongoing financial support and/or assistance, you will find information about the services and support offered by the Ministry of Social Development (MSD) on this link [add relevant MSD link/s from the Te Whariki document]."

ACC Partnering with MSD Flowchart

ACC Partnering with MSD

NOTE What if cover for a Complex Mental Injury is declined?

Generate and issue the SCU999 letter. Amend as appropriate and remove the following paragraph.

'Our ability to approve claims has been set out in ACC's legislation. We've said we're unable to approve your claim, this does not mean we saying that what you have experienced has not affected you, or that what is happening to you is unimportant, only that we can't cover it.'

NOTE

What if the decision is confirming cover for Mental-Injury - for either Mental Injury caused by Physical Injury (MICPI) or for Work Related Mental Injury (WRMI)?

For both instances send the 'CVR51 Approve cover mental injury' letter

Amend the letter appropriately to reflect the individual situation.

NOTE What if the decision is not

NOTE What if the decision is not to cover all injuries for a mental injury?

Issue the MIS12 - Approve Mental Injury and include the following after the paragraph which mentions the client's date of injury.

'Based on Assessment information we have received, we are unable to approve the following injury/injuries The report indicates that the event (s) you experienced didn't cause the mental injury/injuries.

[Add Mental Injury diagnosis]

NOTE What if the preferred option is email?

Follow the system steps for Emailing from Eos using a template and attach the 'ACC255 Working Together' document.

NGCM - FINAL Emailing from Eos using a Template - System Steps

NOTE What if the preferred communication is by post?

Generate the appropriate decision letter. At Recovery Plan level 'Add Activity' and select 'NGCM - Send Letter' task. Attach the letter to the task, include a note to print and include the "ACC255 Working Together" document.

NG GUIDELINES Sending Letters in NGCM

NOTE How do I know when a decision letter is required?

Refer to the Business Rules below to understand when we need to communicate a decision relating to support(s) for a client in writing.

NOTE How do I know what supporting information to send with a written decision?

This is dependent on the decision itself and consideration is on case by case basis – dependent on the client, the nature of the decision and the amount of information we had considered.

The reason for the decision should be sufficiently clear in the letter that providing supporting information will generally not be required. However, if you have a case where you feel that providing supporting information may be appropriate, then you could check this with our Practice Mentor support.

Communicate Decisions about Client Supports

- **b** Update the Recovery plan with the outcome.
- This process ends.

Make Cover Decisions for Mental Injury Caused by Physical Injury v23.0



Summary

Objective

To enable recovery team members to make cover decisions on some new claims for mental injury caused by physical injury (MICPI) without having to access Recovery Support/Clinical Services teams.

Background

A proportion of claims that come to Clinical Services for advice regarding cover for Mental Injury Caused by Physical Injury (MICPI) will be dealt with quicker and more consistently if recovery team members follow this process. Some cover decisions could be made without any input from Clinical Services.

Owner Expert Out of scope
Out of scope

Procedure

Determine if another open claim exists in a Recovery Team

Cover Assessor, Lodgement Administrator

a In Eos, check for any open claiims.

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 is there is an existing open managed claim?

Go to (NGCM) Match Claim to Recovery Team.

End of Process.

PROCESS Match Claim to Recovery Team

2.0 Check that eligibility criteria are met

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Check that there is a covered physical injury. The related physical injury may already be covered on an earlier claim or being diagnosed how along with the mental injury.
- b Check the date of injury is correct. The date on which a person suffers mental injury because of physical injuries suffered by the person is the date on which the physical injuries are suffered.
 - Cover Criteria for Personal Injury
- c Check the relevant claim documents (eg ACC45, ACC18 (available to GP/hospital only), letter from GP or provider requesting cover for mental injury, ACC54 application form for Independence Allowance/Lump Sum), medical records to establish if the injury meets mental injury criteria, using the Mental injury Because of a Physical Injury Policy and Mental Injuries Policy

Mental Injury Because of a Physical Injury Policy

Mental Injuries Policy

ACC45 ACC Injury claim.pdf

ACC54 Independence Allowance Lump Sum application NOTE What if there is no physical injury diagnosis provided by the lodging provider?

Contact the provider to obtain the diagnosis of the physical injury by phone or email asking for the diagnosis of the physical injury.

NOTE What if the GP advises there was no physical injury to client as a result of the accident event?

This process ends. Go to Decline Claim, issue the CVR999 Cover Decline letter, using letter option 15 - MENTAL INJURY - No physical injury.

PROCESS Decline Claim

NOTE What if you are unsure whether injury meets the criteria for mental injury?

Seek Internal Guidance.

PROCESS Seek Internal Guidance

NOTE If physical injury cover can be established either from an earlier lodged claim for this accident event or that the physical injury being diagnosed now meets the criteria for cover, go to step 3.0.

3.0 Create relevant documents and investigate

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

NOTE NGCM Request for clinical records. What if you are a Recovery Team Member?

Follow the Request Clinical Records process, ensuring that you provide the applicable information from task (d) above to the Recovery Administrator to action the request to the GP.

PROCESS Request Clinical Records

a Determine if a decision can be made in the statutory timeframes. If not, you will need to extend the timeframes, please see the 'extend decision timeframe' process for more detail.

NOTE Go to 'extend cover decision timeframes' process

PROCESS Extend Cover Decision Timeframe

- b Contact client to confirm eligibility of claim using criteria set out in Mental injury Because of a Physical Injury Policy. Advise the client what information will need to be collected, including medical or clinical notes relating to all mental health records and all relevant GP records predating the injury by two to five years (or a longer period if there is a known mental health history over an extended period of time), and that this information will be shared with the selected provider who will be carrying out the required assessment once all information has been obtained. Advise that we also require client to complete the ACC4244 and ACC6300.
- C Generate the following client documents in EOS CVR13 letter, PSYIS02 form,ACC4244 form and ACC6300 form and send to client. (The CVR13 and ACC4244 will require editing to fit the claim type as these documents are use for both MICPI and WRMI claims). Set a task for 2 weeks time for follow-up of the return of this information.

- d Ask the lodging provider to complete an ACC4245 form and relevant medical records by creating a Purchase Approval for service code MEDR and utilising the CVR14 letter within the purchase order and attaching the ACC4245 form. Ensuring the CVR14 letter clearly advises the period of time we are requesting medical and mental health records for 2 or 5 years ,or more if applicable. An ACC6300 is not required to request this information from the lodging provider as the claim form signed by the GP and client is sufficient for this purpose. If you are requesting this information from a provider who is not the lodging provider, an ACC6300 form signed by client will be required. Set a task for 1 weeks time to follow-up on the return of this information.
 - ACC4245 Mental Injury Report
- e Search all electronic and physical claim files for information relevant to the mental injury investigation.

NOTE What information is relevant?

- · All information about the covered physical injury
- All psychiatric or psychological information in reports such as:
- pain assessment reports
- vocational information and assessments conducted by psychologists
- counselling reports
- information pertaining to any sensitive claims
- f Ensure all relevant documentation on any physical files is copied and scanned to the managed claim file but do not include any sensitive claim information on the physical injury claim.

4.0 Assess information received from Client and Provider

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Confirm the client ACC4244 is complete and the ACC6300 is signed by the client. If there is information missing from the ACC4244 form, call the client to obtain this information. Use the signed ACC6300 to request any additional information from any other providers that the client has advised of on the ACC4244.
- b Confirm the ACC4245 is complete and all medical records requested have been provided. If there is missing information, contact the provider to ask this be provided.

NOTE If all the relevant information is received from the client and all relevant providers, proceed to Arrange Mental Injury Assessment for Cover process.

PROCESS Arrange Mental Injury Assessment for Cover

5.0 Check the Mental Injury Assessment Report is of acceptable quality

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check that the report is clear, logical and complete.

NOTE What report checks should you complete?

- All sections of the report have been completed.
- · Client is considered competent to give consent.
- · Injury, client, and provider details are correct.
- · Diagnosis is clearly stated.
- There is a causal formulation that makes sense (ie an explanation for development of symptoms and causal link to injury event).
- There are clear, logical and practical treatment recommendations.
- b Check the assessor has considered whether there are any specific cultural issues that require attention or that may affect how the claim is handled, including diagnosis and treatment.
- C Check that there are no significant discrepancies in the information available.

NOTE What discrepancies should you check for?

Examples of significant discrepancies would include:

- Different diagnoses at different times,
- Different reports of the physical and/or mental symptoms experienced following the physical injury.
- Any symptom validity issues highlighted in the assessment report or elsewhere.

6.0 Determine if claim is complex

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine if the claim is complex.

NOTE What is a complex claim?

A complex claim is one in which:

- the claim has gone or is going to review
- the client is suicidal, dangerous, has significant conduct issues, has a forensic history of significant sexual or violent offences, and/or is currently in prison
- there are other mental injury claims on the client's record (eg mental injury caused by sexual abuse, mental injury caused by physical injury, work-related mental injury, or treatment injury mental injury); and/or
- there is a history of significant pre-existing or concurrent concerns with mental health or substance abuse, in addition to the purported mental injury.
- Clients in Prison Policy
- b Check that this is a single claim or has earlier claims all related to the same event with no other mental injury claims
- C Check that the assessor has made reference to the relevant background and collateral information.

NOTE If the claim is determined to be complex, address the details of the complexity in the ACC1517 form to be completed in step 8.0

7.0 Confirm causation

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Confirm that the assessor has stated that one or both of the diagnosed conditions was caused by the physical injury, or that the physical injury materially contributed to the development of the condition.

NOTE What if the assessor states that there is more than one cause of the mental injury? The physical injury needs to be one of the causes of the diagnosed disorders but does not need to be the only one. Terms such as 'causally contributed', 'materially contributed' are acceptable terms to indicate a causal link. NOTE What if the assessor indicates that the mental injury was caused by the event and not the physical injury or its consequences? The physical injury must represent at least one significant causative factor. If it appears that the injury was negligible and that the event was the cause of the mental injury, go to step 8.0

NOTE What if the diagnosis was post-traumatic stress disorder (PTSD)?

In the case of PTSD, to attract cover for mental injury caused by physical injury the physical injury need not be serious if the injury was also accompanied by the threat of serious injury or death. In some cases the physical injury may be minor but may be part of a causal nexus, for example post-traumatic stress disorder caused by the trauma of violent assault during which only a minor physical injury was sustained. In these cases the event (or its direct consequences) must be sufficiently traumatic in nature such that the combination of the event and injuries was sufficient to cause a mental injury.

Mental Injury Because of a Physical Injury Policy

NOTE What if the assessor says that the disorders were not caused by, but were 'exacerbated' or 'maintained' by the injury event?

Go to step 8.0

8.0 Complete ACC1517 and seek internal written guidance

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Generate the ACC1517 in EOS and complete this form based on the information on file and the information provided in the assessor's report. Make sure to indicate in the ACC1517 if you have identified any relevant points from steps 5, 6 and 7 of the process. LEAVE THE ACC1517 DOCUMENT STATUS AS 'INCOMPLETE' to allow the written guidance to be added to the document.

NOTE Who do I seek written guidance from?

Utilising the ACC1517 form, the Psychology Advisor provides written guidance for mental injury claims. The Psychology Advisor may also recommend seeking additional guidance from Technical Services or the Complex Mental Injury Panel. Consider the Delegations Framework when seeking guidance.

PROCESS Seek Internal Guidance

NOTE Recovery Team Members must also seek
Written Guidance from a Technical Specialist
in all cases (accept or decline) as per NGCM
Delegations

NGCM Delegations (Te Whāriki)

9.0 Accept cover for mental injury

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Add the accepted injury diagnosis to the claim, including any physical injury diagnosis that has been identified and has not already been accepted for cover.

NOTE What if a READ code is not specified for the accepted diagnosis?

Search for the Read code that matches the accepted diagnosis.

List of all the READ codes
https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&

b Issue the appropriate decision letter.

NOTE What decision letter do you use?

Go to the Issue Recovery Decision process and utilise letter CVR51 Claim approve - mental injury - client

PROCESS Issue Recovery Decision

10.0 Decline cover for mental injury

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a What if the mental injury is declined?

NOTE Issue decline cover decision utilising letter CVR999, using the appropriate option within the letter for the decline reason.

PROCESS Decline Claim

PROCESS Issue Recovery Decision

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS

Decline Claim

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

Make Cover Decisions for Work-Related Mental Injury Claims viso



Summary

Objective

To enable recovery team members to make cover decisions on some new claims for work-related mental injury without having to access Recovery Support/Clinical Services teams.

Background

A number of claims are referred to the Clinical Services team that do not need clinical advice. In future, it would be quicker for recovery team members to follow this process.

Owner

Out of scope

Out of scope

Procedure

1.0 Determine if another open claim exists in a Recovery Team

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Eos, check for any open claims.

NOTE How do you check there is an active ma-

The yellow indicator on the General Screen shows the client has an active managed claim.

NOTE What is there is an existing open managed claim?

Go to (NGCM) Match Claim to Recovery Team.

End of Process.

PROCESS Match Claim to Recovery Team

2.0 Check that eligibility criteria are met

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Check the relevant claim documents (eg ACC45, ACC18 (available to hospital/GP only), letter from GP or provider requesting cover for mental injury, ACC54 application form for Independence Allowance/Lump Sum), medical records and cover criteria policy to establish if the work-related mental injury criteria are met.
- **b** Call the client to discuss the eligibility criteria and to establish that all the relevant criteria within Step 2.0 have been clarified and considered to be met. If the eligibility criteria is met, continue your call with the client and go to Step 3.0 (b).
- Check if the claim is an Accredited Employer claim on the Accredited employers list (for work-related claims only).

NOTE What if the identified employer is an Accredited Employer?

Transfer the claim to the Accredited employer, unless the claim is for a motor vehicle accident event. If the claim is for a motor vehicle event, the claim is managed by ACC and not by the Accredited Employer.

PROCESS Identify and Transfer Work-Related Injury Claim to Accredited Employer (AE)

Accredited Employer List (Te Whāriki)
Transfer of an accredited employer claim Policy

Work-related mental injury policy

Mental Injury Policy

d Check that the work-related event occurred after 01/10/2008 or, if the event occurred prior to 01/10/2008, that the client first received treatment for the mental injury after 01/10/2008.

NOTE What if the client first received treatment for the mental injury prior to 01/10/2008?

The eligibility criteria may not be met. Go to Seek Internal Guidance from a Technical Specialist via Hotline guidance on Ext 50118

PROCESS Seek Internal Guidance

Check that the client was ordinarily resident in NZ at the time of the event.

NOTE What if the client was overseas at the time of the event?

If the event occurred overseas, but the client was ordinarily resident in NZ at the time, then the client may be eligible for work-related mental injury. Note that it is the date of the event, not the date of development of the mental injury, that is relevant to this criterion.

NOTE What does ordinarily resident mean?

A client is ordinarily resident in NZ if they were visiting or living abroad with the intention of returning to NZ within six months of departure, or working abroad for an NZ employer or the spouse or child of such a person with the intention of returning to NZ.

f Check that the client was at work at the time of the event.

NOTE What constitutes being 'at work'?

The client is considered to be at work if they were at the location of the event for the purpose of employment. This includes being at a place of employment during a break.

g Check that the client directly experienced a single event at work, or a series of events at work that arose from the same cause or together comprised a single incident.

NOTE What does 'directly experienced' mean?

The client must have been directly involved in or witnessed the event at close proximity. This excludes seeing the event on television or CCTV, reading about the event or seeing pictures in the media, or hearing the event or hearing about the event on the telephone from another person.

NOTE What constitutes a 'series of events'?

An example of a series of events would be when a police officer or soldier is exposed to several similar life-threatening situations over a short period of time (weeks or months, not years).

h Check that the event is something that would provoke extreme distress, horror or alarm in most people.

