06 October 2020

[redacted]

Tēnā koe [redacted]

Your Official Information Act request, reference: GOV-006570
Thank you for your email of 1 September 2020, asking for the following information under the Official Information Act 1982 (the Act):

- *Can you please provide me with a copy of the Policy / Process document for ACC's handling of Validating a Claim - including contacting client or provider for information at Lodgement?*

On you 9 September 2020, you confirmed you were seeking the processes and policies for making a decision on claims for cover.

Our response
There are processes which relate to validating claims for the purpose of claims registration and also policies and processes relating to making cover decisions. To ensure we have fully responded to your request we are providing you with all the policies and processes that fall under these two groups. Please find all these documents, as listed below, attached.

Validate claim
- Action returned accredited employer claim
- Assign new ACC45 number
- Confirm accident location
- Confirm gender
- Contact client or provider for information at lodgement
- Identify client
- Identify client's employer
- Identify client's provider
- Merge duplicate part records
- Obtain client authority for claim registration
- Resolve provider competency issue
- Resolve provider, vendor or facility status issue
- Respond to provider request for contact
- Update client address
- Update client phone number
- Verify claim information

Make cover decision
- Accept claim
- Assess claim for cover (treatment injury)
- Assess claim for cover_PICBA
- Assess cover for an additional injury or change in diagnosis
- Assess cover for hearing loss claim
- Audit claim and cover decision

- Complete cover decision
- Consider risk of harm
- Decline claim fie to incomplete registration
- Decline claim
- Decline hearing loss claim
- Determine cover for accidental death
- Extend cover decision timeframe
- Identify and link duplicate claims_standard
- Make cover decision for mental injury caused by sexual abuse
- Make cover decision for keloid and hypertrophic scars
- Make cover decision for mental injury caused by physical injury
- Make over decisions for work-related mental injury claims
- Make cover decisions on additional diagnosis request for rib fracture
- Manage a work injury dispute
- Managing hearing loss supports
- Monitor cover decision timeframes_held claim
- Resolve service failure
- Transfer claim when automatic matching fails

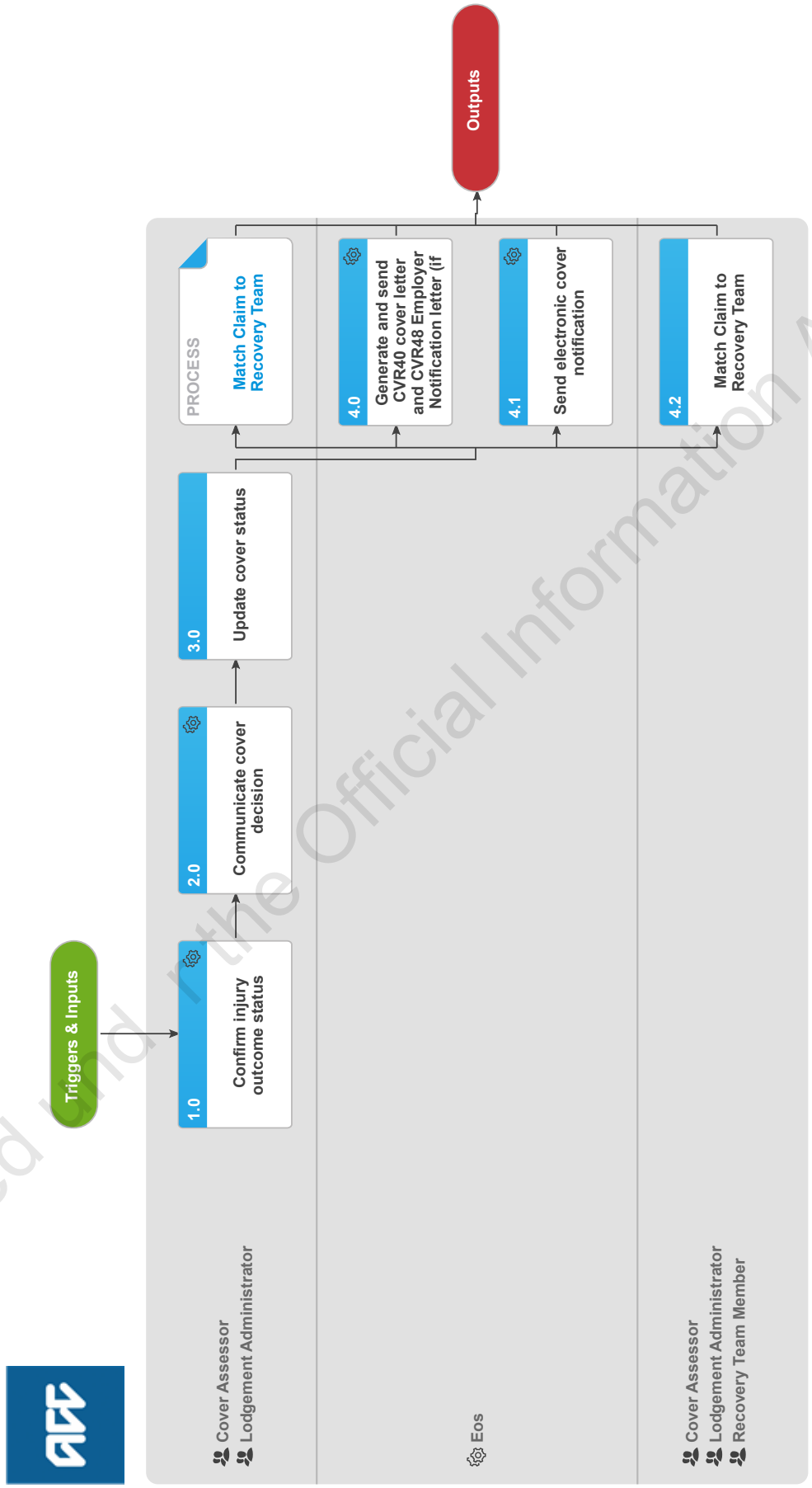
Please note, that the staff named in the attached documents are named as subject matter contacts for internal queries and are not those staff who created or updated the documents.

Questions about our response
If you have any questions, you can email me at GovernmentServices@acc.co.nz.

Nāku iti noa, nā

Sasha Wood
Manager Official Information Act Services
Government Engagement & Support

Accept Claim v8.0



Accept Claim v8.0

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 [redacted]

Expert [redacted]

Procedure

1.0 Confirm injury outcome status
Cover Assessor, Lodgement Administrator

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

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

2.0 Communicate cover decision
Cover Assessor, Lodgement Administrator

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

- Accept cover letter criteria for PICBA claims

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

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

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

- Upload an Incomplete Electronic Document
- CVR43 Claim approve - decline in ury
- CVR45 - Claim approve- non-work injury - claimant
- CVR47 - Claim Approve - work injury - claimant
- CVR70 Cover approve add injury - claimant
- WSI02 Accept cover - client
- CVR41 Claim approve - generic - claimant

NOTE What if the client's address is not valid?

c Print and sign the letter.

d Add the Working Together information sheet.

- ACC255 Kōrero 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?

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

3.0 Update cover status
Cover Assessor, Lodgement Administrator

a 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)?

- 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?

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 gen erated. Eos transfers the letter data to an external mail house who print and send the letter to the 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

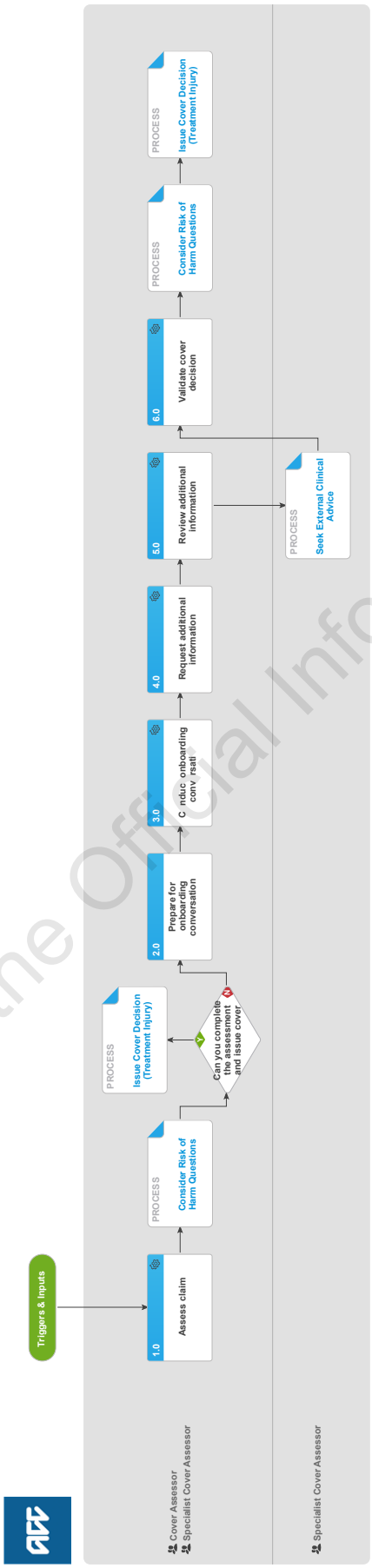
Cover Assessor, Lodgement Administrator, Recovery Team Member

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

Assess Claim for Cover (Treatment Injury) v5.0



Assess Claim for Cover (Treatment Injury) v5.0

Summary

Objective
To assess information on a claim and decide whether it meets the criteria for cover for a treatment injury.

Background
This process was developed to allow a consistent framework for Cover Assessors and Specialist Cover Assessors to investigate all claims requesting cover under Treatment Injury legislation. This process ensures consistency across the organisation in the steps required for this to take place.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Assess claim

Cover Assessor, Specialist Cover Assessor

a Review the client's claim and party record, including the ACC45, ACC2152 (if on file), all clinical documents and all open tasks on the claim.

NOTE What if there is a request for treatment on the claim, ACC18, ARTP, weekly compensation request or other requests i.e. dental treatment, hearing aids, prosthesis and district nursing care?

b Generate ACC2184 Cover decision tool if required.

NOTE When is ACC 2184 is required?

c Confirm this is a newly lodged claim.

NOTE What if the claim is a re-assessment and the information is not new?