NOTE What kind of events would usually be expected to cause extreme distress, horror or alarm in most people?

The events that typically cause this response would be those outside of the normal range of human experience. Most people have very distressing life events such as bereavements, divorce, or financial stressors. Events that would provoke work-related mental injury include those in which there is exposure to actual or threatened death or serious injury, for example a train driver who witnesses the death of a member of the public who falls onto the track.

NOTE What if the claim does not appear to meet the eligibility criteria?

Go to Seek Internal Guidance process

PROCESS Seek Internal Guidance

3.0 Create relevant documents and investigate

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine if a decision can be made in the statutory timeframes.

NOTE What if the decision cannot be made in the statutory timeframes?

Go to 'extend cover decision timeframes' process

PROCESS Extend Cover Decision Time-

b Contact client to confirm eligibility of claim using criteria set out in Work-related mental injury policy. Advise the client what information will need to be collected, including medical or clinical notes relating to all mental health records and all relevant GP records pre-dating the injury by two to five years (or a longer period if there is a known mental health history over an extended period of time), and that this information will be shared with the selected provider who will be carrying out the required assessment once all information has been obtained. Advise the client that we will be asking the employer form information about the work place event and for copies of any incident or WorkSafe reports. Advise that we also require client to complete the ACC4244 and ACC6300.

Work-related mental injury policy

- C Generate the following client documents in EOS CVR13 letter, PSYIS02 form, ACC4244 form and ACC6300 form and send to client. (The CVR13 and ACC4244 will require editing to fit the claim type as these documents are use for both MICPI and WRMI claims). Set a task for 2 weeks time for follow-up of the return of this information.
- Contact the employer for information about the work place event utilising CVR15 Acknowledge witness work event claim employer letter, generated in EOS. This can be sent to the employer via email if the appropriate contact person and email address is known. This letter may require modification of the details of what we are requesting to suit each claim.

e Ask the lodging provider to complete an ACC4245 form and relevant medical records by creating a Purchase Approval for service code MEDR and utilising the CVR14 letter within the purchase order and attaching the ACC4245 form. Ensuring the CVR14 letter clearly advises the period of time we are requesting medical and mental health records for 2 or 5 years ,or more if applicable. An ACC6300 is not required to request this information from the lodging provider as the claim form signed by the GP and client is sufficient for this purpose. If you are requesting this information from a provider who is not the lodging provider, an ACC6300 form signed by client will be required. Set a task for 1 weeks time to follow-up on the return of this information.

ACC4245 Mental Injury Report

NOTE NGCM Request for clinical records. What if you are a Recovery Team Member?

Follow the Request Clinical Records process, ensuring that you provide the applicable information from task (e) above to the Recovery Administrator to action the request to the GP.

PROCESS Request Clinical Records

f Search all electronic and physical claim files for information relevant to the mental injury investigation.

NOTE What information is relevant?

- All information about the work event including information from the employer (CVR15)
- All psychiatric or psychological information in reports such as:
- pain assessment reports
- vocational information and assessments conducted by psychologists
- counselling reports
- information pertaining to any sensitive claims
- g Ensure all documentation relevant on any physical files is copied and scanned to the claim. Ensure the documentation does not include sensitive information.

4.0 Assess information received from Client, Provider and Employer

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Confirm the client ACC4244 is complete and the ACC6300 is signed by the client. If there is information missing from the ACC4244 form, call the client to obtain this information. Use the signed ACC6300 to request any additional information from any other providers that the client has advised of on the ACC4244.
- **b** Confirm the ACC4245 is complete and all medical records requested have been provided. If there is missing information, contact the provider to ask this be provided.
- C Confirm that the information received from the employer includes the following: Date of the event, the client's involvement in the event and any incident/investigative reports, WorkSafe reports or Police reports

NOTE If all the relevant information is received from the client, the employer and all relevant providers, proceed to Arrange Mental Injury Assessment for Cover process.

► PROCESS	Arrange Mental	Injury Assess
	ment for Cover	

5.0 Check the Mental Injury Assessment Report is of acceptable quality

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check that the report is clear, logical and complete.

NOTE What report checks should you complete?

- · All sections of the report have been completed.
- Client is considered competent to give consent.
- Injury, client, and provider details are correct.
- · Diagnosis is clearly stated.
- There is a causal formulation that makes sense (ie an explanation for development of symptoms and causal link to injury event).
- There are clear, logical and practical treatment recommendations.
- b Check the assessor has considered whether there are any specific cultural issues that require attention or that may affect how the claim is handled, including diagnosis and treatment.
- C Check that there are no significant discrepancies in the information available

NOTE What discrepancies should you check for?

Examples of significant discrepancies would include:

- · Different diagnoses at different times.
- Different reports of the physical and/or mental symptoms experienced following the physical injury.
- Áný symptom validity issues highlighted in the assessment report or elsewhere.

6.0 Determine if claim is complex

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine if the claim is complex.

NOTE What is a complex claim?

A complex claim is one in which:

- the claim has gone or is going to review
- the client is suicidal, dangerous, has significant conduct issues, has a forensic history of significant sexual or violent offences, and/or is currently in prison
- there are other mental injury claims on the client's record (eg mental injury caused by sexual abuse, mental injury caused by physical injury, work-related mental injury, or treatment injury mental injury); and/or
- there is a history of significant pre-existing or concurrent concerns with mental health or substance abuse, in addition to the purported mental injury
- Clients in Prison Policy
- b Check that this is a single claim or has earlier claims all related to the same event with no other mental injury claims.
- **c** Check that the assessor has made reference to the relevant background and collateral information.

NOTE If the claim is determined to be complex, address the details of the complexity in the ACC1517 form to be completed in step 8.0

7.0 Confirm causation

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Confirm that the assessor has stated that one or both of the diagnosed conditions was caused by the workplace event, or that the event materially contributed to the development of the condition.

NOTE What if the assessor states that there is more than one cause of the mental injury?

The workplace event needs to be one of the causes of the diagnosed disorders but does not need to be the only one. Terms such as 'causally contributed', 'materially contributed' are acceptable terms to indicate a causal link.

What if the assessor states that the disorders were not caused by, but were 'exacerbated' or 'maintained' by the workplace event?

Go to step 8.0

8.0 Complete ACC1517 and seek internal written guidance

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Generate the ACC1517 in EOS and complete this form based on the information on file and the information provided in the assessor's report. Make sure to indicate in the ACC1517 if you have identified any relevant points from steps 5, 6 and 7 of the process. LEAVE THE ACC1517 DOCUMENT STATUS AS 'INCOMPLETE' to allow the written guidance to be added to the document.

NOTE Who do I seek written guidance from?

Utilising the ACC1517 form, the Psychology Advisor provides written guidance for mental injury claims. The Psychology Advisor may also recommend seeking additional guidance from Technical Services or the Complex Mental Injury Panel. Consider the Delegations Framework when seeking guidance.

PROCESS Seek Internal Guidance

NOTE Recovery Team Members must also seek
Written Guidance from a Technical Specialist
in all cases (accept or decline) as per NGCM
Delegations

-	NGCM Delegations	(To Mhāriki
	NGCIVI DEIEGALIONS	(IE VVIIALIKI

9.0 Accept cover for work-related mental injury

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Add the accepted injury diagnosis to the claim, including any related physical injury diagnosis that has been identified and has not already been accepted for cover.

NOTE What if a READ code is not specified for the accepted diagnosis?

Search for the Read code that matches the accepted diagnosis.

- List of all the READ codes https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&
- **b** Confirm the date from which the person is to be regarded as suffering mental injury is the date on which the client first received treatment for the injury.

o m	accident Compensation Act (2001) Section 36: Date in which person is to be regarded as suffering nental injury	
	ttps://www.westlaw.co.nz/maf/wlnz/app/document?d	
	the appropriate decision letter.	
NOTE	What decision letter do you use? Go to the Issue Recovery Decision process and utilise letter CVR51 Claim approve - mental injury - client PROCESS Issue Recovery Decision	
Cover Addinator,	e cover for mental injury ssessor, Recovery Assistant, Recovery Coor- Recovery Partner	
	if the mental injury is declined?	
NOTE	Issue decline cover decision utilising letter CVR999, using the appropriate option within the letter for the decline reason.	
	PROCESS Decline Claim	
PROCES	S Decline Claim Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner	
PROCES	S Issue Recovery Decision Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner	

Mental injury Because of a Physical Injury Policy v11.0



Summary

Objective

Use this guidance to determine cover for a mental injury because of a physical injury.

Background

In order for a mental injury from physical injury to be covered by the Accident Compensation Act 2001 it must be a personal injury. There are three main criteria for determining whether a mental injury qualifies as a personal injury:

- there must be cover for the physical injury claim
- there must be a clinically significant mental condition
- the physical injury must be a material cause of the mental injury.

Owner

Out of scope

Expert

Out of scope

Policy

1.0 Mental injury without a covered physical injury

- a In most instances ACC does not provide cover for mental injury in situations where no physical injury is covered, eg:
 - a mental injury to a person witnessing a cal accident but who does not sustain physical injuries
 - mental injury to a mother learning of her child's death.
 However, there are some situations where ACC will provide cover for mental injuries not caused by a physical injury, eg:
 - mental injuries caused by an AC Act 2001, Schedule 3 sexual offence are covered, even if there are no physical injuries involved
 - work-related mental injuries caused by witnessing traumatic events are covered
 - mental injuries caused by a non-covered physical injury sustained in a treatment context.

Accident Compensation Act 2001, Schedule 3, Cover for mental injury caused by certain acts dealt with in Crimes Act 1961

http://www.legislation.govt.nz/act/public/2001/0049/lat

Treatment injury mental injury Policy

2.0 Mental injury because of a physical injury

a In most cases for the mental injury to have cover it must be caused by a physical injury, but the physical injury does not have to be the only cause of the mental injury.

In each case you must base your decision on the facts of the case and the mental injury assessment. In general, though, it should be clear from the mental injury assessment that the physical injury was a material cause of the mental injury. If you're unsure, contact Technical Services for assistance.

3.0 Criteria for assessing mental injury because of a physical injury

- a A cover decision for a mental injury because of a physical injury can often be considered 'simple' or 'complex'. The attached table shows the criteria for simple and complex mental injury because of physical injury decisions.
 - Criteria for assessing mental injury caused by physical injury (MICPI).PNG
 - Assessing a claim for mental injury

4.0 Traumatic injury circumstances

a With injuries involving particularly traumatic circumstances, such as serious motor vehicle accidents or violent assaults, it may not always be clear whether the mental injury is attributable to the physical injury, the accident or the surrounding circumstances. The mental injury may have resulted from a combination of those factors.

Even if the mental injury was sustained in traumatic circumstances ACC is able to cover a mental condition if the mental injury assessor advises that the physical injury was a material cause of the mental injury.

5.0 Special case: Post-traumatic stress disorder

- a For a physical injury to be considered a material cause of post-traumatic stress disorder and other related disorders (PTSD), it is reasonable to expect the physical injury to have been either:
 - serious
 - · accompanied by a threat of serious injury.

If the mental injury assessment report indicates the physical injury is a material cause of PTSD and other related disorders, it should reflect that the physical injury was serious or accompanied by threat of serious injury. Otherwise the report must include a detailed explanation of why the physical injury is considered a material cause.

The injury does not have to satisfy ACC's serious injury profiles to be regarded as serious for this purpose. The advice from the mental injury assessor is relevant to deciding whether the injury is serious as envisaged by the DSM IV multi axial criteria or one of the other diagnostic systems recognised by ACC in defining a clinically significant mental injury.

In general, ACC will consider a threat of serious injury to have been made in the circumstances set out in the attached table.

ш

consider a threat of serious injury table.PNG

If claims involve a physical injury that occurred some time ago and the possibility of a mental injury is only now being identified, any evidence of a threat of serious injury having been made should generally exist from the time of the physical injury.

Mental Injury Policy v8.0



Summary

Objective

To be covered under the Accident Compensation Act 2001 (AC Act) a mental injury must be both:

- a personal injury. See the AC Act 2001, Section 26
- · a clinically significant behavioural, cognitive or psychological dysfunction. See the AC Act 2001, Section 27.

Out of scope Owner **Expert**

Out of scope

Policy

1.0 Personal injury

- a The following types of mental injury fall within the definition of a personal injury:
 - mental injury caused by physical injury
 - · mental injury caused by certain criminal acts
 - work-related mental injury.

2.0 Clinically significant

- a For ACC to accept that a mental injury is "clinically significant" it will usually:
- b be diagnosed using one or more of the following standardised systems:
 - · Diagnostic and statistical manual of mental disorders fourth edition - text revision (DSM-IV-TR)
 - Diagnostic and statistical manual of mental disorders fifth edition (DSM-5)
 - See DSM-IV-TR to DSM-5 for a summary of the differences between the two editions
 - · International classification of diseases 10th Revision (ICD-10)
 - Psychódynamic diagnostic manual (PDM)
 - Diagnostic classification of mental health and developmental disorders of infancy and early childhood - Revised (DC:0-3R)
 - Mental health definitions DSM-IV-TR to DSM-5
- be diagnosed by a mental injury assessor who has:
 - a qualification which meets at least level 8 (postgraduate) of a New Zealand Qualifications Authority (NZQA) recognised course or its equivalent, with a focus
 - assessment, classification and formulation in psychopathology
 - abnormal psychology
 - skills in using two or more models of therapeutic inter-
 - the consequences of: sexual abuse/assault; and/or physical injury; and/or workplace trauma
 - the use of psychometric tools (if using psychometrics)
 - · a minimum of two years' full-time equivalent postgraduate supervised clinical experience in one or more of the areas of mental injury covered by ACC
 - met the supervision requirements of the professional bodies to which they belong
 - · met the cultural competency requirements of the professional bodies to which they belong.

d There are some circumstances under which a mental injury will not be diagnosed using one of the above standardised systems. In these circumstances, the assessor must evidence that the mental injury is nevertheless a 'clinically significant behavioural, cognitive or psychological dysfunction'.

3.0 Mental consequences

a Under the 1972 and 1982 AC Acts, ACC provided cover for the physical and mental consequences of an injury or the accident.

See:

- AC Act 1972, Section 2
- AC Act 1982, Section 2.

(If a person has cover for physical injuries under the 1972/82 Acts, it's not always clear whether ACC should treat a subsequent claim as one for 'mental injury' under the AC Act 2001, or for 'mental consequences' under the 1972/1982 Acts. If clarification is needed, contact Legal Services.)

Legal Services

AC Act 1972, Section 2

https://www.westlaw.co.nz/maf/wlnz/app/document?d

AC Act 1982, Section 2

https://www.westlaw.co.nz/maf/wlnz/app/document?d

Mental injuries to clients under 16

Children under the age of 16 are not eligible to have the impairment effects of a mental injury assessed, for lump sum only, unless there are compelling reasons. This is because long-term mental impairment effects cannot be accurately established.

See the AC Act 2001 Schedule 1, Part 3, Clause 57.

AC Act 2001 Schedule 1, Part 3, Clause 57
https://www.westlaw.co.nz/maf/wlnz/app/document?d

5.0 Mental injury assessments

- a A mental injury assessment must be carried out by a qualified assessor. See the AC Act 2001 Schedule 1, Part 3, Clause 58. ACC can ask clients to undergo assessments
 - AC Act 2001 Schedule 1, Part 3, Clause 58 https://www.westlaw.co.nz/maf/wlnz/app/document?d

6.0 Deciding apportionment for lump sum or independence allowance for mental injury

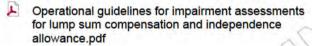
- a So that we can determine the amount of a lump sum or independence allowance, we consider the recommendations of a qualified assessor about what proportion of a client's mental injury is:
 - · related to conditions covered by ACC
 - · not related to conditions covered by ACC.

The assessor deducts any impairment that they think has not resulted from the covered injury from the whole of the person's impairment, which leaves the portion that is used to calculate the amount of support. This is known as apportionment.

For a client to be eligible, at least 10% of their impairment must be claim-related.

Resources for determining apportionment are the:

- Operational guidelines for impairment assessments for lump sum compensation and independence allowance
- ACC User Handbook to the AMA Guide to the Evaluation of Permanent Impairment 4th edition.



Monitor Cover Decision Timeframes :: Held Claim vs.0



Summary

Objective

To monitor held claims and, if necessary, take action to make sure a cover decision is made within legislated timeframes.

This process applies to the Lodgement and Triage team only.

Background

ACC operates under strict legislative timeframes for making cover decisions. If we don't meet these timeframes, a client's cover decision is deemed in their favour under the AC Act 2001, Section 58. These timeframes vary depending on the type of injury. The lodgement and triage function monitors claims that don't yet have a cover decision to make sure a decision is made before the deadline.

Owner

Out of scope

Out of scope

Procedure

1.0 Access data

Cover Assessor, Lodgement Administrator

a Review the Policy information below about cover time-frames and deemed decisions (if necessary).

Deemed cover decisions when timeframes not met Policy

Timeframes to determine cover Policy

b Access the relevant data in InFact. See the guides below.

Held Claims Report prepare data
Held Claims Report save settings

2.0 Identify relevant claims

Cover Assessor, Lodgement Administrator

a In the Department Queue(s) list accessed in Step 1.a, pull a list of the claims you need to investigate.

- Ignore the claims that are 10 days or more away from the decision required date.

b In the Actioned Cases list accessed in Step 1.a, pull a list of the claims you need to investigate.

- Ignore the claims over 2000 days old - these are broken.

- Ignore the returned AE claims with a Held cover status.

3.0 Initiate claim action - department queues

Cover Assessor, Lodgement Administrator

a In the Department Queue(s) list pulled in Step 2.0, open the claim in Eos that's closest to having a deemed decision and confirm that the appropriate action has already been taken on the claim.

NOTE What do I do to see if action has been taken?

- whether the task description has been updated.
- the Contacts tab.
- the Documents tab.

NOTE What do I do if no action has been taken on the claim?

Go to task b.

NOTE What do I do if there's a task due after the date a decision would be deemed?

Go to task b.

NOTE What do I do if there's a task due before the date a decision would be deemed?

No action is required. Go to task d.

b If you have the expertise to make a cover decision, allocate the claim to yourself.

NOTE What if I don't have the right expertise?

Talk to a leader or manager.

- C Make a cover decision. Go to the Assess Claim for Cover process below to do this.
- d Repeat steps a-c until all identified claims in the Department Queue(s) list have been checked.

PROCESS

Assess Claim for Cover :: PICBA

Cover Assessor, Lodgement Administrator

LO Initiate claim action - actioned cases queue
Cover Assessor, Lodgement Administrator, Senior
Cover Assessor

a In the Actioned Cases list pulled in Step 2.0, open the claim in Eos that's closest to having a deemed decision and confirm that the appropriate action has already been taken on the claim.

NOTE What do I do to see if action has been taken?

- whether the task description has been updated.
- the Contacts tab.
- the Documents tab.

NOTE What do I do if action has already been taken on the claim, but has no task?

Email the person who transferred the claim to actioned cases and let them know to create a task for when the decision is due. Go to task d.

NOTE What do I do if there's an appropriate task on the claim?

Email the person who transferred the claim to actioned cases to let them know they need to move the claim out of the Actioned Cases queue. Go to task d.

NOTE What do I do if the claim hasn't been allocated to anyone?

Go to task b.

b If you have the expertise to make a cover decision, allocate the claim to yourself.

NOTE What if I don't have the right expertise?

Talk to a leader or manager.

- C Make a cover decision. Go to the Assess Claim for Cover process below to do this
- **d** Repeat steps a-c until all identified claims in the Actioned Cases list have been checked.

► PROCESS

Assess Claim for Cover :: PICBA

Cover Assessor, Lodgement Administrator

Provide Internal Guidance - Written value



Summary

Objective

To provide guidance to frontline staff via a Written Guidance eForm in Salesforce or Eos.

Background

Written Guidance is available for any of the following areas:

- Clinical Services
- Technical Services

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Triage and Allocate requests for Written Guidance

Senior Triage and Workflow Coordinator

a In Salesforce, select the next 'Triage Written Guidance request' task in the 'Triage Clinical Services' queue or 'Triage Technical Services' queue.

If you are a Clinical Senior Triage and Workflow Coordinator or a Technical Specialist, ensure you put the task into your name.

NOTE For additional information about the Written guidance process refer to the FAQ document below.

Recovery Support FAQs.docx

NOTE What if you are working out of an Eos queue?

Depending on the business unit who sent the task, allocate this to an appropriate Clinical or Technical staff member in Eos.

NOTE What if the description field for a High priority request says **REHAB HIGH PRIORITY REFERRAL**

These requests are sent through as High Priority, but guidance for these requests need to be prioritized over other high priority requests. Ensure you Triage and allocate these high priority tasks over the other high priority tasks.

- b Open Eos by selecting [Launch Eos claim]. Ensure you keep this screen open when you complete the next step in the process.
- Select [Assign or Clarify Guidance] to review the details of the request and determine if there is enough information to pass the request to an advisor or department queue.

You need to review the documents tab or document groups sub-tab, to ensure there is sufficient information on file for a written guidance request - refer to the decision tree written guidance slides for information on this.

If you determine that you cannot successfully allocate this task, close out of the Assign or Clarify guidance tab, go back to the task, and change to ownership of the task back to the Triage queue.

Recovery Support Decision Tree

NOTE What if there is not enough information and clarification is required?

For minor clarification, attempt to contact the requestor directly via call or IM. The requesting staff member will then updated the relevant information on the Guidance Request by selecting [Add additional Information to a Guidance Request].

For major clarification, or if minor clarification attempt was unsuccessful, select [Request Clarification] while in the Triage Written Guidance request task.

If there already appears to be a guidance request on file that is addressing the requestor's query, send the request back for clarification and determine if the guidance transcript uploaded on XX/YY/ZZZZ addresses their query.

NOTE What if you get a written guidance request from a Surgery or Additional Treatment staff member with the description TACDUN?

Allocate this request to one of the appropriate clinical advisors who can provide guidance on these queries.

NOTE What if you need to reassign a task to another Advisor or Specialist?

Check the tick box in the relevant queue, and transfer it by selecting [Change Owner]. This can also be done for multiple tasks.

This can also be done directly from the task, by Selecting [Change owner] from the 'Provide Written Guidance' task and entering the appropriate owner/department queue.

NOTE What if you get a written guidance request for a Mental injury claim or disentitlement for a Wilfully Self-inflicted (WSI) or suicide claim?

These requests must be sent to a Psychology Advisor.

If the claim is a Treatment Injury Mental Injury claim (TIMI), or Work Related Gradual Mental Injury claim (WRMI) then a ACC1517 or ACC6178 form must be filled out as these claims must be referred to the Complex Mental Injury Panel via a Psychology Advisor.

NOTE What if a written guidance request needs to be returned to the requesting staff member due to the HASTEN initiative?

- 1. Select [Return Request Due to HASTEN Initiative] and provide a reason for this.
- 2. The HASTEN initiative has been implemented to unnecessary written clinical advice requests that can be more appropriately answered with Promapp "self service" knowledge products, seeking advice from Team Leader and/or Practice Mentor channels.
- 3. When you receive written guidance requests from frontline staff, and you are aware of self service content that is available to answer their query, or if the query is better suited for a Team Leader, or Practice Mentor, ensure you provide this information to the requestor.

d Assign the task to the relevant staff member or queue. If you need to add any particular details to the request, enter this into the description field of the task once its been assigned. Refer to the relevant Triage salesforce report, to confirm how many tasks each advisor has in their queue.

NOTE What if the request for guidance is on a 'ACC5971 - Elective Surgery Information Summary and Clinical Comment' form?

Copy the text in the description, transfer the task to the appropriate Surgery PCA, then paste the information back into the description field.

If the Surgical PCA does not use Salesforce, you will need to email the document group created by the requestor directly to the PCA.

Once you receive the PCA's guidance back and they have confirmed it is ready for the requestor to review, ensure the guidance is in the ACC5971.

Go into the PCA's personal queue, and close the task by selecting 'Provide Guidance'. Enter in the qualifications box: "Refer to comment by [Insert advisors name and qualification] on ACC5971". Then paste this information into the mandatory boxes below this one.

If the requestor asks for clarification, you will need to re-allocate the clarification request to the PCA's personal queue, then email the clarification request to the PCA directly (You can do this by copying and pasting the clarification question from the screen after you select 'Assign or clarify guidance').

NOTE (Technical Services) What if you need to add an additional category and sub-category to the written guidance request you have allocated?

Refer to the document below, then add the relevant information into the task description in salesforce

Written Guidance categories and timeframes

2.0 Provide Written Guidance

Clinical Team Member, Technical Team Member

a In Salesforce, select the next task in either 'My Assigned Tasks - Recovery Support', or the applicable department queue to your role. Review the provide written guidance task, then select [Provide or Clarify Guidance].

NOTE For additional information about the Written guidance process refer to the FAQ document below.

Recovery Support FAQs.docx

NOTE What if the description field for a High priority request says **REHAB HIGH PRIORITY REFERRAL**

These requests are sent through as High Priority, but guidance for these requests need to be prioritized over other high priority requests. Ensure you action these high priority tasks over the other high priority tasks.

NOTE What if you are picking up a task from a shared queue?

When you select [Provide or Clarify Guidance], the task will automatically go into your name. You can still change the ownership of the task by selecting [Change Owner], but this is not required.

NOTE What if you are picking up a task from an Eos queue?

If you are receiving a request for written guidance via Eos, you will need to complete the guidance in Eos.

There are a number of teams who will not be requesting guidance via Salesforce i.e: Remote claims, Review requests, TPA and Technical Accounting

NOTE What if you need to transfer the task to a new owner?

Check the tick box in the relevant queue, and transfer it by selecting [Change Owner]. This can also be done for multiple tasks.

This can also be done directly from the task, by Selecting [Change owner] from the 'Provide Written Guidance' task and entering the appropriate owner/department queue.

NOTE What if you are a Clinical Advisor and you have received a request regarding Surgical guidance via the

clinicaladvisorsurgery@acc.co.nz inbox?

- 1. These requests come via the Surgery and Additional Treatment team at ACC. Ensure you document this as a record of hotline guidance in salesforce.
- 2. If you believe this query needs to be sent as a written guidance request inform the requestor and ask them to re-submit the request.
- 3. Advise the requestor to use the decision tree tool when trying to determine whether or not to send requests via the above email address vs the written guidance form in salesforce.

NOTE What if you get a written guidance request for a Mental injury claim or disentitlement for a Wilfully Self-inflicted (WSI) or suicide claim?

Guidance must be provided by a Psychology advisor, and may need to go to the Complex Mental Injury Panel. Refer to the document below to determine what claims need to go to the Panel, and what the referral process is.

CMIP process for Advisors and Specialists

NOTE What if you are a Surgical PCA and you have a request for written guidance?

- 1. Complete the above step, and refer to the relevant claim documents located in the document group called 'Surgery PCA referral.'
- 2. Send your guidance to the Clinical Triage team
- 3. Transfer the owner of the task back to 'Triage Clinical Services queue.' (You need to select the drop down option in the 'Change Owner' pop up box, and change from 'Users' to 'Queues', in order to do this).

The process ends here.

b Select the previous tab in Salesforce to launch the client's Eos claim, using the [Launch Eos claim] button.

c Determine if you have all the relevant information to provide Written Guidance. Then, enter your Qualifications, Analysis and Recommendations into the relevant fields in the eform or ACC document, to complete your guidance.

NOTE What if there is not enough information and clarification is required?

For minor clarification, contact the requestor directly via call or IM.

If required, the requesting staff member will then update the relevant information on the Guidance Request by selecting [Add additional Information to a Guidance Request].

For major clarification, select [Clarification Required] then specify what you need from the requestor in the 'Clarification Questions' free text box.

NOTE What if the guidance request is related to a decision making authority?

For Technical services: Ensure you select the tick box at the bottom of the Written Guidance form labelled 'Decision making authority'

If the request is relevant to a shared delegation, ensure you have discussed the decision with the clinical staff member.

If the delegation requires a higher level decision making authority, contact the relevant person requesting them to add their comment onto the client's file, then ensure they have contacted you to confirm this is completed.

If the delegation sits with Clinical, ensure you specify this in your clinical summary. For information on delegations, refer to the spreadsheet below.

Delegations Framework

NOTE What if you need to save a draft of your guidance request to complete later?

At the bottom of the written guidance form select the tick box labelled [Save as Draft] then click [Next]

When you are ready to complete your guidance request, go back to the written guidance request in salesforce and select [Edit Written Guidance], to complete your guidance.

NOTE What if the requestor has cancelled the request for written guidance?

You will receive a notification via the bell icon on the top right hand corner of the screen. If this is the case, close out of the guidance request and move onto another task.

NOTE What if the requestors query is located in an ACC document (eg ACC1517 Determining cover for a mental injury claim)?

Before selecting [Provide or Clarify Guidance], Select [Launch EOS Claim] and enter your guidance into the document stated in the request.

Then in Salesforce, select [Provide or Clarify Guidance] and complete the written guidance form and in your recommendations enter "Guidance provided in ACC form (Specify the document)".

NOTE What if additional advice is required from another team/advisor or specialist?

Select [Yes], when presented with this question, then select the relevant role and add your comments.

NOTE What if you are considering referring the client for a Medical Case Review?

Before providing your recommendation, refer to the documents below

Recovery Support to Determine Need for a Medical Case Review (MCR)

MCR Quick Reference - Question Selection

NOTE What if you want to seek advice from Legal services?

Refer to the Legal services team space below

Legal Services team space

NOTE What if you need to add images to support your analysis?

Images can be inserted into the guidance you provide in Salesforce. For information on what images are supported and how to ensure they display correctly, please refer to the document 'Adding images in Salesforce' below.

Adding images in Salesforce

NOTE What if you have entered incorrect information into the guidance you've provided?

Please make sure to review the guidance you provide before submitting as there is no way to remove once it has been saved and sent through to the next team and/or requester.

Where the guidance has been submitted and you've included the incorrect client details, you will need to request that the front line team cancel the request and submit a new one.

3.0 Provide and Review feedback

Clinical Team Member, Technical Team Member

a If applicable, provide feedback on the guidance request.

NOTE How do you provide feedback on the guidance request?

Once you have submitted your guidance, you will be given the option to provide feedback on the guidance request. If you want to provide feedback, select this option and complete the mandatory fields.

b If applicable, review feedback on the guidance provided.

NOTE What if you want to review some feedback you have received?

You will be notified you have received feedback by getting an alert notification from the "bell" icon in Salesforce. If you select this you will be able to review the feedback.

Alternatively, if you select the nine dots in the top left corner of the Salesforce window, and search for "Feedback", you can select this Feedback option.

From here you can select the drop down arrow to show different list views which display feedback from a range of dates.

NOTE What if you are a Team Leader and you want to subscribe to a feedback report?

Complete the steps below in Salesforce:

- Open the new report Folder "Feedback Reports"
- Open the new report "My Team's Feedback Last 7 days"
- Click the down arrow at the top right of the report and select subscribe
- Schedule when you want the report subscription email e.g. 9am on a Monday every week. Confirm recipient being added and run report as = "Me"
- Result will be an email to your inbox at that time/day, with a link to the report in Salesforce
- Last step will be to use the Team Leader filter, to narrow the results to your team members i.e. use the name your Salesforce user is set up with

Request Clinical Records v87.0



Summary

Objective

To request medical or clinical records from a client's vendor, so that we have enough information to make a cover, support or treatment decision.