NOTE What if the claim is a re-assessment and the information is new?

Cover criteria for medical misadventure Policy

NOTE What if the claim is a duplicate?

NOTE What if you identify the claim is consequentia to another claim?

d Following an initial review of the claim, document your findings in Eos in a contact

NOTE What should be written in the contact?

e Determine whether the client has suffered a personal injury.

NOTE What if the client did not suffer a personal injury?

NOTE What if the claim is for a mental injury?

Mental Injury Because of a Physical Injury Policy

Statutory timeframes for mental injuries Policy

Treatment injury mental injury Policy

f Assess whether the personal injury occurred within the context of treatment. Refer to the 'Context of Treatment Policy'.

Context of Treatment Policy

NOTE What if the injury did not occur within the context of treatment?

g Determine if there is a direct causal link between the treatment sought or received and the personal injury. Refer to 'Causal Link Policy'.

Causal Link Policy

NOTE What if there is no direct causal link?

h Consider whether the injury was a necessary part or ordinary consequence of treatment. Refer to 'Necessary Part or Ordinary Consequence of Treatment Policy'.

Necessary Part or Ordinary Consequence of Treatment Policy

NOTE What is the injury was a necessary part or an ordinary consequence of the treatment?

i Check if any exclusions to cover apply. Refer to 'Treatment Injury Exclusions from Cover Policy'.

Treatment Injury Exclusions from Cover Policy

NOTE What if any exclusions to cover apply to the treatment injury claim?

j Ensure that you are closing the relevant tasks for the information or work that you have completed on the claim. An example would be if you have assessed and competed the work associated with an 'Alert you have mail' task, 'NGCM - Medical Notes Received', or other task type that is NOT a master claim task (Confirm Cover Decision) or other legislative task

k Review the knowledge articles for the particular treatment by going to the page below (search under 'Knowledge for Cover Assessors'), if applicable.

Next Generation Case Management landing page

l Updating Eos with relevant information

NOTE What do you document in the 'contacts' following/during assessment of the claim?

PROCESS

Consider Risk of Harm Questions

Cover Assessor, Specialist Cover Assessor

Can you complete the assessment and issue cover decision?

Cover Assessor, Specialist Cover Assessor

YES.... PROCESS **Issue Cover Decision (Treatment Injury)**

NO.... Continue

2.0 Prepare for onboarding conversation

Cover Assessor, Specialist Cover Assessor

NOTE What if you're a Cover Assessor and you think you cannot complete the assessment because it's a complex claim?

a Determine what consent is necessary to collect medical and other records: ACC45, verbal consent, ACC6300 Authority to collect medical and other records, or ACC163 Authority to collect information about a deceased person.

NG GUIDELINES Obtain Verbal or Written Authority

NOTE When is a ACC6300 required?

NOTE What if the client is deceased?

NOTE What if verbal consent is appropriate?

NOTE What if you need to request consent to lodge a mental injury claim?

b Determine if the client requires an Authority to Act (ATA)

NOTE What if the client requires an Authority to Act?

c Determine what clinical information is required to make cover decision. Communicate the requirements to the client during the onboarding conversation.

NOTE When should you request ACC2152?

NOTE What if you require an audiology assessment?

d Determine if the client can provide the additional information. Collect this information during the onboarding conversation.

e Check if the client has any existing language or cultural needs.

NOTE What if the client does have language or cultural needs?

NG GUIDELINES Suppo ting the Diverse Needs of our Clients

When to use an interpreter Policy

Working with an interpreter process (CHIPS)

ezispeak - phone interpreting service for ACC (CHIPS)

3.0 Conduct onboarding conversation

Cover Assessor, Specialist Cover Assessor

a Contact the client or person acting on the client's behalf by their preferred method of communication. There must be an Authority to Act (ATA) on file if contacting someone other than the client.

NOTE How many contact attempts should be made?

NOTE What if you are unable to contact the client after making the above contact attempts?

b Follow the 'TI Onboarding conversation' guide.

TI Onboarding conversation

c In Eos, upload the completed onboarding conversation to the 'Documents' tab.

NOTE What if you identify the client's condition is rapidly deteriorating?

NOTE What if the client has not given consent to continue to investigate the claim during the Onboarding conversation?

NOTE What if a client mentions self-harm or suicide?

NG GUIDELINES Managing Threat of Self-harm Calls

NOTE What if the employer is a registered AEP participant and the client's injury is related to work?

Accredited Employer list for work related claims
http://thesauce/team-spaces/chips/employers/accredited-employer-claims/reference/accredited-employers-list/index.htm

Participating Accredited Employers for non-work related claims
http://thesauce/team-spaces/tpa-non-work-injury-service/participating-accredited-employers/index.htm

d Complete outstanding actions.

NOTE What if you need to lodge an additional claim for mental injury?

Referral for New Claim Lodgement

4.0 Request additional information

Cover Assessor, Specialist Cover Assessor

a Follow the appropriate process below for requesting additional information.

NOTE What if you require additional information because cover decision is being reviewed?

NOTE What if you require clinical records/report or ACC2152?

NOTE What do I need to consider when writing questions to a provider?

Clinical questions guide

NOTE What if you require internal clinical, medical or technical guidance (Tier 1 and 2)?

NOTE What if you require written internal clinical, medical or technical guidance (Tier 3)?

NOTE What if you require external clinical advice?

NOTE What if you require an archived physical claim file?

NOTE What if an Audiology (audiometry - percentage of hearing loss) assessment is required?

NOTE What if a mental injury or Otolaryngologist/ENT (hearing loss) assessment is required?

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

Psychiatric assessment memorandum template

Psychiatric assessment memorandum example

NOTE What if a face to face (other) specialist medical assessment is required?

b Determine if the timeframe to make cover decision needs to be extended. Refer to the policy below.

How to manage legislative timeframes Policy

NOTE What if you need to advise of extension or request extension agreement?

c Updating Eos with relevant information

NOTE What do you document in the 'contacts' following/during assessment of the claim?

5.0 Review additional information

Cover Assessor, Specialist Cover Assessor

a Review new information to make a cover decision.

NOTE What if you need more information?

NOTE How do you review the ENT assessment?

Review ENT assessment

NOTE What should you do with the open task associated with the information that you have reviewed?

NOTE What are the next steps following a mental injury assessment (once the client has undergone an independent psychiatric review?

b In Eos, update the 'Medical' tab and 'Treatment Injury' tab based on the new information received.

NOTE What if you need to extend the timeframe up to 9 months (extension request)?

NOTE What if the client has not responded to you or not returned the extension letter to ACC agreeing to extend timeframes?

NOTE What if you are notified that the client has died during the investigation of the claim?

NOTE What if you're a Cover Assessor and think the claim should be assessed by a Specialist Cover Assessor or the claim might require External Clinical Advice?

c Updating Eos with relevant information

PROCESS **Seek External Clinical Advice**

Specialist Cover Assessor

6.0 Validate cover decision

Cover Assessor, Specialist Cover Assessor

a Review 'Claim validation framework guide'.

Claim validation framework guide

b Answer the questions in 'Claim validation framework guide.'

NOTE What if you're unsure of the decision?

NOTE What if the claim is considered high risk or high cost?

When to request complex claims endorsement

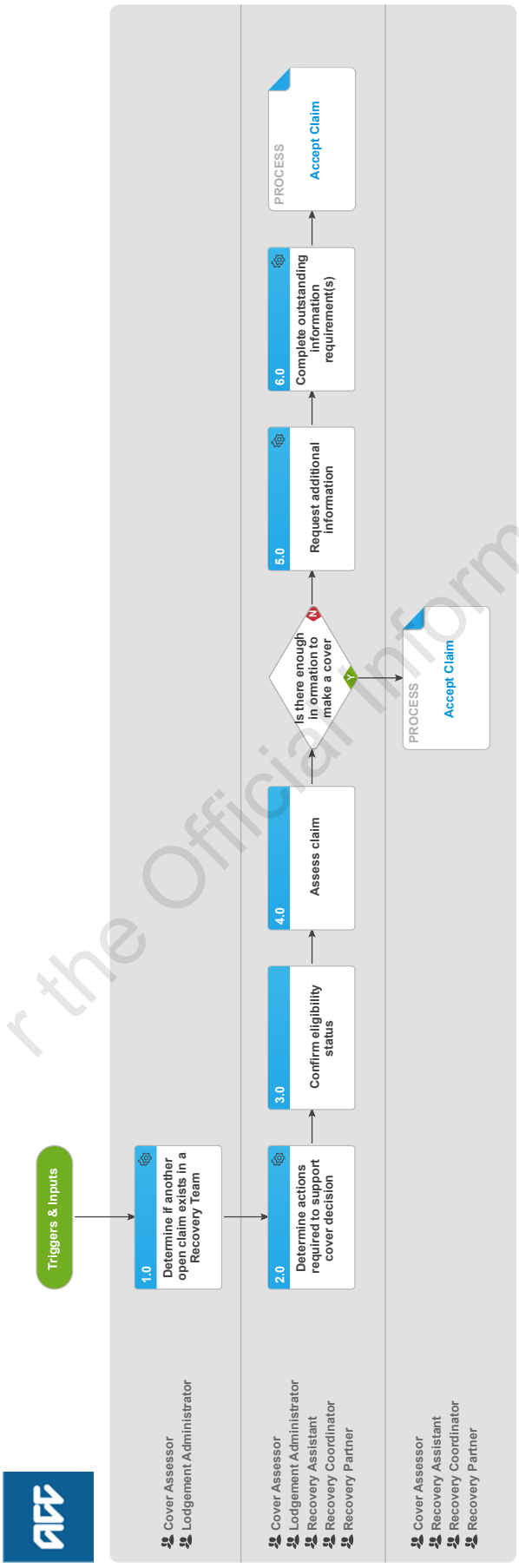
PROCESS **Consider Risk of Harm Questions**

Cover Assessor, Specialist Cover Assessor

PROCESS **Issue Cover Decision (Treatment Injury)**

Cover Assessor, Specialist Cover Assessor

Assess Claim for Cover :: PICBA v17.0



Assess Claim for Cover :: PICBA v17.0

Summary

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

This process applies to the Lodgement and Triage team only, it does not apply to the Remote Claims Unit, Wellington Central Branch or any specialist teams (Hearing Loss, Dental etc.).