Background

ACC must request medical or clinical records from a client's vendor if we don't already have enough information to make a cover, support or treatment decision. ACC can ask external vendors, including General Practitioners (GPs), District Health Boards (DHBs) and specific treatment vendors (such as physiotherapists or chiropractors) to provide ACC with medical or clinical records related to the case.

Client medical or clinical records help in a range of situations. They:

- · help inform cover, support or treatment decisions
- provide further information about the injury, client and diagnosis
- · help develop the rehabilitation plan
- · help identify and manage any risks.

Each time we request information about a client or a claim, the client should be aware of the request and why we need the information.

Owner

Out of scope

Out of scope

Procedure

PROCESS

Create or Update Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS

Arrange Medical Case Review (MCR) Assessment

Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS

Seek Internal Guidance

Clinical Advisor, Practice Mentor, Technical Specialist

1.0 Determine requirement for clinical records Recovery Assistant, Recovery Coordinator, Recovery

Check the claim for information already on the claim,

- before proceeding.
- b Determine what type of medical or clinical records you need to obtain by referring to the links below.
 - Best Practice Guidelines for requesting medical notes
 - Request medical or clinical records Policy
 - Summary of the Health Information Privacy Code Policy
 - Personal Information Requests Policy

NOTE What if you require notes from Oranga Tamariki?

The process for this is scheduled to be written into Promapp as part of a larger piece of work. In the interim, use the following document.

Oranga Tamariki Clinical Notes

NOTE What if you need to request records from New Zealand Police?

Only collect information from the Police where that information is necessary for the management of the claim (e.g. to make a cover decision or to provide appropriate treatment/rehab etc)

Only collect information from the Police after discussing the request with the client. Ensure all actions below have been completed first before proceeding with the request:

- A clear contact note is on file outlining the reasons for the request
- We have the client's permission to request this information
- A signed ACC6300 is either linked to the task or the recovery team member has advised where to find this form on the claim.

Note: The ACC6300 Authority to collect medical and other records form alone is not sufficient, as it does not mention the Police and most people would not assume that it would be used for this purpose.

If you are unsure whether you should be requesting information from the Police or how to handle that information once received, contact the Privacy Team via email privacy.officer@acc.co.nz or on their hotline number 46464.

New Zealand Police - Request for Official Information

NOTE What if you need clinical or medical records from a DHB?

Check if the reason for requesting the records aligns with one or more of the scenarios for requesting District Health Board (DHB) clinical records

Scenarios for requesting District Health Board clinical records - Reference

NOTE What if the information request is for a prison facility

you will need to know the current/last facility the client was held.

you must contact them first to confirm they hold the records and confirm the vendor number and email address to send the information request then follow the GP request

NOTE What if you need to obtain Specialist records or High Tech imaging?

Specialist notes or High Tech Imaging contracts require them to send through their reports within 5 working days of the patient consultation. Only submit a request for these records if it has been more than 5 working days and they have not been received. A Purchase Order is not required for these requests.

NOTE What are the timeframes for receiving information?

If you are requesting information from a DHB, the timeframe is:

- non-urgent request 21 working days
- urgent request 6 working days

If you are requesting information from a non-DHB (GP, Medical Centre), the timeframe is:

- non-urgent request 11 working days
- urgent request 6 working days
- c In Eos, in the Consent tab of the Recovery Plan, check if the client has provided authority to collect medical and other records from third parties or has an ATA in place.

NOTE What if there is no authority on the client's claim, or the authority has expired?

Refer to the NG GUIDELINES Obtain Verbal or Written Authority for guidance.

If an ACC6300 is needed, Go to the Obtain Client Authority to Collect Information process.

PROCESS Obtain Client Authority to Collect Information

NG GUIDELINES Obtain Verbal or Written Authority

NOTE What if you need notes older than 5 years and there are multiple claims for the client?

At least one claim must have a signed Authority to Collect information (ACC6300) within the current year. Discuss with the client if you need to request information not already on file. Document their verbal authority.

NOTE What if you are requesting Mental Health notes?

Before requesting Mental Health notes a signed ACC6300 Authority to collect information must be on the file.

NOTE What if you need notes where a client has an active claim, but you require notes for other claims for the same client that are inactive?

Check the other claims for information before proceeding to request information.

Request for notes on Multiple claims, but to one provider, Task on active claim noting all claim numbers

Request for notes on previous claims:
The task should be created on the active claim (if no active claim, task on the claim you need) in the task, note which claim number you need clinical notes for and add the vendor as a participant

d Check that the client has been seen by the Vendor you are requesting records from for this injury/claim.

on claim

NOTE What if the Provider is under contract?

To check to see if a Provider is under contract, search via MFP, if under contract a purchase order is not required. When completing the eform, in the 'Purchase Order Number required' drop down box, select 'No'.

NOTE What if the client has been seen by (including but not limited to) a Specialist or Surgeon at a Private Hospital?

Contact the Specialists rooms to confirm where this request should be sent. Eg. Private Hospital or Specialists rooms. Add the specialist name to the request for information.

NOTE What if the claim is for a client with a Mental Injury?

If you are requesting mental health records from any of the following providers, you must contact them first to confirm they hold the records and confirm the email address to send the information request:

 GP records - Please confirm the name of the Doctor they saw. If there are multiple names, preferably

list the most recent one. If the Doctor is a locum of the Practice, please provide a name of someone

who is registered at the practice. The request will be made under their name instead.

- Physiotherapist or Allied Health providers Specialist or other records
- Mental Health Services or programmes which could be funded through Primary Health Organisations or Non-Governmental Organisations Ensure a contact action is used to record this conversation.

If the email address provided has not been verified, go to Verify Provider and Vendor email addresses then return to this process.

DHB's and Oranga Tamariki are the exception to this as we are not able to verbally confirm that they hold information. If requesting from a DHB, follow the usual process. If requesting from Oranga Tamariki, see note above under 1.0b.

e in Eos, check the correct Vendor is entered as a participant on the claim.

NOTE What if the Vendor hasn't been added as a participant?

Add the Vendor as a participant to the claim

NOTE What if the provider has not been set up as a Vendor?

In MFP, confirm the provider is not a Vendor. Contact the Vendor to confirm they hold the records and confirm the email address, physical address and contact phone number for follow-up In the task to Recovery Administration - note the use of Vendor ACC Default J99966 & above information

11	Particinant
IVIANAGE	Participant

- f In Eos, add a NGCM Information Requests activity and complete as per the Requesting Clinical Records system steps
 - Requesting Clinical Records
- **g** Complete the eform with all the relevant information and instructions for Recovery Admin to action.

NOTE What if the information request is for a GP Practice?

Please indicate the name of the Doctor they saw. If there are multiple names, preferably list the most recent one.

If the Doctor is a locum of the Practice, please provide a name of someone who is registered at the practice. The request will be made under their name instead.

NOTE What if the information request relates to notes needed to make a cover decision?

Edit the task and change the priority to 'High'.

NOTE What if the claim is for Mental Injury but requesting notes for physical injuries only

When creating your task, add title in task description PHYSICAL INJURY NOTES ONLY, not in the request Eform - then complete the eform with all the relevant information and instructions for Recovery Admin to action. Include: List the diagnoses that you would like notes on and the name of the most recent Doctor who treated them at the facility. If the ACC45 has sensitive material, we will need to have a current ACC6300 to proceed.

NOTE What information do you need to include in the information request task?

Refer to the 'Referring Tasks to Recovery Administration - Principles'. Ensure you record all claims numbers you are requesting notes on if requesting notes on more than one claim.

Referring Tasks to Recovery Administration - Principles

NOTE What if the request for clinical notes is from a DHB?

Refer to 'Contacts for requesting District Health Board clinical records' to locate who to request the information from and add the DHB as a participant using the correct vendor code.

Contacts for requesting District Health Board clinical records

NOTE What if the request is for hard materials?

Clearly state in the task description "Hard materials [type of material] required from [provider] to be sent to [your address]".

NOTE What if you are requesting medical notes for multiple claims from the same vendor?

Note the following in the task:

- · Specific "from" and "to" dates.
- If you are requesting additional notes for a claim from the same vendor, to avoid duplication check the from and to dates on the previous request.

For example: 1st request for medical information "from" date is 21/06/2019 to 21/08/2019 (Present date in which the purchase order was created). Next request will go "from" 21/08/2019 "to" 21/10/2019.

NOTE What if the Vendor is a DHB?

In the NGCM - Information Request, note that the client's ACC6300 needs to be sent with the request.

NOTE What if you are requesting information prior to seeking internal guidance or information has been requested by an advisor?

Request the additional information using the Request Clinical Records process above. Then extend the target date of the clarification task to later than the due date of the medical notes task. Ensure you update the clarification task description to reflect you have requested additional information.

h Add a note in the Recovery Plan, under the appropriate Life Area recording the reason for the information request.

NOTE What if you're a Cover Assessor?

Edit the 'Confirm Cover Decision' task and add the details to record the request for information.

2.0 Review request for clinical records

Recovery Administrator

- a Upon allocation of the 'NGCM Requested Information' task in Salesforce, open the associated task in Eos and select [Do Task] from your task queue.
- **b** Review the task to check Recovery Team member has provided the name of the Vendor.

NOTE What if the information needed is from overseas?

Refer to the Making an overseas payment link below for more information.

Making an overseas payment http://thesauce/team-spaces/chips/compensation/wee

NOTE What if the name of the Vendor hasn't been provided in the task?

The Vendor details should be included in the task. If the details are missing, contact the requestor for the information and ask them to add as a Participant on the claim.

NOTE What if the vendor has not been added as a Participant on the claim?

The Recovery Team member should be adding the vendor as the Participant on the claim. but if this has not been completed, contact the Recovery Team Member asking them to add the Vendor as a participant before creating the purchase order

NOTE What if the vendor is noted as Vendor ACC Default J99966?

Some records may be requested from Vendors who are not set up as an ACC Provider. In this case, the Vendor Default of J99966 is used. edit the letter: remove the ACC address and add vendor name and address copy and paste from the task

NOTE What if the request is for medical notes for multiple claims?

When requesting notes on Multiple claims, but to one provider, the Purchase Order is created on the active claim; all claims numbers should be listed in the letter.

Request for notes on previous claims: When requesting notes on a previous claim, the task should be received on an active claim which notes the claim number the notes are needed for. Purchase Order and request letter should be completed on the previous claim number. Close the request task- this will create a follow up task, edit this follow up task with the previous claim number the Purchase Order was created on.

c Check the task to determine if you need to generate a Purchase Order.

NOTE What if you don't need to create a Purchase

Go to Activity 4.0 (d) Create and send request.

d Identify the vendor type for the information request.

NOTE What if the information request is for GP records?

Go to Activity 3.0.

NOTE What if the information request is for DHB records?

Go to Activity 3.1.

NOTE What if the information request is for Physio-NOTE What information do you need to create the therapy records? **Purchase Order?** Go to Activity 3.2. Choose the appropriate Entitlement Code or a combination of codes: NOTE What if the information request is for Spe-MEDR – (is an hourly rate for the time taken by cialist records? the Medical Practitioner to prepare and review Go to Activity 3.3. the medical notes). COPY - (is the cost for practice admin staff to **NOTE** What if the request is for Oranga Tamariki? photocopy and prepare existing medical notes use the following document below. Use SCU05 that may be paper based). template enclosed in the Request Oranga Tamariki Notes. *If you mark the request as 'Urgent', provide the Oranga Tamariki Clinical Notes reason. NOTE What if the request is for hard materials? After selecting the Entitlement code(s), proceed If the request is for hard materials (ie tooth as follows: sample), include the address of the staff member 1) Rehab Action / Claim: Treatment (Search) requesting it in the "How to send the requested 2) Tick the 'Medical Notes/Reports - Tmt (Quick information" section of the letter. **NOTE** What if the request is for New Zealand Police 3) Quantity Approved: MEDR - 1, COPY - up to max of 30 Use the document below. Ensure all actions 4) Frequency: Quarter below have been completed first before pro-5) Create PO ceeding with the request: 6) Purchase Method: Non-Contracted. · A clear contact note is on file outlining the reasons for the request If there are questions for the GP vendor, select • We have the client's permission to request this the 'MD02a GP - Further info - Medical Notes information Vendor' letter. In this case, select 'In total' as the A signed ACC6300 is either linked to the task or [Frequency] when raising the PO, this will ensure the recovery team member has advised where to the document template populates the right quanfind this form on the claim. tity. Alternatively, manually amend the template to change quantity from 0 to 1. This should be completed by the recovery team member before proceeding with the request. Approve the Purchase Order. New Zealand Police - Request for Official Infor-What if you get a Limited Payment error message when authorising the Purchase Order? If you have received a request to amend a Pur-NOTE What if the information request is for Treatment Injury claim? chase Order or create a Purchase Order for Check the cover status on the General tab and client reimbursements, change the limited payment indicator. Claim Type, eg Cover Status - Accept, Claim Type Treatment Injury - ticked 1) In Eos, go to the 'Validations' tab, select 'Edit' If Treatment Injury ticked and Held Claim, follow and update the Limited Payment List Indicator to Request Clinical Records for Treatment Injury -'No'. 2) Select 'OK'. linked below 3) Go back to the Purchase Order to authorise. If Treatment Injury ticked and accept follow 2.0 d Once you have authorised the Purchase Order Request Clinical Records for Treatment Injury and notified the vendor remember to change the Limited Payment List Indicator to 'Yes'. d Any mention of sexual abuse or sensitive claims needs to 3.0 Request GP records be changed to "Mental Injury" Recovery Administrator e Generate the MD01a GP - Further Info - Medical Notes -Can I request Clinical Records electronically Vendor letter by selecting 'add documents'. via SureMed? ACC's preferred method for requesting Clinical Admin Template - MD01a GP Further Info - Medical Records from GP's is electronically through the Notes - Vendor SureMed portal. If needed you can still request NOTE What if the request relates to a Mental Injury Clinical Records manually by continuing with this claim? process. Refer to the admin template for what needs to be PROCESS Request GP Clinical Records updated in the MD01a letter. SureMed MD01a GP Further Info Medical Notes - Vendor a View the [Add Info] tab in the task. Mental Injury Template b Create the Purchase Order. NOTE What if the request is urgent? Creating purchase orders using general + QE Update the sentence under the 'How to invoice ACC' with the following: 'Please forward the requested reporting within 5

When emailing add URGENT to the email sub-

ject line.

NOTE What if there are questions to be included in What if you get a Limited Payment error mesthe information request? sage when authorising the Purchase Order? Generate the 'MD02a GP - Further info - Medical If you have received a request to amend a Purchase Order or create a Purchase Order for Notes - Vendor' letter. client reimbursements, change the limited pay-Admin Template - MD02a GP Further info - Medical ment indicator. Reports - Vendor 1) In Eos, go to the 'Validations' tab, select 'Edit' NOTE What if the claim is for Mental Injury but requesting notes for physical injuries only and update the Limited Payment List Indicator to Follow the task template for physical injury 2) Select 'OK'. records request, use NGCM Email template. 3) Go back to the Purchase Order to authorise. Make no mention of any mental injuries. We are not requiring mental health notes, do not Once you have authorised the Purchase Order and notified the vendor remember to change the f Amend the MD02a letter to include the 'from to dates' Limited Payment List Indicator to 'Yes'. provided in the task by the Recovery Team member and d Any mention of sexual abuse or sensitive claims needs to paragraph relating to the Client's privacy. be changed to "Mental Injury" NOTE What text do you include? e Generate the ACC2386 - DHB (Vendor) request for copy "In order to consider this request we require of notes by selecting 'add documents'. copies of the following information from [Date] to [Date]" Admin Template - ACC2386 Clinical Records Request District Health Board g Text to include in all letters What if the request relates to a Mental Injury Privacy claim? As we are dealing with a client's medical or clinical Generate the 'ACC2386 DHB request for copy of records, it is important that both you and ACC comply notes' letter. Using the instructions in the temwith the requirements of the Privacy Act 2020 and the plate modify the letter for a Mental Injury request. Health Information Privacy Code 2020. ACC asks that ACC2386 Clinical Records Request District Health you supply only the information we need to make a cover, Board Mental Injury Template support or treatment decision about this claim, and do not give us any client information that we do not need for that What if there are questions to be included in purpose. Please review any records and remove any the request? unrelated information before you send files to us. Generate the 'MD02c-DHB-Further Info - medical reports - vendor' letter. Admin Template - MD02c - DHB Further info - Med-3.1 Request DHB records ical Reports - Vendor Recovery Administrator NOTE What if the claim is for Mental Injury but a View the [Add Info] tab in the task. requesting notes for physical injuries only b Create the Purchase Order. Follow the task template for physical injury records request, use NGCM Email template. Creating purchase orders using general + QE Make no mention of any mental injuries. Contacts for requesting District Health Board clinical We are not requiring mental health notes, do not add this. NOTE What information do you need to create the Purchase Order? Use Entitlement Code DHBC. 3.2 Request Other Clinical records ie, Physio-If questions need to answered by a DHB Spetherapist or Allied Health cialist, use Entitlement Code: DHBR1. **Recovery Administrator** a View the [Add Info] tab in the task. After selecting the DHBC Entitlement code, proceed as follows with steps 1 - 6 as below. If you b Create the Purchase Order. require further information, refer to the 'Creating Creating purchase orders using general + QE purchase orders using general + QE System Steps' document below. 1) Rehab Action / Claim: Treatment (Search) 2) Tick the 'Medical Notes/Reports - Tmt (Quick add)

5) Create PO

Records).

C Approve the Purchase Order.

3) Quantity Approved: 1 4) Frequency: Quarter

6) Purchase method: non contracted 7) Choose the correct vendor. (Use the link above for contacts for requesting DHB Clinical

ACC > Claims Management > Manage Claims > Gather Additional Information or Advice > Request Clinical Records Uncontrolled Copy Only: Version 87.0: Last Edited 01 February 2022 16:18: Printed 16 May 2022 21:54

NOTE What information do you need to create the Purchase Order?

Use Entitlement Code: STPR.

If you have questions requiring answering by the Physiotherapist, Osteopath, Chiropractor or Podiatrist use Entitlement Code: MEDR.

*A contracted physiotherapist may request STPR when they need to spend significant time reviewing and redacting information before sending the notes to ACC, in which case ACC should fund.

After selecting the relevant Entitlement code, proceed as follows:

- 1) Rehab Action / Claim: Treatment (Search)
- 2) Tick the 'Medical Notes/Reports Tmt (Quick add)
- 3) Quantity Approved: 1
- 4) Frequency: Quarter
- 5) Create PO
- 6) Purchase method: Non-contracted
- 7) Choose the correct vendor or just type in the correct vendor code.
- c Approve the Purchase Order.

NOTE What if you get a Limited Payment error message when authorising the Purchase Order?

If you have received a request to amend a Purchase Order or create a Purchase Order for client reimbursements, change the limited payment indicator.

- 1) In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2) Select 'OK'.
- 3) Go back to the Purchase Order to authorise.

Once you have authorised the Purchase Order and notified the vendor remember to change the Limited Payment List Indicator to 'Yes'.

- d Any mention of sexual abuse or sensitive claims needs to be changed to "Mental Injury"
- e Generate the MD01b Allied Further info Medical Notes Vendor by selecting 'add documents'.

NOTE What if the request is urgent?

Under 'How to invoice ACC', update the sentence 'Please forward the requested reporting within 10 days' to 5 days.

NOTE What if there are questions you need to include?

Generate the MD02b Allied - Further info - Medical Notes - Vendor letter.

Admin Template - MD02b Allied Further info - Medical Reports – Vendor

NOTE What if you need to fax the letter?

Generate the 'MD01b Allied - Further info - Medical Notes fax - Provider'.

Admin Template - MD01b Allied Further info - Medical Notes - Vendor

NOTE What if the claim is for Mental Injury but requesting notes for physical injuries only

Follow the task template for physical injury records request, use NGCM Email template. Make no mention of any mental injuries. We are not requiring mental health notes, do not add this.

- **f** Amend the MD01b letter to include the 'from to dates' provided in the task by the Recovery Team member and paragraph relating to the Client's privacy.
- g Text to include in all letters

Privacy

As we are dealing with a client's medical or clinical records, it is important that both you and ACC comply with the requirements of the Privacy Act 2020 and the Health Information Privacy Code 2020. ACC asks that you supply only the information we need to make a cover, support or treatment decision about this claim, and do not give us any client information that we do not need for that purpose. Please review any records and remove any unrelated information before you send files to us.

3.3 Request Specialist or other records

Recovery Administrator

- a View the [Add Info] tab in the task.
- **b** Any mention of sexual abuse or sensitive claims needs to be changed to "Mental Injury"

NOTE What if the claim is for Mental Injury but requesting notes for physical injuries only

Follow the task template for physical injury records request, use NGCM Email template. Make no mention of any mental injuries. We are not requiring mental health notes, do not add this.

Check if there is a requirement to submit questions to the vendor.

NOTE What if questions are not needed for the information request?

Proceed to Activity 4.0 (d) Create and send request.

NOTE What if the Specialist or 'other' does not have a verified email address?

If you are requesting notes from a Specialist and they do not have a verified email address, then:

- 1) Call and verify as the first option
- 2) Only if absolutely necessary (if they don't want the request emailed) create a letter to FAX as per the steps in 4.0 e Note 1.
- d Create the Purchase Order.

NOTE What information do you need to create the Purchase Order?

Entitlement Code: MEDR

Entitlement Type: Intervention Medical Notes /

Reports - Tmt (Quick Add)

Quantity: 1

Frequency: In Total

Purchase Method Non-Contracted

If there are questions for the Specialist vendor, select the 'MD02a GP - Further info - Medical Notes - Vendor' letter. In this case, select 'In total' as the [Frequency] when raising the PO, this will ensure the document template populates the right quantity. Alternatively, manually amend the template to change quantity from 0 to 1.

e Approve the Purchase Order.

NOTE What if you get a Limited Payment error message when authorising the Purchase Order? If you have received a request to amend a Purchase Order or create a Purchase Order for

client reimbursements, change the limited payment indicator.

- 1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to
- 2). Select 'OK'.
- 3). Go back to the Purchase Order to authorise.

Once you have authorised the Purchase Order and notified the vendor remember to change the Limited Payment List Indicator to 'Yes'.

f Generate the MD02a - GP Further info - Medical Reports letter and modify as per the task. Send an email using the Medical Notes Request Email template and modify accordingly.

Admin Template - MD02a GP Further info - Medical Reports - Vendor

g Text to include in all letters and emails

Privacy

As we are dealing with a client's medical or clinical records, it is important that both you and ACC comply with the requirements of the Privacy Act 2020 and the Health Information Privacy Code 2020. ACC asks that you supply only the information we need to make a cover. support or treatment decision about this claim, and do not give us any client information that we do not need for that purpose. Please review any records and remove any unrelated information before you send files to us.

4.0 Create and send request

Recovery Administrator

- a Edit the documents and letters:
 - 1) Change the 'Staff Name' from your name to 'ACC'
 - Copy the document name under the 'Recipient Details' heading and paste into the Document Description' box
 - 3) Untick 'Record a Contact' and then 'Next' (the document will be generated in Word for you to complete)
 - 4) Complete the document using the information provided located in the 'Additional Information' tab
 - 5) Check the details you have entered are correct
 - 6) Save the document and close.

NOTE What if the task includes questions from a **Recovery Team Member?**

Refer to the NG GUIDELINES Sending Letters in NGCM to confirm whose signature should be

NG GUIDELINES Sending Letters in NGCM

- **b** In Eos, mark the status of the document as complete,
- c Complete privacy checks on the completed documents.

Privacy Check Before Disclosing Information Policy

NG SUPPORTING INFORMATION Inbound and **Outbound Document Checks**

d Create an email using the appropriate template and attach the document(s). Add the client's NHI at the beginning of the email subject field.

NOTE What email template should you use?

If Purchase Order created, use 'Medical Notes Request (Purchase Order) If no Purchase Order created, use 'Medical Notes Request' Modify accordingly.

A copy of the lodgment form (ACC45/46/42) NOTE must be sent with every DHB request, or an ACC6300 if there is one on file

NOTE What if the request relates to a Mental Injury

Create an email in outlook. Copy and paste the following text and modify accordingly:

Kia Ora,

ACC have received a claim from *client first name* relating to their Mental injury.

We require Mental health information from between 00/00/0000 and present, to help us make decisions about their claim.

Our preference is to receive all documentation by email, if this is not possible just let us know.

If you have any queries, please do not hesitate to email recoveryadmin1@acc.co.nz or call 0800 222 435 Ext. 22.

Ngā mihi

NGCM - FINAL Emailing from Eos using a Template - System Steps

What if the request is for records across mul-NOTE tiple claims?

The Recovery Team Member will identify the claims in the task. Only one purchase order is needed (if required) on the active claim.

What if the Vendor's address has not been NOTE verified?

Go to Verify an Existing Provider, Vendor or Facility Email Address.

PROCESS Verify an Existing Provider, Vendor or Facility Email Ad-

NOTE What if the request is URGENT?

State this clearly in the body and subject line of the email.

What if the request relates to a Mental Injury NOTE claim?

If the claim relates to a Mental Injury (e.g. stress related injuries), you will need to manually remove the injury details from the Medical Notes Admin Email template(s).

NOTE: Details of a client's physical injury won't populate on the Medical Notes Requests email templates used by Recovery Administration for Purchase Orders or non-Purchase Orders for Sensitive Claims in the Assisted or Partnered Recover teams.

NOTE What if you need to send a FAX?

Fax the requests do the following:

- (A) For users with Fax Access
- 1). Print/Fax the request using RightFax
- 2). Navigate back to Eos
- 3). Add a new contact stating: "MD01a [document date and time], sent via fax to: [faxnumber] on [date and time]".
- (B) For users without Fax Access
- 1). Create the request
- 2). Update the task details with "Please Fax, Vendor #, Fax #, [Document attached]
- 3). Link the request to the task
- 4). Set the priority as 'High'
- 5). Transfer back to the Admin queue

For guidance on how to use RightFax refer to the document below.

RlghtFax Instructions

e Perform despatch check.

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- f Send the email.
- g In Eos, close the task. This will automatically generate a Follow up Requested Information task for Recovery Administration
 - NOTE What if the request was set as High Priority?

Edit the Follow Up Requested Information task and set to 5 business days.

NOTE What if you were requesting records across multiple claims?

Edit the description in the follow up task to include a list of all the claim numbers and dates are requesting records for. Copy the details from the task.

5.0 Review clinical records received

Recovery Administrator, Recovery Team Member

- a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.
- **b** Perform privacy checks

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

Privacy Check Before Disclosing Information Policy

- In Eos, upload the information to the claim.
 - NGCM Filing Away System Steps
- d Update the document and contact properties with an accurate description of the information received.

NOTE What if you are a Recovery Team Member?

Locate and edit the associated 'NGCM - Follow up Requested Information' task stating clinical records have been received. Recovery Admin will update the 'Information Requested' tab and close the task.

- e Select the 'Information Requested' tab on the Recovery Plan subcase, mark the request as 'Complete' and state 'Information Received', select OK.
- f Close the 'NGCM Follow up Requested Information' task stating clinical records have been received. A NGCM - Review Requested Information task will be auto generated and assigned to the Recovery Team or Individual managing the claim.

IOTE What if you receive a Review Requested Information Task and the information is incomplete?

Close the task.

Select 'Information Incomplet and click OK. Add the details of the information that is missing in the comment box and select a target date. Click OK. The task will auto-route to Recovery Administration.

if NGCM - Follow up Requested Information'request was set as High Priority? after closing and creating Review Requested Information Task or the information is incomplete Edit task to high

6.0 Follow up request for clinical records

Recovery Administrator

- a Following the task assignment in Salesforce, navigate to Eos and select Do Task from your task queue.
- b In Eos, check the 'Documents' tab to confirm the requested information has not been received before proceeding to contact the vendor.

NOTE What if you're unable to locate the information in the documents tab?

- 1) Check the shared inbox to see if the email has arrived but has not yet been filed away
- 2) If the information is in the shared inbox, file it away to the claim
- Copy and paste the email subject line into the Salesforce search bar, opens the related task and close.
- 4) Check the client's party record under Documents
- 5) If the vendor has email ACC back with no attach notes, File away, update task with template below

Response from vendor:

See contact:

Action:

C Contact the vendor to follow up on the requested information. Ensure that you check what has previously been requested and only follow up the request for subsequent information (using the date ranges on the request form).

NOTE How many times do you follow up with the vendor?

*If it a SureMed request, follow the SureMed promapp pg

Make two attempts to follow up with the Vendor Check Task date inline with below, if not, correct the target date (count from Creation Date), update the task description e.g. 'JL 18/09/2019 task date correction'.

DHB, the timeframe is:

- non-urgent request 21 working days
- urgent request 6 working days

non-DHB (GP, Medical Centre), the timeframe is:

- non-urgent request 11 working days
- urgent request 6 working days
- 1). The first attempt should be made by phoning the vendor, to confirm receipt of initial request.
- · Unless you are following up a DHB request email only (only follow up Urgent DHB notes before 20 days)
- · If you are successful in contacting the vendor, Update your task with template below:
- · If leaving a message, ensure you provide sufficient details for the vendor to identify the client whose information we require, e.g. Client full name, NHI or claim number or ACC45 number,

Update your task with template below:

When calling:

(Initials)(Date) - Follow up #

Number called:

Person who you spoke with:

Outcome:

Expected timeframe:

Notes will be sent via:

If you are unable to leave message, e.g.: line busy, unable to connect or no VM. Put the task on hold, try 2-3 times during the day to establish a successful contact or to leave a message . If unable to make contact, send final email (follow process 2)

 Reset the follow up task target date and time (between 10.00-15.00), if said notes already sent, push task out 3 days (giving time to be received/upload); If no timeframe, push task out 2 weeks. (10 working days)

Exceptions: If the vendor has been in touch and has asked for more time or explained their circumstances, then adjust accordingly

2). Edit the task description with below template (do not delete any information from the task)

When emailing: (Initials)(Date) - Follow up # Email sent to: See contact dated: Additional info: Response from vendor: See contact: Action:

From the Documents tab in Eos, locate the original request letter that was sent to the vendor.