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

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

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

Owner [redacted]

Expert [redacted]

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?

NOTE What if there is an active managed claim?

2.0 Determine actions required to support cover decision
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Open the [Confirm Cover Decision] task.

Do a task with information requirements

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

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

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

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

NOTE What if the claim has the default provider ID?

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

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3.0 Confirm eligibility status
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

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

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

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

4.0 Assess claim
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

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

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

NOTE What if it's a change or additional diagnosis?

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

- Triage Traffic Light
- Registration Reference Book Spreadsheet
- Guidelines - Sprains, Strains and Contusions
- Guidelines for accepting cover for Concussion

NOTE What information do you need to consider for the change or additional diagnosis request?

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

NOTE What if the claim does not meet the criteria for cover?

Is there enough information to make a cover decision?

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

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

NO.... Continue

5.0 Request additional information

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

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

NOTE What if you need to ask the client or provider for additional information at lodgement?

NOTE What if you require clinical records?

- Request medical or clinical records Policy (Section 7)
- Requesting clinical records from District Health Boards (CHIPS)
- Contacts for requesting District Health Board clinical records

NOTE What if you require clinical advice?

NOTE What if a client or provider cannot provide the requested information?

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

NOTE How much time do you have to make a cover decision?

- Timeframes to determine cover Policy

NOTE What if the cover decision timeframe needs to be extended?

6.0 Complete outstanding information requirement(s)

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

a Update the Cover Decision Required information requirement to [Complete] and also update the Cover Assessment Required information requirement to [Complete] if it's present on the claim.

- Complete information requirement

b Clear Information required Tab in EOS and associated tasks

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

NOTE What if there's one or more outstanding address-related information requirements (Address is Invalid, Client Address Matches Previous Home Address, Client Already Has an Address Starting Today, Client Already has a Post Address Starting Today)?

NOTE What if there's an outstanding Phone Number Verification information requirement?

NOTE What if there's an outstanding Vendor Status Removed or Facility Status Removed information requirement?

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

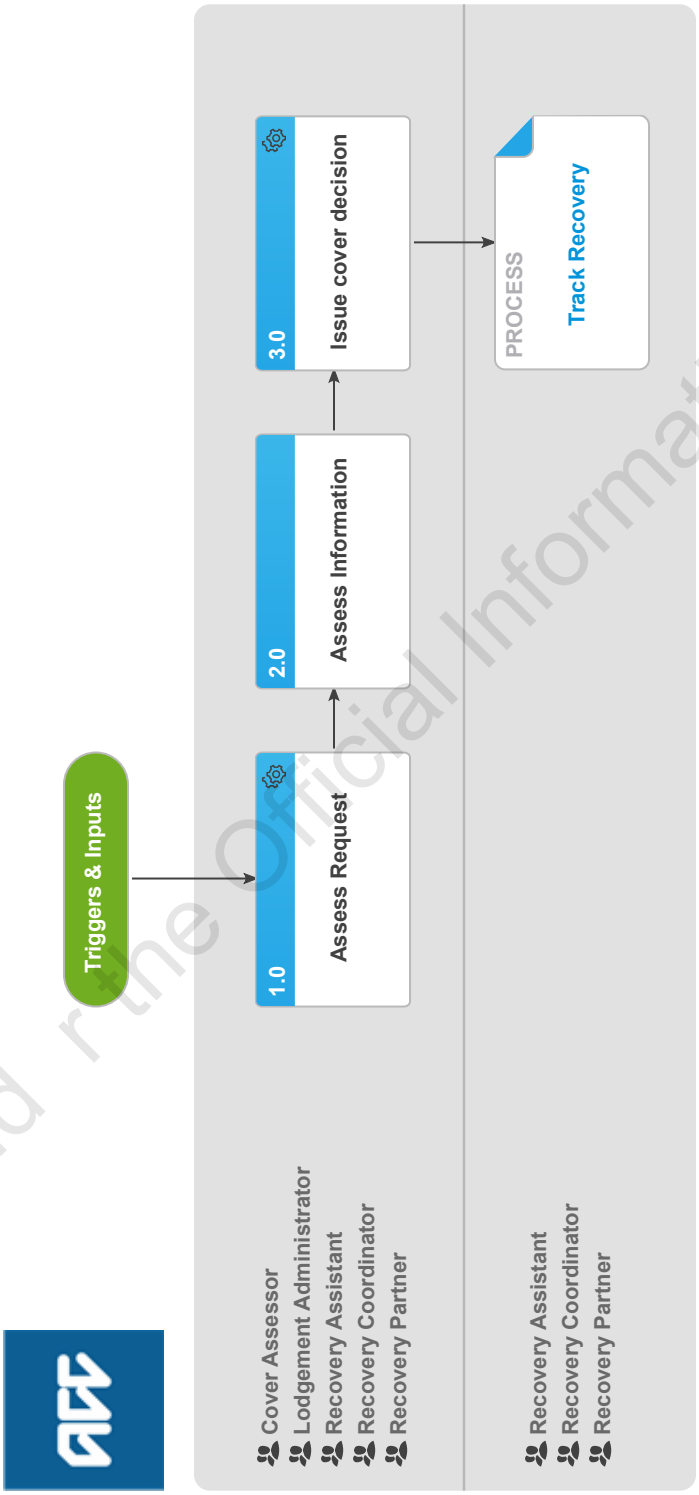
NOTE What if there's an outstanding Case Alias Check Required information requirement?

PROCESS

Accept Claim

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

Assess Cover for an Additional Injury or Change in Diagnosis v9.0



Assess Cover for an Additional Injury or Change in Diagnosis v9.0

Summary

Objective
The objectives of the process are
• to assess 'new injury' against cover criteria, so that the client can request supports.
• to action information about '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
Usually, providers change or add a diagnosis if they made a mistake on the original claim form, completed further diagnostics and assessments, and identified new symptoms. The additional or changed diagnosis is referred to as 'new diagnosis' or '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 and support 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

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

Owner [redacted]

Expert [redacted]

Procedure

1.0 Assess Request

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

a Review the information received.

NOTE What new information will you receive to indicate a change in diagnosis or additional injury?

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

b Confirm the client has an accepted claim.

NOTE What if the request is for a new event?

Referral for New Claim Lodgement

NOTE What if the request is for a sensitive claim?

NOTE What if the cl ent, provider, or advocate has called and advised ACC verbally of the request?

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

NOTE What if you are in Assisted Recovery?

d In Eos, add new diagnosis in the 'Medical' tab, update the Source of new diagnosis and set the Outcome Status to 'investigating'.

Add an Injury Code

e In Salesforce, in the Recovery Plan at Life Area: Health Factors or diagnosis change, update with: Request for new diagnosis [name] received through [source] on [the date received].Cover decision is due on [date].

2.0 Assess Information

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

a Check you have minimum required information on the request.

NOTE What is the minimum information required for a change of diagnosis?

b Determine if additional injury / change of diagnosis can be covered based on the information available.

NOTE How do you know if you are able to approve cover the additional injury / change of Diagnosis?

TOOL - Add or change diagnosis decision traffic light

c Review the claim for any additional information needed to make a decision.

d Determine the cover process you need to follow for the injury type.

NOTE What if it's a physical injury caused by accident (PICBA)?

NOTE What if it's a request for cover for Mental Injury caused by Physical Injury?

NOTE What if it's a request for cover for a work related mental injury?

NOTE What if it is a sensitive claim?

NOTE How much time do you have to make a cover decision on an additional injury?

NOTE What if you cannot make a decision in the legislative timeframe?

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

Deemed cover decisions when timeframes not met Policy

3.0 Issue cover decision

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

a In Eos, update the 'Medical' tab, set the Outcome Status of the new diagnosis to 'Approved' or 'Declined'

NOTE What if it's a deemed cover decision?

b In Salesforce, in the Recovery Plan, update Life Area: Health Factors or diagnosis change: Diagnosis [name] - accepted or declined.

NOTE What if it's a deemed cover decision?

c In Salesforce, add a contact to document your rationale for decision.

d Generate the CVR70 cover approve - add injury claimant letter.

NOTE What if it's a deemed cover decision?

CVR75 Deemed Cover - client letter

NOTE What if the additional injury is declined?

CVR999 Cover decline decision - client

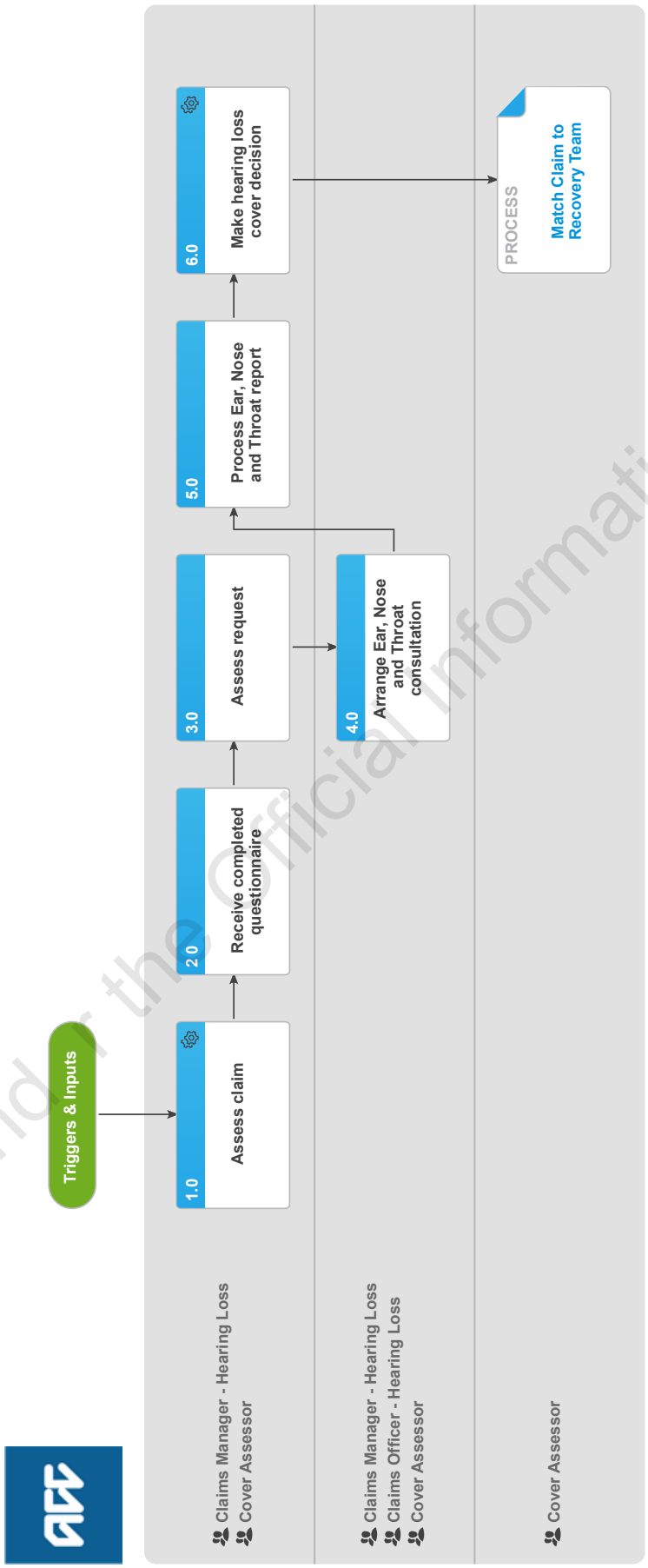
SCU999 Cover decision

e Close 'NGCM - Cover Decision Required' task.

PROCESS **Track Recovery**

Recovery Assistant, Recovery Coordinator, Recovery Partner

Assess Cover for Hearing Loss Claim v8.0



Assess Cover for Hearing Loss Claim v8.0

Summary

Objective
To assess cover for new hearing loss claims so that clients can receive a decision on their claim and request treatment.

Background
This is the cover process for work-related, noise-induced hearing loss and acoustic trauma. It also assists with the cover process for treatment injury claims related to hearing loss or when a client has multiple injuries including hearing loss.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Assess claim

Claims Manager - Hearing Loss, Cover Assessor

a In Eos, receive new claim to assess for Hearing Loss.

b In the Claims tab, confirm there's no duplicate claims.

NOTE What if a duplicate claim exists and there's already cover approved?

- HLS32 Acknowledge duplicate claim - client
- Link duplicate claims during registration
  http://thesauce/team-spaces/eos-online-help/specialist-functions/registering a-claim/link-duplicate-claims-during-registration/index.htm

c Confirm claim details are accurate and that the claim is for a Hearing Loss claim.

NOTE What if the claim isn't a hearing loss claim?

- Transfer a claim
  http://thesauce/team-spaces/eos-online-help/managing-work claim/department-claims/transfer-a-claim/index.htm

d Add a 'Hearing Loss' Rehabilitation Action to the claim.

- Add or edit a rehabilitation action
  http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/add-or-edit-a-rehab-action/index.htm

e Contact the client to discuss the claim. If possible, complete the client questionnaire over the telephone with them.

NOTE What if I can't contact the client or it's not appropriate to complete the questionnaire on the phone?

- HLS03 Acknowledge trauma claim client
- HLS06 Acknowledge ONIHL claim client
- ACC610 Hearing Loss accident questionnaire
- ACC724 Hearing loss questionnaire
- ACC6300 Authority to co lect medical and other records

NOTE What if the claim is a request for hearing loss supports?

2.0 Receive completed questionnaire

Claims Manager - Hearing Loss, Cover Assessor

a Confirm you ve received the completed client questionnaire.

NOTE What if the questionnaire hasn't been returned?

- HLS10 Reminder Questionnaire - client

NOTE What if the questionnaire is still not returned after a second follow up?

b Confirm the questionnaire is completed fully.

NOTE What if the questionnaire isn't completed correctly or is incomplete?

3.0 Assess request

Claims Manager - Hearing Loss, Cover Assessor

a Determine that the claim is NIHL-related and any of the 'Noise-induced hearing loss' (Section 3) criteria are met.

- Criteria for hearing loss claims

NOTE What if the claim is NIHL-related however none of the criteria are met or the claim is trauma related?

b Send an HLS08 Acknowledge ONIHL claim - employer letter and an ACC725 Hearing loss - employer's report to your client to take to their employer.

HLS08 Acknowledge ONIHL claim - employer

ACC725 Hearing loss report for employers

c Check that you have received an acceptable audiometric report.

Accident Compensation (Occupational Hearing Assessments Procedures) Regulations 1999
https://www.westlaw.co.nz/maf/wlnz/app/document?startChunk=1&endChunk=1&docguid=I83e83630e15811e08eefa443f89988a0

NOTE What if I haven't received an acceptable audiometric report and you've also requested an employer report?

HLS14 Audiologist letter

d Check the audiometric report is completed correctly.

NOTE What if the report is inaccurate or incomplete?

NOTE What if I haven't received the audiometric report and/or employer questionnaire after 21 days?

NOTE What if I haven't received the audiometric report and/or employer questionnaire by the agreed date?

e Add the hearing Loss indicator to the claim and load information in the hearing loss indicator eform

Add a hearing loss indicator screen
http://thesauce/team-spaces/eos-online-help/how-to/indicators/add-hearing-loss-indicator/index.htm

NOTE What information should be loaded into eform?

f Assess whether the total hearing loss meets the minimum 6% threshold

NOTE What if the total hearing loss is less than 6%?

Criteria for hearing loss claims

Accident Compensation Act 2001, Sections 20, 26, 30 and 61
https://www.westlaw.co.nz/maf/wlnz/app/document?&src=search&docguid=I679d8e68e03211e08eefa443f89988a0&epos=1&snippets=true&fcwh=true&startChunk=1&endChunk=1&nstid=std-anz-highlight&nsds=AUNZ_LEGCOMM&isTocNav=true&tocDs=AUNZ_NZ_LEGCOMM_TOC&context=26&extLink=false&searchFromLinkHome=true

4.0 Arrange Ear, Nose and Throat consultation

Claims Manager - Hearing Loss, Claims Officer - Hearing Loss, Cover Assessor

a Review the client's claim history to check for any existing hearing loss claims

b Contact the client to determine if they wish to see an ENT specialist in person or have their claim assessed on the papers.

c Complete the purchase order and support documentation ensuring that you advise the ENT specialist about any existing hearing loss claims, to help with their assessment

Purchase Orders
http://thesauce/team-spaces/eos-online-help/how-to/purchase-orders/index.htm

d Attach all supporting documentat on to the ENT referral pack

NOTE What supporting documentation should be included in the referral pack?

e Complete the ACC6173 Information Disclosure Checklist then send the referral pack to the ENT specialist

ACC6173 Information Disclosure Checklist

5.0 Process Ear, Nose and Throat report

Claims Manager - Hearing Loss, Cover Assessor

a Check the ENT report

ACC723 Otolaryngologist report

NOTE What if you have not received the report?

NOTE What if inaccurate or incomplete?

b Confirm that you have all information necessary to make a cover decision

Criteria for hearing loss claims

NOTE What if you do not have all necessary information to make a cover decision?

NOTE What if you are unsure how to proceed?

NOTE What if the timeframe is expiring and you still don't have enough information?

6.0 Make hearing loss cover decision

Claims Manager - Hearing Loss, Cover Assessor

a Assess information and determine cover decision

- Accident Compensation Act 2001, Section 20, 26, 30 and 61
  https://www.westlaw.co.nz/maf/wlnz/app/document?&src=search&docguid=I679d8e68e03211e08eefa443f89988a0&epos=1&snippets=true&fcwh=true&startChunk=1&endChunk=1&nstid=std-anz-highlight&nsds=AUNZ_LEGCOMM&isTocNav=true&tocDs=AUNZ_NZ_LEGCOMM_TOC&context=19&extLink=false&searchFromLinkHome=true
- Criteria for hearing loss claims

NOTE What if claim does not meet hearing loss cover criteria?

b Update the hearing loss indicator eform

NOTE What information needs to be updated on hearing loss indicator eform?

- Edit an indicator
  http://thesauce/team-spaces/eos-online-help/how-to/indicators/edit-an-indicator/index.htm

c Create a purchase order from the HL Indicator e-form and send the client approval letter to provide supports

- Create a Purchase Order
  http://thesauce/team-spaces/eos-online-help/how-to/purchase-orders/create-a-purchase-order/index.htm

d Update the cover status in Eos to 'Accept'

- Update cover status
  http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/update-cover-status/index.htm

NOTE What if the claim is work-related?

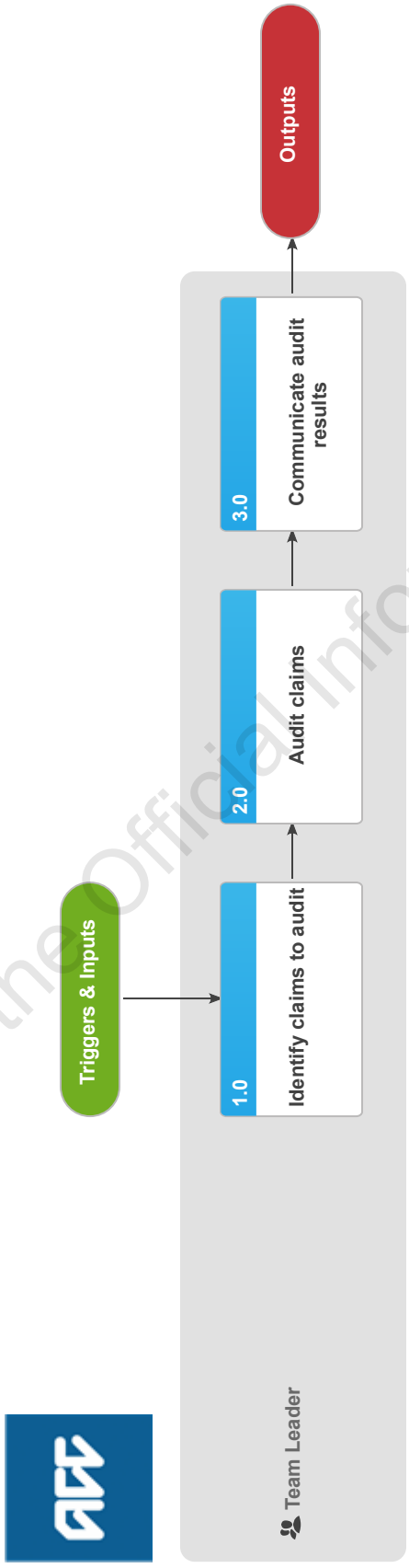
- Manage Participants
  http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/manage-participants/index.htm
- Cost allocation for gradual process claims

e Go to the Match Claim to Recovery team process below to determine the appropriate team to manage the claim.