ACC > Claims Manage@reate/neweennail from template and copyoand Advice > Request Clinical Records paste original email (in contacts tab) add the Frinted 16 May 2022 21:54 additional content below. In the Email subject





		NGCM - FINAL Emailing from Eos using a Template - System Steps			N	NOTE	What if the vendor is unable to provide the requested information? Add the response into the task to notify the Recovery Team Member. In Eos, record this conversation as a contact on the claim. Reason: Contact with Provider Direction:Outgoing method of Contact:Phone Description: Name: (who you spoke to) PH#: Detail: (of the conversation)	
	1	NOTE	E What if the vendor has advised that they no longer hold the client's records as the client has transferred to another GP practice? Make a note of what the previous vendor has advised on the NGCM – Information Not Received task once the NGCM – Follow up Requested Information task has been closed. Copy in the relevant notes that have been left on the task for the team/RTM to follow.					
		d Close the 'NGCM - Follow up Requested Information' task. Information Not Received						
							he 'NGCM - Continue to Follow up Requested	
	I	Follow ι	and paste the task description from the 'NGCM - up Requested Information' task into the 'NGCM - nation Requested not Received' task.			Information' task, and select 'Information Requested No Received'.		
	ı	NOTE	What other information should you include? Include any other relevant information e.g. 'Voic Message says the clinic has closed down'.			overy	clinical records Assistant, Recovery Coordinator, Recovery	
					аç	onfirn	n you have received the records requested,	
7.0	Re Pai	covery rtner	ne if clinical records are still required Assistant, Recovery Coordinator, Recovery		N	OTE	What if you need help to interpret the information? Go to the Seek Internal Guidance process. PROCESS Seek Internal Guidance	
i	(ceived'	iew the 'NGCM - Information Requested Not Re- ed' task to determine if you still require the medical or cal records.) _N	OTE	What if the records received are incomplete? Follow the system steps below.	
		NOTE	What if you no longer require the medical or clinical records? Select the NGCM - Information Requested Not			Inf	ormation Incomplete	
					b P	// "	privacy checks.	
			Received task. Follow the systems steps for Information not Received. This process ends.			NO	vacy Check Before Disclosing Information Policy S SUPPORTING INFORMATION Inbound and	
		Info	ormation Not Received				itbound Document Checks	
		NOTE	What if you still require the medical or clin-		N	OTE	What if the clinical records require redacting or third-party information removed?	
			ical records? Close the 'NGCM - Information Requested Not Received' task.				Email the document for Mental Injury use recoveryadmin1@acc.co.nz; for all others use recoveryadmin@acc.co.nz	
			In the 'Choose Next Step' screen, select option 'Continue to follow-up'. An 'NGCM - Continue to Follow up Requested				When emailing to Recovery Administration, provide clear instructions or highlight Document, on the information that needs redacting.	
	>		Information' task will automatically generate route to Recovery Administration Team.				NOTE: Do not add any third-party information into the task or email because this cannot be removed in the future and tasks are provided to a	
8.0	rec	cords					client when they request their claim information. Instead state 'please remove third party information on page xx'.	
/ /	a	Followir	Administrator ng the task assignment in Salesforce, navigate to		m	ation'	open the 'NGCM – Review Requested Infortask, select the option to accept records and ne task.	
	/ ! [_	d select 'Do Task' from your task queue. ntinue To Follow Up Requested Information		Ci	USC 11	ie lask.	
		NOTE Setting target date		40	0 A of	Action incomplete request for clinical record		
		NOTE	Set the target date and time (between 10.00-15.00) for a week after (5 working days) Exceptions: If the vendor has been in touch and has asked for more time or explained their	10.	req	uirec	ncomplete request for clinical record, if I Administrator	
					_ E	Eos and	ng the task assignment in Salesforce, navigate to d select 'Do Task' from your task queue.	
	-	possible	circumstances, then adjust accordingly vendor - discuss the request to determine (if e) the reason(s) why they have been unable to the requested information.		to OI	dete iginal en cli	ne 'NGCM - Incomplete Information Request' task rmine what information is missing. To view the information request, go to the [Add Info] tab and ck on the 'Inherited' tab. ormation Incomplete	
					c c		t the vendor to obtain the missing information.	

NOTE What methods and templates do you use for this?

Call the vendor to discuss what's missing from the original request and ask if they can send the information to ACC. In Salesforce, record this conversation as a contact on the claim.

NOTE What if the vendor insists on an email?

Using the appropriate Eos template, email the vendor and attach the original clinical request and advise the vendor of the missing information as outlined by the Recovery Team Member in the task, and then close the task.

An email example could be:

"Thank you for sending the requested medical information on (insert date). We have reviewed the medical notes and noticed some information is missing. Could you please send a copy of (insert what information is missing here) to us at your earliest convenience. Thank you"

This will then create the NGCM - Follow up Request for Clinical Records task.

d In Eos, close NGCM - Incomplete Information Request task. This will then create the 'NGCM - Follow up Request for Clinical Records' task.

Chack to ass if it has generated a Fallow Up Requests.

Check to see if it has generated a Follow Up Requested Information task.

If it has generated a follow up task, make a note on the task to specify that it is the follow up of the Incomplete Information Request task and set the task target date for 10 working days from task creation.

NOTE If it hasn't generated a follow up?

- · Go to the 'Task' tab on the ACC45 Claim
- Click on the 'Incomplete Information Request' task so it brings it up in the preview space below. Do not fully open it.
- · Click on the 'Process View' tab
- Find the blue square
- Click the play button on the right side of the square
- This should have generated the Follow Up Requested Information task
- Follow the steps above regarding editing the task and the target date
- e Edit the 'NGCM Follow up Request for Clinical Records' task and record your initials, today's date, attempt number and discussion had with the provider regarding the missing information.
- f Go to Activity 6.0, 'Follow up Request for Clinical Records' if required.



Resolve Provider Competency Issue v13.0



PROCESS Contact Client or Provider for Infor-Summary mation at Lodgement Cover Assessor, Senior Cover Assessor **Objective** To ensure the provider who lodged the claim is approved by ACC and is qualified to submit the injury Read code(s) so that a 3.0 Create purchase order cover decision can be made. Cover Assessor, Senior Cover Assessor **Background** a Create a purchase order for the future GP to invoice ACC Eos has checked the claim and identified that the provider who using the system steps below. Use the default vendor ID lodged the claim is unable to submit the Read code(s) on the (J99966) for this purchase order claim. It has raised a Provider Competency Failed information Create a purchase order requirement for someone to resolve. **b** Add the relevant document to the purchase order. Out of scope Owner Generate a purchase order document Out of scope **Expert Procedure** 4.0 Send form Cover Assessor, Senior Cover Assessor 1.0 Check diagnosis codes a Add the CVR04 Diagnosis questionnaire request letter in Cover Assessor, Lodgement Administrator, Senior Upload an Incomplete Electronic Document a Open the provider's party record and confirm their provider type. CVR04 Diagnosis questionnaire request - claimant **b** Review the diagnosis codes on the claim. **b** Edit the form and letter with the relevant information, including a return email address. Ensure that you've spe-C Open the 'Who can lodge claims for different injuries' cified they must see their GP and not their original lodgwebpage below and search using the provider type and Read Code. ing provider. Who can lodge claims for different injuries? Mark the letter as Complete in Eos. https://www.acc.co.nz/for-providers/lodging-claims/wh Print and send the letter with a pre-paid envelope. d If you can't find the Read Code under the provider type, What if the client asked for the form to be first consult with a colleague to confirm and if you are emailed? unable to confirm the provider competency has failed. Send the form via Fmail Toolset if the client has a verified email address in Eos. NOTE What if the Read Code is in the list? If the Read Code is in the list, then the provider competency has passed. Return to Assess Claim for Cover. This process ends. **Monitor progress** PROCESS Assess Claim for Cover :: Cover Assessor, Senior Cover Assessor PICBA After the 5 working day target, check the claim and call the client to ask when their appointment is to see the GP. b If the client needs more time, extend the target date on 2.0 Contact client the task. Cover Assessor, Senior Cover Assessor NOTE What if the information I've requested can't a Contact the client and explain that their lodging provider be provided before the cover decision due is unable to diagnose the injury they have submitted. date? Advise that they need to see their GP, who must fill in the Extend the cover decision timeframe. Go to the ACC125 Additional information on diagnosis form and Extend Cover Decision Timeframe process to do return it to ACC before the claim can continue to be this. considered for cover. Go to the Contact Client or Provider **PROCESS** Extend Cover Decision Timefor Information process below to do this. frame What if the client doesn't answer after two attempts? What if there's no contact from the client and the form isn't returned within 21 days of the Go to step 6.0 to post the form to them. claim lodgement date? **b** Confirm whether they want to have the ACC125 Addi-Decline the claim due to lack of information. Go tional information on diagnosis form emailed or posted to to the Decline Claim process below to do this. them. Check that their postal address is valid and that This process ends. they have a verified email address on file so it can be

6.0 Update claim and purchase order

Cover Assessor, Senior Cover Assessor

a Once the ACC125 Additional information on diagnosis form has been returned, check that the new provider is able to lodge the Read codes written on the form.

PROCESS Decline Claim

c Add a contact to note the conversation and to advise if

the form is being emailed or posted.

Add a client contact

NO ⁻	IOTE What if the provider is not able to lodge the Read codes(s) on the form? Go back to step 5.0	
b Uplo	Ipload the ACC125 form to the claim.	
	File an inbound email	
c Add	dd the new provider as a participant on the claim.	
	Add a participant	
ven	Ipdate the purchase order by replacing the default endor ID with the new provider's vendor ID number so ney can invoice for the appointment.	
	Edit a party within a purchase order	
	needed, update the claim with any new information uch as other Read codes.	
	Edit claim details - general	
	Make a cover decision. Go to the Assess Claim for Cover: PICBA process below to do this.	
PROCE	CESS Assess Claim for Cover :: PICBA Cover Assessor, Senior Cover Assessor	

Seek Internal Guidance v104.0



Summary

Objective

To assist in making decisions by receiving internal specialist guidance from a number of different areas:

- Clinical Services
- Technical Services
- Practice Mentors
- Payments
- Technical Overpayments
- Privacy

Background

Seeking internal guidance is a three tiered process:

Tier 1 - Self-Service: Using the information available on Promapp and Te Whāriki to make a decision

Tier 2 - Hotline Guidance: Guidance provided by a short (less than 15 minutes) phone call

Tier 3 - Written Guidance: Comprehensive guidance provided within a written guidance form in Salesforce, which creates a transcript in Eos

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Complete Self-Service Guidance

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

- a Review the following on the client's claim:
 - claim history and current circumstances
 - read and consider relevant documents
 - check for and review previous guidance
 - check for and review outstanding investigations
 - · check for outstanding reports and/or records
- **b** Refer to Promapp to check if next steps can be identified in using one or more of the following:
 - Process pages having knowledge of the objective, background and expected outcome of the range of services provided by ACC could help you determine the next steps to progress your client's recovery.
 - Policy pages having knowledge of legislation, payments and legal aspects of the services and supports
 provided by ACC could help you determine the next steps
 to progress your client's recovery.
 - Service pages having knowledge of the services provided by contracted Providers could help you determine the next steps to progress your client's recovery.

NOTE What if you are trying to make a cover decision?

Refer to the processes in the Make Cover Decision group in Promapp or refer to the Cover Traffic Light tool to assist in determining cover for particular injuries or injury types.

٦	Make	Cover	Decision
	Wake	COVE	Decision

TOOL - Add or change diagnosis decision traffic light

NOTE What if you need additional guidelines, tools and information to support case management?

Refer to the Te Whāriki site to search.

Te Whāriki Home Page

NOTE What if you need to obtain approval for services/costs outside of your delegation?

Refer to the Delegations Framework to determine whether you can approve. If approval is needed, refer to Activity 3.1 to Request Written Guidance

Delegations Framework

c Attempt to problem solve the issue with your Team Leader prior to seeking guidance, and that you have put together a question that is appropriate for clinical or technical guidance.

NOTE What kind of query is considered not appropriate for clinical or technical services?

Ensure you are not contacting an advisor or specialist asking "What are the next steps on a claim", or "Whether or not ACC can fund something", you must attempt to provide more information relevant to the client's injury.

2.0 Determine Appropriate Type of Guidance

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

- a Use the Recovery Support Decision Tree tool linked below to determine what kind of guidance you need.
 - Recovery Support Decision Tree

NOTE What if you are still unsure what type of guidance is needed?

Attempt to run through the decision tree tool alongside your Team Leader. If you are still unsure, contact a Practice Mentor to discuss your issue and the best way forward.

NOTE What if you need to request guidance on a Surgery claim?

If you require guidance on a Surgery claim, there are two channels, ensure you use the decision tree tool to determine which one to use:

- For invoicing and coding queries that are appropriate for hotline guidance, email your query to clinicaladvisorsurgery@acc.co.nz
- · For written guidance queries:
- If you are seeking guidance from a Principal Clinical Advisor (CAP referral), refer to the CAP referral process document under activity 3.1 (a)
- For invoicing and coding queries that are appropriate for written guidance on a Surgery claim, use the written guidance request form in Salesforce. Once you've submitted your guidance request, update the task description with the code "TACDUN"

NOTE What if you are working in the Remote Claims Unit or requiring guidance on a Staff claim or High Profile claim?

Refer to the knowledge article below on how to request Hotline and Written Guidance for the above scenarios

Remote claims, Staff and High Profile claims - Seek
internal guidance

NOTE What if a provider is requesting to speak directly with a Psychology Advisor?

The following external Psychology hotline numbers can be shared with providers: Sensitive claims: 09 354 8425 Physical injury: 09 354 8426

This is for PROVIDERS ONLY and must not be released to clients.

b Go to Activity 3.0 to request Hotline Guidance, or Activity 3.1 to request Written Guidance.

3.0 Request Hotline Guidance

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

a Prepare for requesting guidance using ISBAR (Identify, Situation, Background, Accident, Request). Continue to refer to the Recovery Support Decision Tree tool for additional things to remember/consider and tips for best practice.

Ensure you provide your full name when requesting hotline guidance.

Hotline ISBAR.PNG

Recovery Support Decision Tree

- **b** Dial extension 50118 and select one of the following options:
 - Select option 1 for Clinical Services. You will then be asked to select from the following options:
 - 1 for Clinical Advisors or
 - 2 for Psychology Advisors sensitive claims
 - 3 for Psychology Advisors physical injuries
 - 4 for Pharmaceutical Advisors
 - 5 for Treatment Injury Medical Advisors
 - Select option 2 for Technical Services. You will then be asked to select from the following options:
 - 1 for Transport for Independence Specialists or
 - 2 for Housing Modifications Specialists or
 - 3 for Technical Accounting Specialists or
 - 4 5 for Technical Specialists in relation to a Sensitive Claim
 - 5 for General Technical Specialists
 - Select option 3 for Practice Mentors. You will then be asked to select from the following options:
 - 1 for advice about a Partnered Mental Injury or
 - 2 for advice about all other enquiries (a physical injury or not directly related to a Mental Injury)
 - Select option 4 for Payments Assessors. You will then be asked to select from the following options:
 - 1 Sensitive Claims Payments
 - 2 Travel
 - 3 All Other Client Reimbursements
 - 4 Payments Assessor
 - · Select option 5 for Privacy Advisors
 - Select option 6 for Client Administration Support related to a physical injury
 - Select option 7 for Client Administration Support related to a mental injury

NOTE What if my query is regarding a mental injury claim?

All requests for guidance on mental injury claims must go to a Psychology Advisor.

NOTE What if the Hotline is not answered?

Keep trying the Hotline. If, after a few more attempts, there is still no answer add a note to the task in Eos (or update the description in Salesforce) and try again at your earliest convenience.

If you are working in Assisted Recovery, update the description to say "Attempt to call the Hotline again", before putting the task on hold so you can pull another one from the queue. Aim to complete any on hold tasks by the end of the day, taking them off hold and returning them to the queue if you're unable to do so.

c Go to activity 4.0 to action the Hotline Guidance.

3.1 Request Written Guidance

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

a Prepare for requesting guidance using ISBAR (Identify, Situation, Background, Accident, Request). Refer to the Recovery Support Decision Tree tool for additional things to remember/consider and tips for best practice.

The Decision Tree Tool references key medical information that must be on file prior to submitting a written guidance request, ensure you have attempted to request this information. Clinical and Technical staff will not be able to provide written guidance if there is insufficient information on file.

NOTE	What are the standards needed when seeking
1 1/1/	guidance?

Refer to the Standards for Seeking Guidance

- Standards for Seeking Guidance
- Recovery Support Decision Tree

NOTE What does a quality referral look like?

Refer to the image for an example.