PROCESS **Match Claim to Recovery Team**

Cover Assessor

Audit Claim and Cover Decision v6.0



Audit Claim and Cover Decision v6.0

Summary

Objective
To audit claims which have had a recent cover decision made by a cover assessor and ensure they meet ACC's quality standards.

This process applies to the Lodgement and Triage Team only.

Background
Lodgement Leaders must audit five claims per month for each staff member that reports directly to them and makes cover decisions.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Identify claims to audit
Team Leader

a Access the relevant data in InFact. To do this go to the CFEE Lodgement dashboard and open the Cover Decision Reasons report then enter the relevant date range and department. From there you can view the cover decisions made by each staff member in the department.

b Identify five claims to audit for each staff member that reports directly to you and makes cover decisions.

NOTE How do I identify which claims to audit?

2.0 Audit claims
Team Leader

a In Eos, open the claim that's been identified for audit.

b Assess the claim against the criteria outlined in the Cover Audit Criteria guide below.

Cover Audit Criteria

c Enter the results into the relevant audit spread sheet saved in the following location: W:/Public/CAC/Cover Assessment/Audits

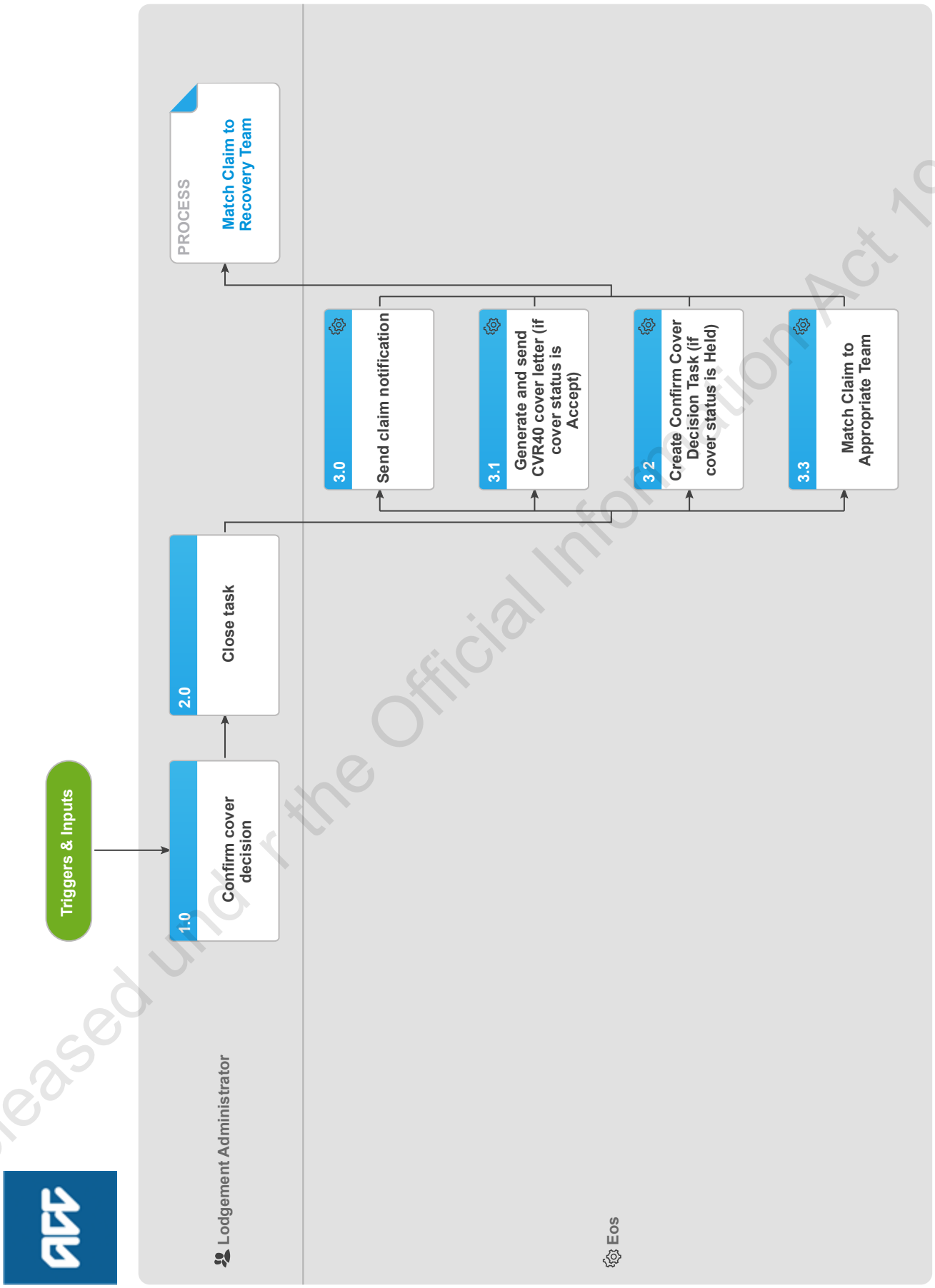
d Repeat steps a-c until all identified claims have been audited.

3.0 Communicate audit results
Team Leader

a Compare staff member's current and past audit results to:
- identify any improvements or otherwise on past issues
- identify if further training is required
- escalate if improvement has not been made within appropriate timeframe (Performance Improvement Plan).

b Inform staff member of their audit results and arrange any follow-up actions based on these results.

Complete Cover Decision QA Check v12.0



Complete Cover Decision QA Check v12.0

Summary

Objective
To ensure that the Cover Decision Service has made the correct decision based on the accident and injury information entered at point of registration.

Background
Eos has identified that the probability of accept score is just above the threshold at which a claim is automatically accepted by the Cover Decision Service. It has created a Quality Assurance task for someone to verify that the decision was correct.

Note: This is likely to be a temporary process. It will be removed when the business has confidence that the Cover Decision Service is only accepting claims that meet criteria for cover, and that the threshold for sending claims for a manual cover decision has been set at an appropriate level.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Confirm cover decision
Lodgement Administrator

a Open the Quality Assurance task.

NOTE What if the ACC45 Claim Form is not yet viewable on the claim?

b Review all available claim information and determine whether the claim meets criteria for cover. Use the policies below to help determine this. The claim should meet the green traffic light rules in the Registration Reference Book .

- Cover for visitors to New Zealand Policy
- Cover criteria for personal injury Policy
- Criteria for injury occurring outside New Zealand Policy
- Registration Reference Book Spreadsheet

c If the claim meets criteria for cover and has a green traffic light then go to step 2.0.

NOTE What if the claim doesn't appear to meet criteria for cover, or has an amber or red traffic light?

- Contact Generator Spreadsheet

2.0 Close task
Lodgement Administrator

a Close the Quality Assurance task

3.0 Send claim notification
Eos

a Once the Quality Assurance task is closed, Eos sends an automatic notification to the client advising them of the cover decision (Accept or Held).

3.1 Generate and send CVR40 cover letter (if cover status is Accept)
Eos

a If the cover status remains as Accept and the Send Auto Accept Letters radio button is set to Yes, 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.

3.2 Create Confirm Cover Decision Task (if cover status is Held)
Eos

a If the cover status has been manually changed to Held, Eos creates a Confirm Cover Decision task (and auto-reminder tasks) so that the claim can be investigated further.

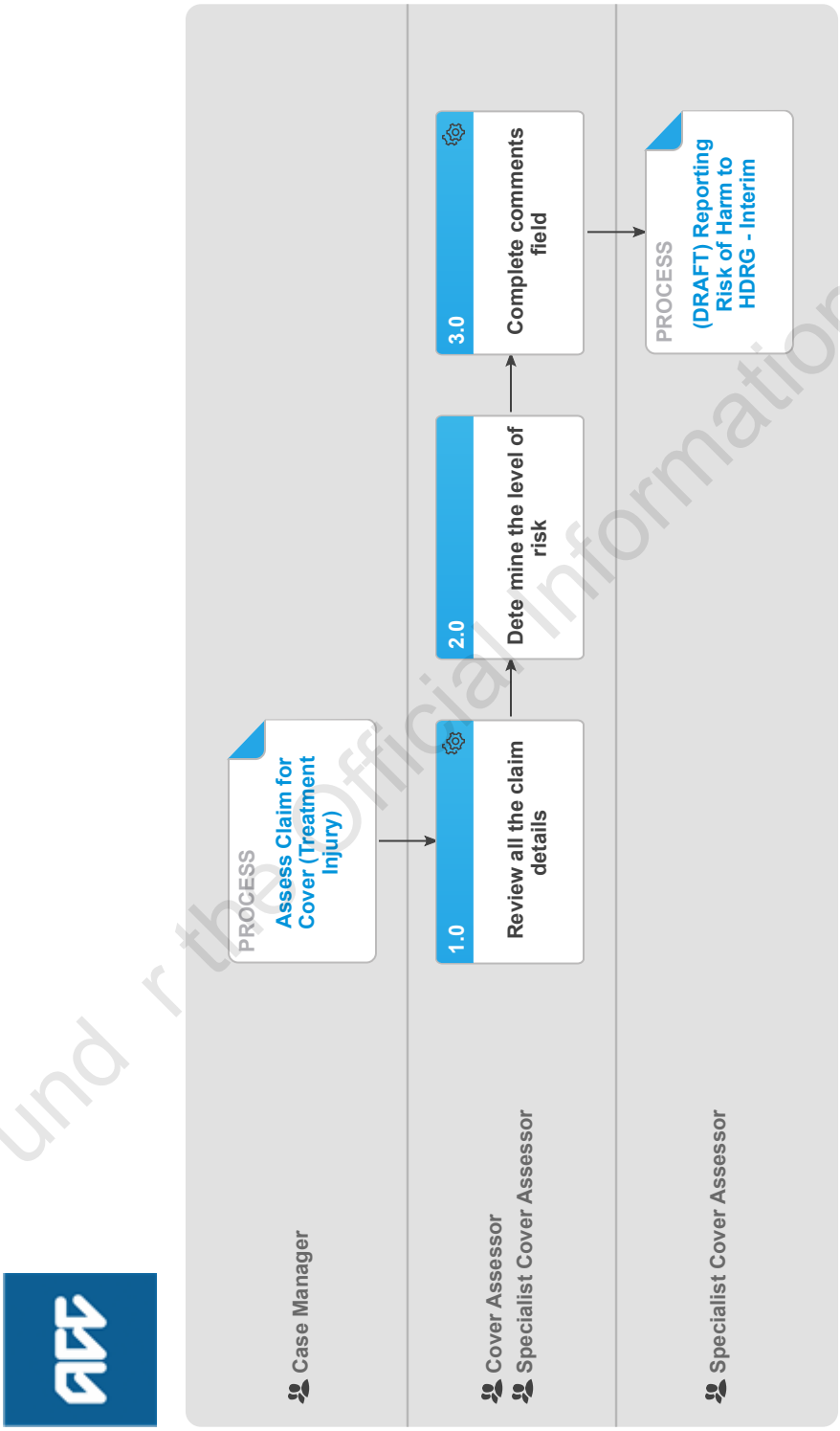
3.3 Match Claim to Appropriate Team
Eos

a If the cover status is Accept, go to the Match to Team process below to determine the appropriate team to manage the claim. If the cover status is Held, Eos will match the claim to the Cover Triage queue (along with the Confirm Cover Decision task) so that it can be assessed further.

PROCESS

Match Claim to Recovery Team
Lodgement Administrator

Consider Risk of Harm Questions v4.0



Consider Risk of Harm Questions v4.0

Summary

Objective
The purpose of risk of harm reporting is to provide information to support the prevention of harm to future patients by the health sector.

Risk of harm from treatment injury is when there is a reasonable or real prospect that the injury may happen to future patients if the same or similar treatment is continued to be done in the same way.

Risk of harm reporting applies to:
• all treatment injury claims, irrespective of whether the claim is accepted or not, and
• personal injury caused by accident (PIBCA) claims that are “like” a treatment injury ie injury caused whilst getting a health treatment from someone who is not considered a registered health professional under the AC Act eg an Acupuncturist.

Background
The aim of reporting is for ACC to:
• foster a learning environment
• help prevent future adverse events
• support a safety net.

Owner [redacted]

Expert [redacted]

Procedure

PROCESS **Assess Claim for Cover (Treatment Injury)**
Case Manager

1.0 Review all the claim details
Cover Assessor, Specialist Cover Assessor

a Review all claim details in Eos.

NOTE What forms do I look for?

- ACC45 ACC Injury claim.pdf
- ACC2152 Treatment Injury Claim
- ACC42 Dental Claim Additional Information
- ACC18 Medical certificate (print sample)
- ACC2018 Assessment report and treatment plan (ARTP)

b In Eos, create a contact or use the ACC2184 Treatment Injury cover decision tool to assist making a cover decision on a treatment injury or consequential injury claim.

- ACC2184 Treatment injury cover decision tool

c Review all details received from internal guidance.

NOTE What if you need guidance?

d Review all details received from external guidance.

NOTE What if you need guidance?

2.0 Determine the level of risk
Cover Assessor, Specialist Cover Assessor

a Consider the seven prevention questions. Refer to the attached document.

- Risk of Harm Questions for Cover Specialists

b Do you consider the event preventable?

NOTE If you have said 'Yes' to any of the questions then:

NOTE If you have said 'No' to all the questions then:

3.0 Complete comments field

Cover Assessor, Specialist Cover Assessor

a In Eos, select the 'Treatment Injury' tab, then select the 'Cover Decision' tab and scroll down.

b Complete the 'comments' field.

You are able to enter up to 2000 characters in the 'comments' field.

NOTE How should I enter my answers into the 'comments' field?

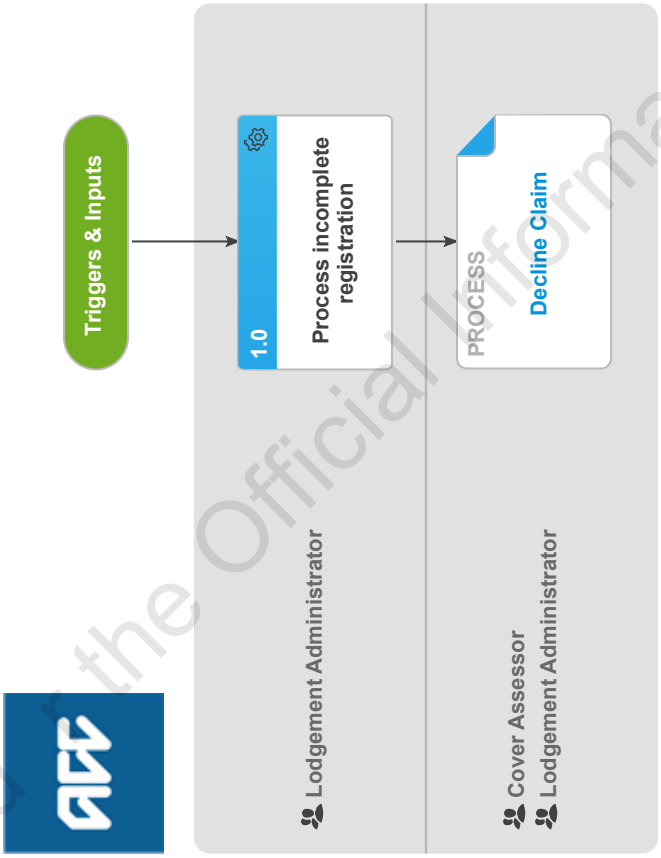
NOTE What do I enter into the mandatory 'comments' field if I do not have any answers/notes?

c In Mircosoft Word, if you have additional notes cut and paste text/evidence into the 'Comments*' field.

PROCESS **(DRAFT) Reporting Risk of Harm to HDRG - Interim**

Specialist Cover Assessor

Decline Claim Due to Incomplete Registration v7.0



Decline Claim Due to Incomplete Registration v7.0

Summary

Objective
To pass a claim through the Cover Decision Service so that a claim can be declined due to a lack of information when the status is incomplete.

Background
A claim can't be declined when the registration status is incomplete. The registration status only becomes complete once a claim has passed through the Cover Decision Service. If a claim needs to be decline due to a lack of information and the status is incom plete (ie it has missing mandatory information), then you must enter default information in the mandatory fields so the claim can pass through the Cover Decision Service and be completed.

Note: This is a #workaround until system functionality is in place that will allow a user to flag when a claim must bypass the cover decision service and be given a Registration Complete status.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Process incomplete registration
Lodgement Administrator

a. In Eos, open the client's party record and turn off notifications.
   - Stop notifications

b. Remove the lodging provider ID from the claim and add the default provider ID J99966 which will ensure the claim is given a [Held] status.

c. Add any other default information required to bypass the mandatory data fields.

d. Click [Next] on the claim intake form to save the changes.

e. Add a contact to the claim stating: 'Default data has been used to progress claim to Registration Complete status so that it can be declined due to lack of mandatory information .

f. Close the Missing Information for Cover task, this will trigger the claim to re-run validations and be sent to the Cover Decision Service where it will be given a [Held] status

g. Open the claim.

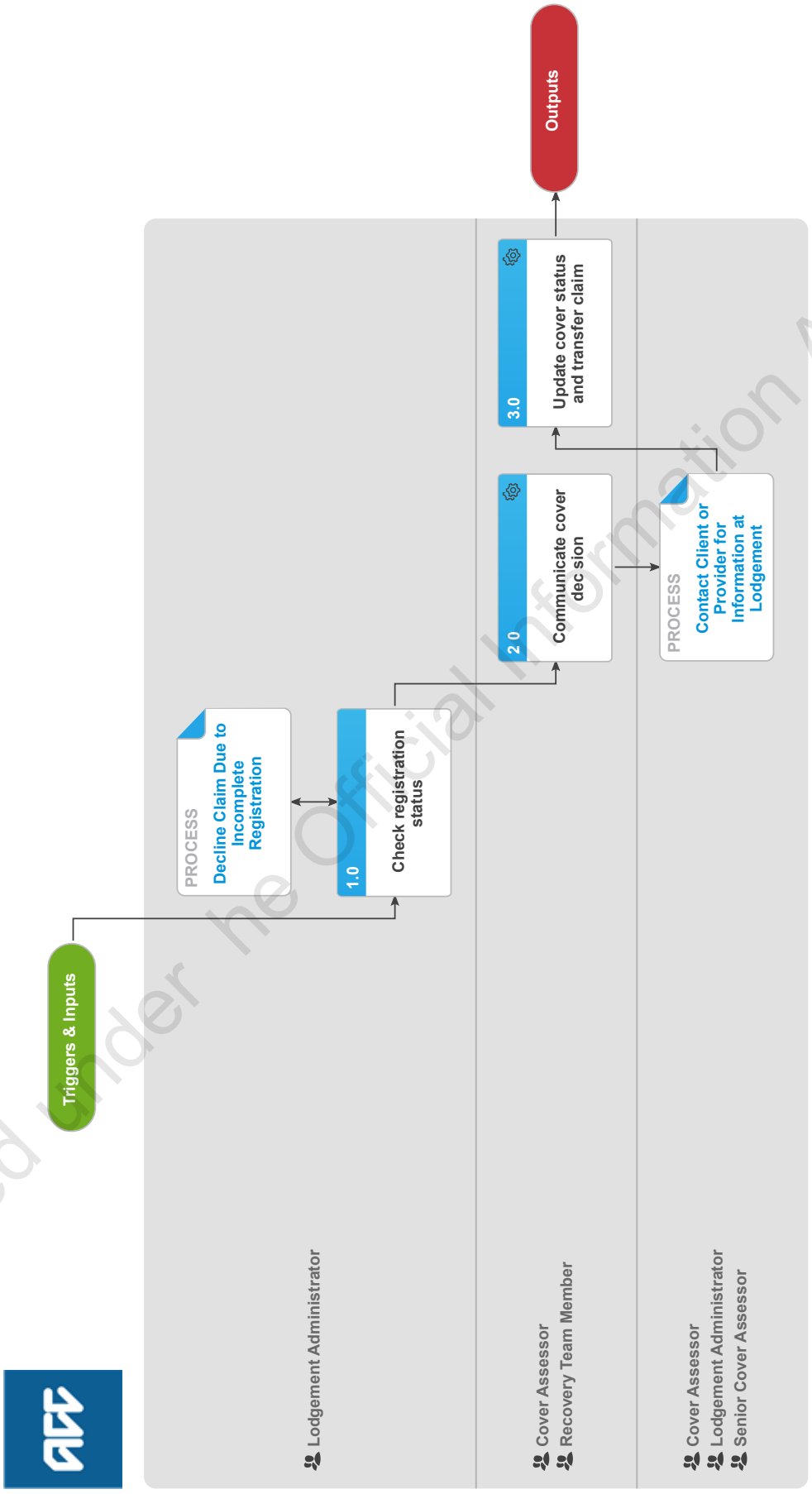
h. Remove the default provider ID and replace it with the lodging provider ID.