Written Guidance example.PNG

NOTE What if you need written guidance from a Principal Clinical Advisor (PCA) for a Surgery claim?

Refer to the CAP referral process (SF) guide below.

٦	CVD	referral	process	(SE
	CAP	reierrai	DIOCESS	OF

NOTE What if you need to request written guidance where there is a CAP referral in progress?

Call the Surgery team on 83566 to discuss whether additional question(s) can be added to the existing CAP referral. Note: CAP will not answer questions regarding ongoing incapacity.

Principal	Clinical	Advisor	consideration	list

Delegations Framework

b Check the necessary supporting documents and information is on the claim.

NOTE What if there are documents and/or information missing on the claim?

Refer to the Request Clinical Records process.

PROCESS Request Clinical Records

c In Salesforce, select the 'Recovery Support' tab and 'Create Guidance'. Follow the steps and complete the fields on the written guidance form.

If there are relevant documents or contacts on file you want the advisor/specialist to review, ensure you specify the document or contact description in the 'Documents or contacts relating to the request' along with the date the document was uploaded (include page/paragraph # if you want to point out a specific piece of information.

If you need to add any particular information regarding who the guidance request should go to (i.e. If this needs to go to a specific specialist discipline), specify this information in the 'Triage Written Guidance' task description. (This is located inside the 'information' heading, ensure you save the change to the description)

Recovery Support FAQs.docx

NOTE What priority should I select for my Written Guidance request?

Check the Written Guidance Priority Categories document to see whether or not your request falls into one of the P1/P2 categories. Speak with your Team Leader if you are unsure whether or not a certain scenario falls into a P1/P2 category.

Written Guidance requests not falling into a P1/P2 category should be submitted as per normal (i.e. Low priority).

Written Guidance requests falling into a P1/P2 category should be submitted as follows:

- · Select 'Yes' under 'Is the request urgent?
- Select 'Other', and ensure you clearly specify the appropriate P1/P2 category code within the 'Reason for urgent request' section.

FYI - The Written Guidance request will be submitted as High priority (Medium priority cannot currently be selected), P2 requests will be corrected to Medium Priority by Triage and Workflow.

High and Medium Priority Categories for Written Guidance Requests

NOTE What if you want to cancel, save as a draft, or add additional information to your guidance request?

• To cancel: Go to the guidance request you have submitted and select 'Cancel Written Guidance,' then provide a reason for cancellation (i.e. if other client information was entered in the request, select the reason as 'Cancelled due to error').

Note - the information submitted in the form is not discoverable by the client until the written guidance has been accepted and a transcript is created in Eos, if you cancel, there will be no record of it on the client's file

• Save as draft: At the bottom of the written guidance form select the tick box labelled 'Save as Draft' then click 'Next', then when you are ready to complete your guidance request, go back to the written guidance request in salesforce and select 'Edit Written Guidance'

If you are saving the request as a draft because you are awaiting some additional information:

For claims assessment staff create a follow up task in Eos to revisit the draft guidance request once the information has been received

For Recovery team members – create a reminder action in salesforce to revisit the draft guidance request once the information has been received

If you need to add additional information to a Written Guidance request that has been sent to Triage or allocated to an advisor – select 'Additional Information to a Guidance request' on the guidance request in salesforce

NOTE What if you are a non-Salesforce user and you require written guidance?

Ensure you request your guidance via the 'Complete Internal Referral' task and then transfer the task into the Regional Clinical Advice - CENTRAL queue or the Operations Support queue.

Please use the referral template document below.

Written guidance template for non-Salesforce users.docx

NOTE What if you require written guidance on a claim not migrated to Salesforce?

There is a system error which means Recovery Team Members cannot access Salesforce in order to make referrals on very old claims.

For very old claims where you are unable to access Salesforce in order to make a request for clinical advice, please action the referral using the NGCM pathway (see below systems steps) on EOS and mark the task as "OLDER EOS CLAIM, SF unavailable".

This label will ensure the Triage Team does not return the task due to being submitted in the wrong queue.

(NGCM) Create Request for Written Guidance

NOTE What if you require written guidance on a Mental injury claim or disentitlement for a Wilfully Self-inflicted (WSI)/suicide claim?

If you require guidance on the below:

- · Work-related Mental Injury (WRMI) claims, and Treatment Injury Mental Injury (TIMI) claims
- Complex mental injury caused by sexual abuse (MICSA) and complex mental injury caused by physical abuse (MICPI) claims, for example, where a combination of clinical, legal and technical factors complicates the decision, for instance: multiple related claims involving technical and medico-legal complexity; where the causal link to injury is unclear or contentious; and/or the diagnosis is unusual or contentious.
- · Wilfully self-inflicted (WSI)/suicide claims where the evidence to support a decision is unclear or equivocal; and/or there are clinical, legal or technical complexities that complicate the decision.

Request written guidance from a Psychology advisor, and complete the forms as outlined below. You need to fill out the relevant sections on either an ACC1517 (Mental Injury Cover form) or ACC6178 (Disentitlement for WSI or suicide claims). Ensure you leave the document as incomplete.

Complete the written guidance request form as per the current process (if you have completed an ACC6178 you can still select the tick box for 'Have one of the above ACC documents been completed') and indicate in your summary 'Refer to the ACC1517 (or ACC6178) document uploaded on XX/YY/ZZZZ'.

The PA will then arrange a Complex Mental Injury Panel (CMIP) comment via Technical Services. Once the Psychology Advisor and CMIP have completed their comments in the ACC1517/ ACC6178, complete these documents and action the recommendations.

You can refer to the delegations spreadsheet below which shows what types of claims need to be referred to the Complex Mental Injury panel.

Delegations Framework

What if you require written guidance from a **Technical Accounting Specialist?**

Refer to the following page for more information on Technical accounting and what information needs to be included with a written guidance re-

NB: Due to the complexity of these requests there is a 3 day Service Level Agreement for urgent (client is in financial distress) tasks and a 20 day Service Level Agreement for all other requests.

PROCESS Referring to the Technical Accounting Specialists for Advice

NOTE What if you are working on a claim that is in 'Actioned Cases'?

Written Guidance must be requested on 'active' claim, you will need to transfer this into the appropriate queue/name.

d Go to Activity 4.1 'Action Written Guidance' once you have received your guidance.

NOTE What if you have already submitted your written guidance request, and you need to update the priority?

If you have received new information that changes the priority of the request, complete the steps below:

- · Open the claim in Salesforce.
- · Click on the 'Recovery Support' tab and then click on the relevant Guidance Number to open
- Now you should be on the 'Details' page. Click on the 'Update Guidance Priority' button to change the priority of the request.
- · Select 'Yes' under 'Is the request urgent?'
- · Select 'Other', and ensure you clearly specify the appropriate P1/P2 category code within the 'Reason for urgent request' section.
- · If your reason for escalation does not meet one of the pre-set categories, you should email clinicaltriage@acc.co.nz with your Team Leader approval and reason for requesting escalation.

FYI - If you wanted to check the progress of the task, you can click on the 'Related' tab and then click on the open task number:

- If the guidance is still with the Triage team, it will be the 'Triage Written Guidance request' task
- If it has already been triaged and allocated to an Advisor queue, it will be the 'Provide Written Guidance' task type.

PROCESS

Provide Internal Guidance - Hotline

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, **Technical Team Member**

PROCESS

Provide Internal Guidance - Written

Clinical Team Member, Senior Triage and **Workflow Coordinator, Technical Team** Member

4.0 Action Hotline Guidance

Cover Assessor, Recovery Team Member, Specialist **Cover Assessor, Treatment and Support Assessor**

a Consider the advice documented by the Advisor, Specialist or Assessor and undertake the next steps.

What if you need to clarify the guidance provided by the Advisor, Specialist or Assessor? Message or call the Advisor, Specialist or Assessor directly to clarify the guidance.

NOTE What if you want an Advisor, Specialist, or Practice Mentor hotline comment to be removed from file or amended?

> The only instances a clinical or technical comment should be removed/ deleted is when the guidance is on the wrong claim. In rare instances the Advisor may need to amend or add an addendum to the guidance. Only an Advisor's or Specialist's manager can delete their own comment, neither a frontline staff member or another advisor can delete your comment.

If the comment needs to be removed/amended ensure you reach out to the advisor or specialist who provided the guidance and include their manager in the discussion.

Receive Written Guidance (Recovery Team Member)

4.1 Action Written Guidance

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

a In Salesforce, review the guidance provided on the Written Guidance request by selecting the 'details' tab.

NOTE What if you are requested to provide clarification on a guidance request?

If this is via IM or call, clarify the question directly with them.

If this is via Salesforce, open the Guidance Request and click 'Provide Clarification on Guidance Request', read the clarification question and provide the clarification. If you need to cancel or put the request on hold you can do this at this step.

If you need to request additional information in order to clarify the request, use the Request Clinical Records process. In Salesforce, extend the target date of the clarification task to later than the due date of the medical notes task. Ensure you update the task description to reflect you have requested additional information (if you are in Assisted Recovery and are returning this to the queue, update the description when you do this).

NOTE What if the written guidance is on a claim not migrated to Salesforce?

For very old claims where you are unable to access Salesforce in order to make a request for clinical advice, a written guidance referral would have been actioned using the NGCM pathway in EOS.

- If you decide to accept the written guidance or to ask for clarification on the written guidance provided, use the Review Written Guidance system steps below.
- If the Advisor had asked for clarification within the written guidance, use the Respond to Clarification Request from Advisor system steps below.

Receive Written Guidance (Recovery Team Member)

Respond to Clarification Request from Advisor (Recovery Team Member)

b Accept the guidance provided by selecting 'Accept Guidance', or request clarification if required.

NOTE What if the advice is unclear or the questions are unanswered?

Select 'Clarification Required on Guidance Provided' and input your clarification question(s).

NOTE What if you want an Advisor or Specialist's written guidance to be removed from file or amended

Comments within a Written Guidance form cannot be deleted or edited once the Advisor or Specialist has submitted their guidance.

If the wrong client's information has been included, please cancel the guidance in Salesforce and submit a new request.

OTE What if your request for written guidance was related to transferring weekly compensation to a different claim for a further injury?

Refer to the below process ("Transfer Weekly Compensation to a New Claim due to Further Injury")

PROCESS Transfer Weekly Compensation from one claim to another

Add an Eform

C Once the guidance has been accepted a transcript will be created in Eos.

NOTE What if guidance indicates I have sufficient information to issue a decision?

See the below page for "Issue Recovery Decision"

PROCESS Issue Recovery Decision

NOTE What if I'm unable to locate my Written Guidance request?

The Written Guidance process is a cog process meaning that when one action is completed it creates a new task in the process to be actioned.

For example: Once the triage process is completed, the 'Triage Written Guidance' task will be closed and a 'Provide Written Guidance Task' is automatically created which is then assigned to the appropriate advisor.

The instructional video below provides an overview of the Recovery Support Written Guidance process in Salesforce and EOS and support in locating the various tasks in this cog process.

An overview of the Recovery Support Written Guidance process in Salesforce and EOS

5.0 Provide and Review feedback

Cover Assessor, Recovery Team Member, Specialist Cover Assessor, Treatment and Support Assessor

a If applicable, provide feedback on the guidance received.

NOTE How do you provide feedback on the Hotline guidance you have received?

In Salesforce, navigate to the Recovery Support tab and select the 'Provide Feedback' option. On the Provide Feedback form, complete the mandatory question and comments sections, and submit your feedback.

NOTE How do you provide feedback on written guidance?

When you accept the written guidance in Salesforce, you will get the option to provide feedback, select this option, and complete the mandatory fields

b If applicable, review feedback on the guidance request you submitted.

NOTE What if you want to review some feedback you have received?

You will be notified you have received feedback by getting an alert notification from the "bell" icon in Salesforce. If you select this you will be able to review the feedback.

Alternatively, if you select the nine dots in the top left corner of the Salesforce window, and search for "Feedback", you can select this Feedback option.

From here you can select the drop down arrow to show different list views which display feedback from a range of dates.

NOTE What if you are a Team Leader and you want to subscribe to a feedback report?

Complete the steps below in Salesforce:

- Select 9 dots to the left of "Work Load Management"
- · Type in "Reports"
- Select "All Folders' and then "Feedback Reports"
- Open the new report "My Team's Feedback Last 7 days"
- Click the down arrow at the top right of the report and select subscribe
- Schedule when you want the report subscription email e.g. 9am on a Monday every week.

 Confirm recipient being added and run report as "Me"
- Result will be an email to your inbox at that time/day, with a link to the report in Salesforce
- Last step will be to use the Team Leader filter, to narrow the results to your team members i.e. use the name your Salesforce user is set up with



Statutory Timeframes for Mental Injuries Policy v10.0



Summary

Objective

Use this guidance when investigating cover for a mental injury claim to ensure that you meet the statutory timeframes and avoid a deemed cover decision.

Background

A November 2008 District Court ruling found that claims for mental injury arising from physical injury are subject to the cover timeframe provisions contained in sections 56 and 57 of the Accident Compensation Act 2001. If we don't meet these timeframes, a client's cover decision is deemed in their favour under the Accident Compensation Act 2001, Section 58.

Out of scope Owner **Expert**

Policy

1.0 Rules

a We must treat each claim for a mental injury arising from physical injury as if it is a new claim for cover, which requires a decision to be made within the statutory timeframe. Under section 56 of the Accident Compensation Act 2001, ACC must determine cover within 21 days of lodgement of non-complicated claims.

According to Section 36(2) of the Accident Compensation Act 2001 the date on which a person suffers mental injury because of physical injuries is the date on which the physical injuries occurred. If a claim for mental injury is lodged more than 12 months after the physical injury, it becomes a complicated claim for cover. Under section 57 of the AC Act cover must be determined within two months of lodgement of complicated claims.

NOTE Example

A client is assaulted in May 2006 and ACC accepts cover for a fractured eve socket and multiple contusions. Two years later ACC receives a medical certificate for post-traumatic stress disorder (PTSD). As the claim for mental injury has been received more than 12 months after the physical injuries, this is considered as a complicated claim for cover.

Accident Compensation Act 2001, Section 36, Date on which person is to be regarded as suffering mental injury

http://www.legislation.govt.nz/act/public/2001/0049/lat

Accident Compensation Act 2001, Section 56, Steps Corporation takes to action claims for cover http://www.legislation.govt.nz/act/public/2001/0049/lat

Accident Compensation Act 2001, Section 57, Steps Corporation takes to action complicated claims for cover

http://www.legislation.govt.nz/act/public/2001/0049/lat

2.0 Time extensions

a In many cases we can't make a decision on a mental injury claim within statutory timeframes because we require additional information, such as a mental injury assessment.

Therefore, as soon as the statutory timeframes are activated we must either make a decision to decline cover or send a CVR30 Time Extension letter to the client.

CVR30 Time Extension - advise - claimant

3.0 Activating timeframes

a We must receive a specific request for cover in order to activate the cover timeframes for a mental injury from physical injury. If it is not clear whether a specific claim for cover for mental injury has been lodged, we must contact the client immediately, telling them that we need an ACC45 lodged by their treatment provider.

In most instances a request for cover should be accompanied by a medical certificate or a preliminary diagnosis of a mental injury from the client's treating practitioner. However in some cases it is unreasonable to ask the client to return to their treatment provider and ACC can take steps to arrange the assessment. ACC does not require an ACC45 if we already have a medical certificate, and are aware from previous correspondence that the client wishes to have cover for a mental injury.

For more information see Examples of timeframe activation for mental injury.