i. Open the client's party record and turn notifications back on.

j. Email the appropriate team to let them know that the claim should be declined, and follow up with a phone call if necessary.

PROCESS **Decline Claim**
Cover Assessor, Lodgement Administrator

Decline Claim v10.0



Decline Claim v10.0

Summary

Objective
To advise a client that we've declined their claim.

Background
A staff member has investigated a claim and determined that they must decline it. They can decline the claim for two reasons:
- There is insufficient information to make a cover decision, or
- The claim does not meet criteria for cover.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Check registration status
Lodgement Administrator

a Ensure the claim's registration status is complete.

NOTE What if it's not complete?

CONDITIONAL **Decline Claim Due to Incomplete Registration**
Lodgement Administrator

2.0 Communicate cover decision
Cover Assessor, Recovery Team Member

a Ensure that all the available information has been considered.

b Call the client to explain the decision. Go to the Contact Client or Provider for Information process below to do this.

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

NOTE What if there's an Assistance Required task on the claim?

NOTE What if the client provides new information about the claim?

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

Upload an Incomplete Electronic Document

CVR999 Cover decline decision client

NOTE What if the client's preferred method of communication is by email?

Send an email with an Eos document (Eos Online Help)

NOTE What if the client's address is not valid?

NOTE What if the client's preferred method of communication is by post or email is not verified?

d Add the Working Together information sheet to the client's letter.

ACC255 Kōrero mai - Working together

NOTE What if you are declining a claim for hernia?

ACC7913 Primary abdominal wall hernias, including groin hernias - A guide to ACC cover

e Privacy check outbound documentation to ensure you are only sending information to the client and provider that is relevant to this claim.

NOTE Do I have to complete the privacy check myself?

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

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PROCESS **Contact Client or Provider for Information at Lodgement**
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

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3.0 Update cover status and transfer claim
Cover Assessor, Recovery Team Member

a In Eos, in 'General' tab, change the Cover Status to 'Decline' and update the Cover Status Reason. Review 'Decline cover status reasons and rationale' guide to determine the correct cover status reason to use.

Update Cover Status

NOTE What if it's a change in or additional diagnosis?

b In Eos, in the 'Contacts' tab, add a contact explaining your cover decision rationale. Review 'Decline cover status reasons and rationale' guide on what to include in your rationale.

Add a client contact

Decline cover status reasons and rationale

c Ensure the relevant Information Required actions have been completed.

d Close the Confirm Cover Decision task and any other open tasks.

NOTE What if it's a change in or additional diagnosis?

Close a Task

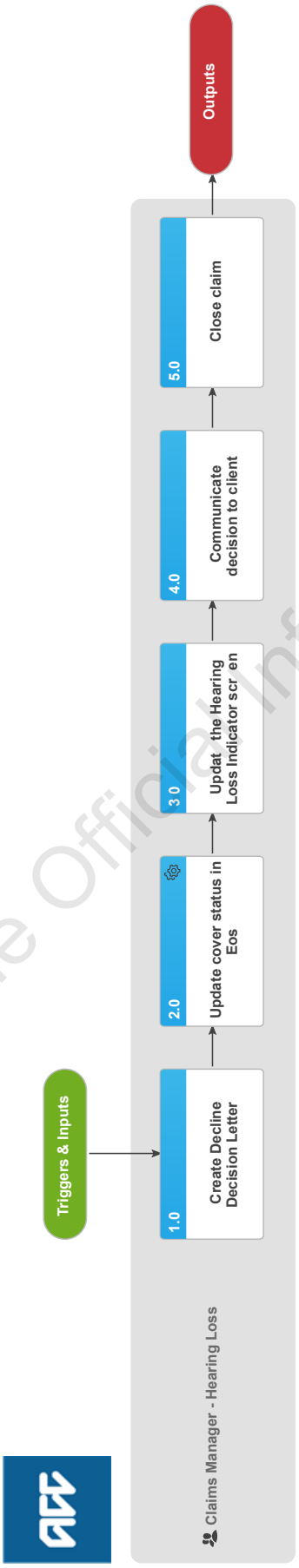
e Transfer the declined claim to your department's actioned cases queue.

NOTE What if I'm declining the claim due to timeframes, and I'm waiting for information to arrive that will help me to make a cover decision?

Transfer a Task to a Department

Move claim to actioned cases (Eos Online Help)

Decline Hearing Loss Claim v5.0



Decline Hearing Loss Claim v5.0

Summary

Objective
The Hearing Loss (HL) teams uses this process to decline hearing loss claims and communicate decisions to clients

Background
Hearing Loss units within Claims Assessment and Client Support based in Hamilton and Dunedin manage the cover process for work-related, noise-induced hearing loss and acoustic trauma. These units also help with the cover process for treatment injury claims related to hearing loss or when a client has multiple injuries including hearing loss.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Create Decline Decision Letter
Claims Manager - Hearing Loss

- **a** Prepare the hearing loss cover decline decision letter
  - HLS999 Hearing Loss cover decline - client
  - **NOTE** What if you will be releasing additional reports to the client, i.e. specialist reports?
  - ACC6173 Information Disclosure Checklist

2.0 Update cover status in Eos
Claims Manager - Hearing Loss

- **a** Change cover status dropdown field in Eos to 'Decline'
- **b** Update the 'Cover Status Reason' and 'Cover Status Change Reason' fields
  - Update cover status
    http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/update-cover-status/index.htm
  - **NOTE** What if the client didn't return the questionnaire form?
  - **NOTE** What if either total or covered hearing loss is less than 6%?
  - **NOTE** What if you haven't received the audiometric assessment?
  - **NOTE** What if you haven't received enough information within the required timeframe to make a decision?

3.0 Update the Hearing Loss Indicator screen
Claims Manager - Hearing Loss

- **a** Note the reasons for your decision in the comments box in the HL Indicator eform
- **b** Check that the audiology and/or ENT report information is correct
- **c** Change the entitlement indicator to 'No'
  - Edit an indicator

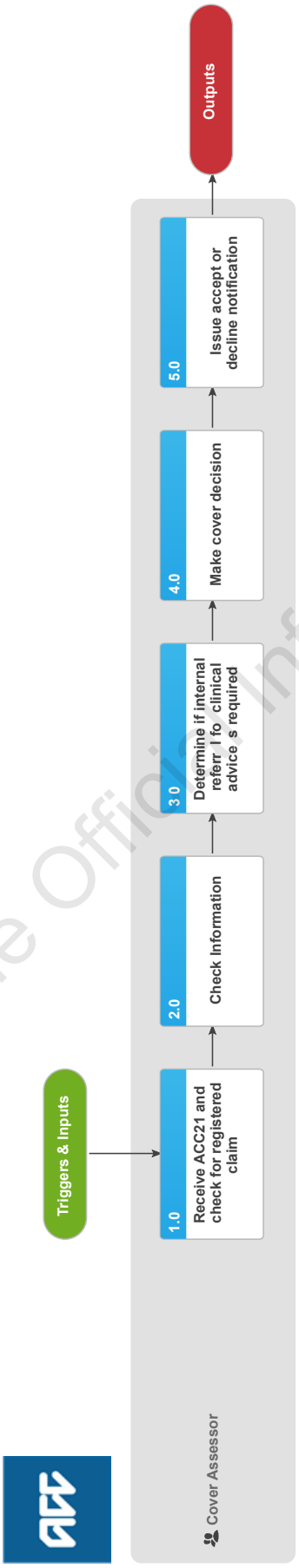
4.0 Commun cate decision to client
Claims Manager - Hearing Loss

- **a** R ng he client and discuss the reasons for the decision
- **b** Send the Hearing Loss cover decline letter
  - HLS999 Hearing Loss cover decline - client

5.0 Close claim
Claims Manager - Hearing Loss

- **a** Close any remaining tasks
- **b** Move the claim to the actioned cases queue
  - **NOTE** What happens next?

Determine Cover for Accidental Death v4.0



Determine Cover for Accidental Death v4.0

Summary

Objective
To determine if a claim has cover for support relating to accidental death.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Receive ACC21 and check for registered claim
Cover Assessor

a Check Eos to ensure the associated claim has been registered, on receipt of an ACC21 Advice of Accidental Death.

NOTE What if the claim is not registered?

NOTE What if you receive notification of an accidental death without an ACC21?

ACD102 Accidental death contact

ACC21 Advice of accidental death

NOTE What if you receive notification of an accidental death through the media?

2.0 Check Information
Cover Assessor

a Review the claim and ensure you have all the information required to make a cover decision.

NOTE What evidence do you need to make a cover decision?

NOTE What if you need information that does not require the creation of a purchase order?

NOTE What if you need medical records?