Examples of timeframe activation for mental injury -Reference

Timeframes to Determine Cover Policy v17.0



Summary	21 day maximum cover decision timeframe
	Advising client of four month maximum cover decision timeframe
Objective Use this guidance to help you meet the legislative timeframes	
when making cover decisions for non-complicated and compli-	Four month maximum cover decision timeframe
cated claims. Refer to this guidance if you do not have enough	Cover decision time limit
information to make a cover decision within the timeframes, and	
require an extension to continue to assess cover.	2.0 Complicated claims
1) Rules	3.0 Complicated claims
2) Non-complicated claims	a The following claims are considered complicated:
3) Complicated claims	personal injury caused by a work-related gradual
4) Additional extension	process, disease or infection
5) Links to legislation	treatment injury
Owner Out of scope	 claims for cover lodged 12 months after the date of
Export Out of scope	accident (late claims)
Expert	 mental injury caused by certain criminal acts (sensitive claims)
Delieu	work-related mental injury.
Policy	
1.0 Rules	We must make a cover decision within two months of a
a ACC operates under strict legislative timeframes for	complicated claim being lodged. If we can't make a deci-
making cover decisions. If we don't meet these time-	sion we must inform the client that we're extending the timeframe up to four months from the date of lodgement.
frames, a client's cover decision is deemed in their favour	Use the CVR30 Time Extension - advise - claimant (42K
under the Accident Compensation Act 2001, section 58.	letter in cases where the client cannot be contacted to be
b For more details about timeframes for cover decisions,	informed about the extension verbally. Where the client
see the business rules below:	can be contacted written confirmation must still be sent via the client's preferred contact method (if known) or via
Maximum cover decision timeframe	email or text (if not known) using the template noted
C For more information about claims for additional diag-	below.
noses or changes in diagnosis, see:	
	"RE: Injury/diagnosis ACC is investigating
	From ACC: We're still working on getting (information) from your (source of information). This information is
PROCESS Assess Cover for an Additional	important to help us assess your claim. We'll be in touch
Injury or Change in Diagnosis	as soon as possible and advise that we are required to
	make a decision by XXXXXX. If you have any questions,
2.0 Non-complicated claims	please call us on 0800 XXXXX "
a We must determine cover within 21 days of lodgement for claims that are non-complicated.	See Accident Compensation Act 2001, section 57.
	b For more detail on timeframes for complicated claims,
b If there is not enough information to make a cover deci-	see the business rules below:
sion within the 21 day timeframe, we must inform the client that a decision cannot be made and the timeframe	Complicated claim definition
is being extended up to four months from the date of	
lodgement. Use the CVR30 Time Extension - advise -	Two month maximum cover decision timeframe
claimant (42K) letter in cases where the client cannot be	Advising client of four month maximum cover deci-
contacted to be informed about the extension verbally. Where the client can be contacted written confirmation	sion timeframe
must still be sent via the client's preferred contact method	Four month maximum cover decision timeframe
(if known) or via email or text (if not known) using the	Cover decision time limit
template noted below.	
"RE: Injury/diagnosis ACC is investigating	
From ACC: We're still working on getting (information)	
from your (source of information). This information is	
important to help us assess your claim. We'll be in touch	
as soon as possible and advise that we are required to	
make a decision by XXXXXX. If you have any questions, please call us on 0800 XXXXX"	
·	
C We must make a final decision within four months of the claim being lodged.	
d See the business rules below for the definition of a non-	
complicated claim, and additional information about the timeframes for non-complicated claims:	

Non-complicated claim definition

4.0 Additional extension

a It's possible to extend the timeframe for a complicated claim cover decision by up to nine months from the date the claim was lodged. The client must agree to this further extension, agreement can be obtained verbally from the client, however written confirmation must still be sent via the client's preferred contact method using the template noted below.

The client should be requested to agree to the additional extension in writing by signing the form attached to the CVR31 Time Extension - request claimant (88.5K) letter, where:

- the client cannot be contacted.
- · additional information is needed to be included or
- there is a need for clear documented information in relation to the extension to avoid any potential miscommunications

Template for written confirmation (non CVR31)

"RE: Injury/diagnosis ACC is investigating From ACC: As discussed with me on XXXX you have agreed to a further extension to making a decision. We're still working on getting (information) from your (source of information). This information is important to help us assess your claim. We'll be in touch as soon as possible and advise that we are required to make a decision by XXXXXX. If you have any questions, please call us on 0800 XXXXX"

We must make a final decision within nine months of the claim being lodged.

b	For	more detail on extending the timeframe for a compli-
		ed cover decision by up to nine months from the date
	of lo	odgement, see the business rules below:
		Asking a client to extend cover decision timeframe
		Nine month maximum cover decision timeframe
		Cover decision time limit

5.0 Links to legislation

Accident Compensation Act 2001, section 56 Steps Corporation takes to action claims for cover http://www.legislation.govt.nz/act/public/2001/0049/lat

Accident Compensation Act 2001, section 57 Steps Corporation takes to action complicated claims for cover

http://www.legislation.govt.nz/act/public/2001/0049/lat

Accident Compensation Act 2001, section 58 Effect of failure to meet time limits

http://www.legislation.govt.nz/act/public/2001/0049/lat

PROCESS Fx

Extend Cover Decision Timeframe

Verify Claim Information v19.0



Summary

Objective

To confirm claim information so that a cover decision can be made. This can include confirming dates, injury diagnosis, accident location and/or whether a client is ordinarily resident in New Zealand.

Background

Eos has identified that the claim has missing or invalid information, or information that needs to be checked, and has raised an information requirement for someone to resolve. There are 7 possible information requirements covered by this procedure which are listed below. These are included in two different task types: Missing Information for Cover and Confirm Cover Decision.

Information requirements included in Missing information for Cover task:

- Accident Date is Not Valid
- Date of Birth is Invalid
- Date of Lodgement is Invalid
- Date of Signing Before Date of Accident
- Date of Signing is Invalid
- Missing or Invalid Diagnosis
- Diagnosis Injury Side is Mandatory
- Work Injury Status Invalid

Information requirement included in Confirm Cover Decision task:

- Check Eligibility - Dates

Owner

Out of scope

Expert

Out of scope

Procedure

1.0 Review claim details

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

Open the claim and review the information requirement (s) (IRs) to identify what aspects of the claim need to be resolved. If you need to contact the client or provider at any stage in this process, then ensure you resolve as many outstanding requirements in a single contact if possible.

NOTE What if the information requirement is about dates?

Go to step 2.0 if there's one or more of the following IRs outstanding:

- Accident Date is Not Valid
- Date of Birth is Invalid
- Date of Lodgement is Invalid
- Date of Signing Before Date of Accident
- Date of Signing is Invalid
- Check Eligibility Dates

NOTE What if the information requirement is about the injury diagnosis?

Go to step 2.1 if there's one or more of the following IRs outstanding:

- Missing or Invalid Diagnosis
- Diagnosis Injury Side is Mandatory

NOTE What if the information requirement is about location or work injury status?

Go to step 2.2 if there's one or more of the following IRs outstanding:

- Accident Location is Missing
- Accident Location is Invalid
- Work Injury Status Invalid

NOTE What if I'm assessing a claim for cover and there's an outstanding Check Eligibility - Overseas IR

Go to the Confirm Accident Location process.

PROCESS Confirm Accident Location

2.0 Confirm dates

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Contact the client or provider to obtain the correct dates.
Go to the Contact Client or Provider for Information
process below to do this.

NOTE If I've received a Check Eligibility - Dates information requirement, how do I know which date is incorrect?

Eos has identified that one or more of these checks has failed:

- Date of lodgement is before the date of accident.
- Date of accident is before client's date of birth.
- Date of accident is after client's date of death.

NOTE What if I've received a claim for a client who's marked as deceased in Eos?

Check NHI and review any relevant information in Eos to see what's happened.

- If it's clear that the client was marked deceased in error, remove the deceased status.
- If it's not clear that the client was marked deceased in error, contact the provider and/or client to confirm the details. If you can't confirm whether the client was marked deceased in error then create a new party record for the client.

NOTE What if I've received a Date of Signing is Invalid information requirement because the provider hasn't signed the claim?

If the client has signed the claim, use the date that the client signed the form for the missing provider signature date.

2.1 Confirm diagnosis

Lodgement Administrator

a If there's more than one diagnosis code, check that the diagnosis code types are the same (e.g. they're all Read codes).

NOTE What should I do if the diagnosis code types are different (e.g. ICD10 and Read) or if a SNOMED code has failed to translate?

Eos will not allow registration to be completed when the diagnosis code types are different. You must update the diagnosis codes so they are one type only. To do this replace the ICD9, ICD10 or failed SNOMED code(s) with an equivalent Read code. Note that it's generally best to replace with Read codes as there are more of them, however you can also change all codes to be ICD9 or all codes to be ICD10.

If you're having difficulty finding an equivalent diagnosis code, talk to your leader.

Once you've updated the code(s), if a z-code has been used go to step 2.b, otherwise go to step 3.0.

b Replace z-code on treatment injury or sensitive claim (if applicable).

NOTE Which code should I replace the z-code with?

If the claim is a treatment injury claim, replace the z-code with U6...

If the claim is a sensitive claim, replace the z-code with SN571

If the diagnosis is listed in the injury comments then the Z code can be updated to reflect that diagnosis.

Once you've updated the code go to step 3.0.

C Contact the client or provider obtain the correct diagnosis information. Go to the Contact Client or Provider for Information process below to do this.

NOTE When should I contact the client?

For missing or invalid information about the injury side.

NOTE When should I contact the provider?

For information about the diagnosis codes. The client isn't authorised to provide this information.

NOTE What if the provider says there's no injury?

Use the TN8.. diagnosis Read code (do not use Z... or T149 diagnosis codes as these will prevent the claim from progressing to the Cover Decision Service).

PROCESS

Contact Client or Provider for Information at Lodgement

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

3.0 Complete information requirement

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Check that there are no other information requirements outstanding.

NOTE What if there are information requirements outstanding in a Missing Information for Cover task?

Action the other information requirements before closing the task. Go to the relevant procedure(s) for guidance.

The only exception is if you've just resolved a Missing or Invalid Diagnosis information requirement. When this IR is raised a Provider Competency Failed IR is also always raised. You should ignore the Provider Competency Failed IR and close the Missing Information for Cover task. Eos will re-run validations and close the Provider Competency Failed IR (as long as the injury diagnosis is within their scope of practice).

NOTE What if I need to make a cover decision on a held claim?

- Update the information requirement you've just resolved to Complete.
- Make a cover decision for the claim. Go to the Assess Claim for Cover process below to do this.
- This process ends.

PROCESS Assess Claim for Cover ::
PICBA

b Close the Missing Information for Cover task.

Work-Related Mental Injury Policy v11.0



Summary

Objective

Refer to this guidance to help you determine cover where a person suffers a clinically significant mental injury caused by a traumatic work related event.

- 1) Overview
- 2) The Client is diagnosed with a clinically significant mental injury
- 3) A work-related event causes the mental injury
- 4) A single, sudden event causes the mental injury
- 5) The event was experienced, seen or heard
- 6) The direct outcome of a sudden event
- 7) The event can reasonably be expected to cause mental injury
- 8) Links to legislation

Background

ACC has been able to consider claims for work-related mental injuries since 1 October 2008.

Owner

Out of scope

Expert

Out of scope

Policy

1.0 Overview

- a Mental injuries not covered by this include:
 - · exposure to traumatic events outside of work
 - · gradual onset workplace stress.
- b The work-related mental injury must have been caused by a single, sudden event that occurred in a client's employment.
- c Unlike other mental injury claims, a work-related mental injury does not need to be linked to a physical injury. If the client receives a physical injury you should also consider whether the claim for cover is for a mental injury resulting from a physical injury as the two claims have different criteria and dates of injury. This will depend on the content of the mental injury assessment. Seek advice from your Team Manager if you are unsure.

d Example:

A bus driver in Manukau swerves to avoid hitting a pedestrian who deliberately steps in front of the bus. The pedestrian is killed instantly when they are clipped by the front end of the bus. As the bus driver is suffering from severe clinical depression because of this event his general practitioner lodges a claim for a work-related mental injury.

2.0 The client is diagnosed with a clinically significant mental injury

- a In order for the mental injury to be covered, it must be diagnosed as being a clinically significant behavioural, cognitive, or psychological dysfunction.
- **b** The diagnosis must be made by a qualified mental injury assessor following a standardised system. For more information, see the link to the 'Mental Injuries' Promapp entry below.
- **c** Temporary distress that constitutes a normal reaction to trauma is not covered.

Mental Injuries Policy

3.0 A work-related event causes the mental injury

- **a** For a work-related mental injury to be covered, it must be caused by a single, sudden event that occurred in a person's place of employment. The person must be at the place for the purpose of employment or at a place of employment during a break.
- b The mental injury assessor's report should identify whether the event was a material or substantive cause of the mental injury.

4.0 A single, sudden event causes the mental injury

- a For a mental injury to be covered, the mental injury must be caused by a single event.
- b The event that caused it must be sudden in onset. A sudden event is one that occurs quickly with little or no warning, but the event itself may last a short or longer time. An event lasting a short time might include a drive-by shooting, while an event lasting a longer could be a hostage situation lasting many hours. Irrespective of their duration, both are sudden events.
- c A series of events that arise from the same cause or circumstance can still be considered a single event. In these situations take care to ensure that all parts of an event are clearly identifiable and occur at a precise point in time. This is different to a gradual process, which refers to a series of recurring events over a longer period that have a cumulative effect.

NOTE Series of events that arose from the same cause or together comprised a single incident

The client may experience a series of events at work that arose from the same cause or together comprised a single incident.

For example: a police officer or soldier is exposed to several similar life-threatening situations over a short period of time (weeks or a few months, not years).

In this case, call the Technical Specialist Hotline for guidance.

5.0 The event was experienced, seen or heard

- a In order for the mental injury to be covered the client must directly experience the event that caused the mental injury. The client must be in close physical proximity to the event and see or hear it in order to experience it.
- **b** A person cannot experience an event directly if they:
 - see it on television, including closed circuit television
 - see pictures of, or read about it, in the news media
 - hear the event on radio or by telephone
 - hear about the event from radio, telephone, or another person.
- C In most cases, a person will see an event directly. In cases where a person experiences the event through hearing it, for example from a room adjacent to that where the event took place, extra care will be required.
- d If a claim is lodged as a result of witnessing an event on a closed circuit television by a person who is required to provide video security surveillance as part of their employment, seek advice from a Technical Specialist.

6.0 The direct outcome of a sudden event

a If the person does not directly witness the event as it occurs, they can still be eligible for cover for a mental injury if they are involved in, or witness, the direct outcome of the event.

To be directly involved in, or witness, the outcome of a sudden event means the person must be physically present at the scene of the event.

A person may be at the scene of the event and:

- · provide medical assistance
- provide emergency response assistance
- be part of a rescue or clean up operation.

7.0 The event can reasonably be expected to cause mental injury

- a In order for the mental injury to be covered, it must be caused by an event that could reasonably be expected to cause mental injury to people generally.
- b Events that could reasonably be expected to cause mental injury would:
 - provoke extreme distress, horror or alarm in almost everyone
 - be outside the normal range of human experience (normal human experience would include bereavement, business loss, and divorce).
- c In cases where the event is significant, there will usually be lots of information that can be gathered from workplace incident reports, and police or emergency services reports, as well as a Department of Labour investigation. The more information that can be obtained, the more robust the cover decision will be.

8.0 Date of work-related mental injury

- a Cover is applicable for work-related mental injury where the client first sought treatment for the mental injury after 01/10/2008. This applies even if the event itself occurred prior to 01/10/2008.
- **b** The date of work-related mental injury is the date when the client first sought treatment.

9.0 Links to legislation

Accident Compensation Act 2001, section 21B Cover for work-related mental injury http://www.legislation.govt.nz/act/public/2001/0049/lat

Accident Compensation Act 2001, section 28 Work-

related personal injury http://www.legislation.govt.nz/act/public/2001/0049/lat