ACD111 Request medical info - vendor

NOTE What if you need a Coroner's Report (eg Cert icate of Interim Findings, Certificate of Findings, Post Mortem Report, or Coroner's Final Findings)?

ACD101 Request for coroner information - other

b Check the cover decision timeframe to determine if you will likely be able to make a cover decision within the statutory time-frame.

Timeframes to determine cover Policy

NOTE What if you need an extension to the statutory timeframe?

ACD103 new accidental death claim - party

ACDIS01 How we can help after someone dies from an injury

ACC163 Authority to collect information about a deceased person

3.0 Determine if internal referral for clinical advice is required
Cover Assessor

a Determine if you need to make an internal referral for written clinical advice (eg because medical information requires a medical advisor's opinion, or you need to consider other factors contributing to the death).

NOTE What should you check before you seek written clinical advice?

NOTE What if you need written clinical advice?

4.0 Make cover decision
Cover Assessor

a Determine whether or not the accidental death claim should have cover by checking the detailed cover criteria, legislation, and all of the information provided.

NOTE What if cover is accepted?

NOTE What if cover is declined?

b Change the status of the 'Planning Activity' to 'Complete'.

5.0 Issue accept or decline notification

Cover Assessor

a Notify the deceased person's representative of either the acceptance or decline of cover.

NOTE What if cover is accepted and we have also received an ACC136 Funeral Grant Payment Authority form?

ACD104 Approve accidental death claim - party

NOTE What if cover is accepted and we have not yet received an ACC136 Funeral Grant Payment Authority form?

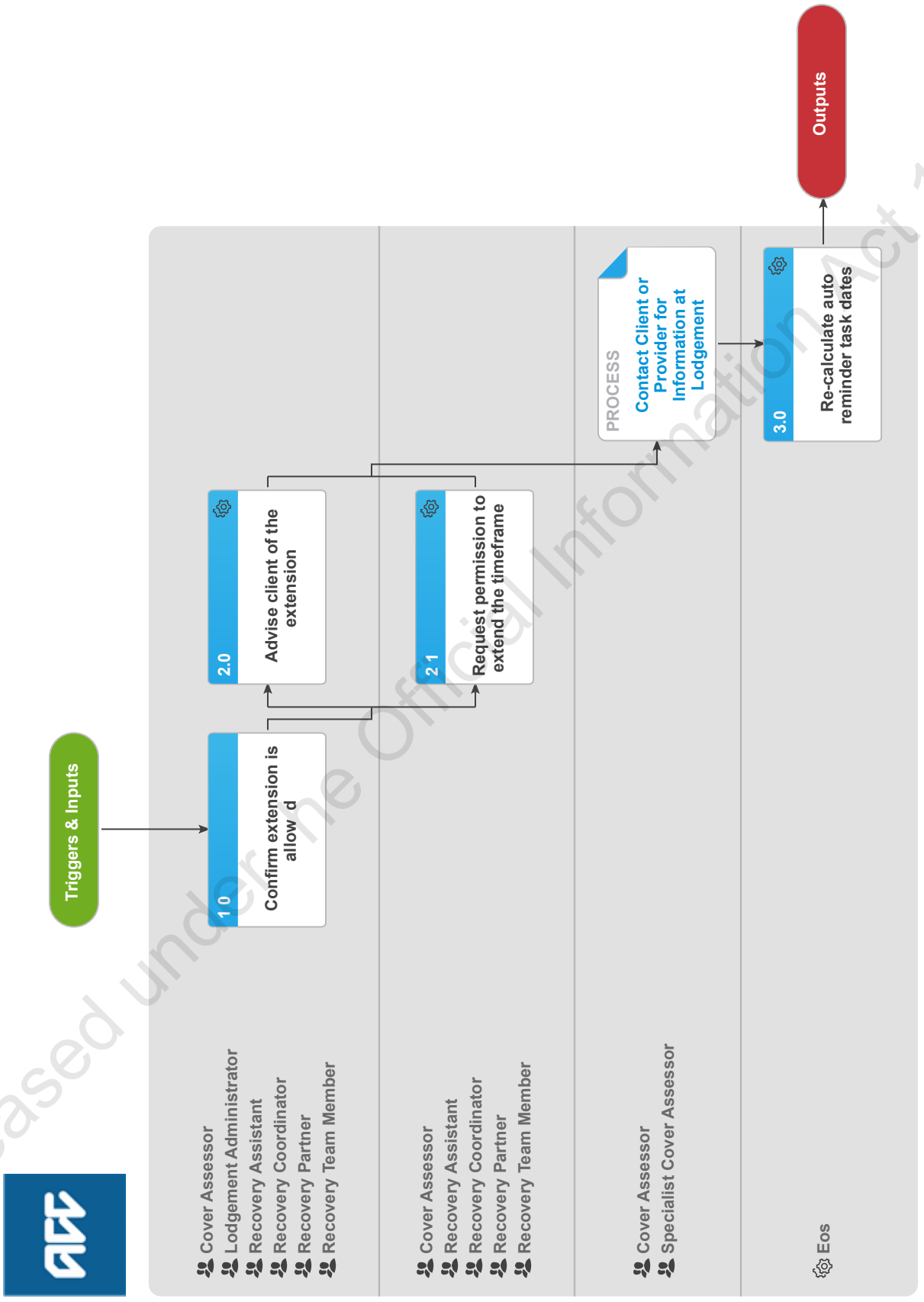
ACD104 Approve accidental death claim - party

ACC136 Funeral grant payment authority

NOTE What if cover is declined?

ACD109 Decline accidental death claim - party

Extend Cover Decision Timeframe v13.0



Extend Cover Decision Timeframe v13.0

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.

Owner [redacted]

Expert [redacted]

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 2.0.
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

a In Eos, in General tab, extend the 'Cover Decision Due Date'.

Extend cover decision due date

NOTE What if it is a change in or additional diagnosis?

NOTE How long can you extend the due date for?

b Enter the reason for extension.

c Call the client to advise of the extension. Use the 'Contact Client or Provider for Information at Lodgement' process to complete this step.

NOTE What do you need to explain during the conversation?

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

d Generate the appropriate extension - advise letter.

CVR30 Time Extension - advise - claimant

NOTE What time extension reason do you need to include in the letter?

NOTE What time extension do you need to apply in the letter?

TI30 Time extension advise

Upload an Incomplete Electronic Document

e Send the letter 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)

f In Eos, generate 'Follow-up cover' task, add in the description [Check if additional information has arrived, first extension issued. Any additional notes if applicable] and set the target date to 14 days prior to the cover decision due date.

2.1 Request permission to extend the timeframe

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

a You must get the client's permission to extend a cover decision timeframe on a complicated claim for the second time.

b Generate the extension request letter.

NOTE How long can you extend the due date for?

Timeframes to determine cover Policy

NOTE When should you generate and send the letter?

CVR31 Time Extension - request - claimant

Upload an Incomplete Electronic Document

c Send the letter 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)

d Receive a signed copy of the letter from the client agreeing to the extension.

NOTE What if a client doesn't agree to the second timeframe extension?

e In Eos, in General tab, extend the 'Cover Decision Due Date' and enter the reason for extension.

Extend cover decision due date

NOTE What if it is a change in or additional diagnosis?

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'.

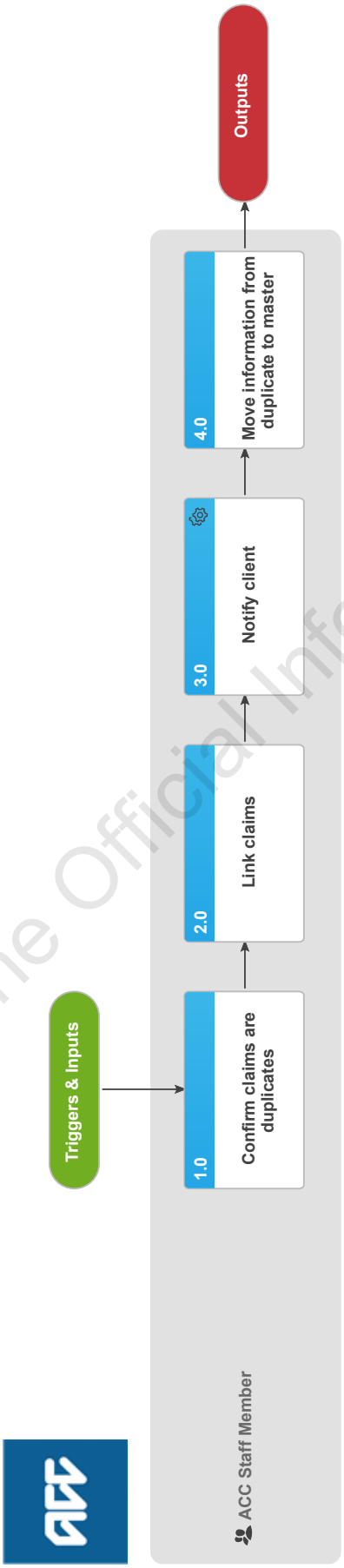
PROCESS **Contact Client or Provider for Information at Lodgement**
Cover Assessor, Specialist Cover Assessor

3.0 Re-calculate auto reminder task dates

Eos

a When the cover decision due date is extended, Eos automatically re-calculates the reminder task due dates.

Identify and Link Duplicate Claims :: Standard v18.0



Identify and Link Duplicate Claims :: Standard v18.0

Summary

Objective
To link two or more claims that are confirmed as duplicates (ie different claims for the same accident) and move relevant data from the duplicate claim to the master claim.

This process addresses identifying and linking duplicate claims at any stage of the claim lifecycle, when a staff member notices a potential duplicate claim.

Background
At times, two or more claim records will be created for the same accident. For example, a client may visit a GP and a physiotherapist for an injury and both the GP and physio may lodge a claim for the injury.

When duplicate claims are found in Eos, they must be labelled as duplicates and any relevant data they hold, such as contacts, tasks or documents must be transferred to the master claim.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Confirm claims are duplicates
ACC Staff Member

a Open the two claims that you've identified as possible duplicates.

b Compare the information in each claim to confirm that they're for the same accident and the duplicate claim criteria are met.

NOTE What are the duplicate claim criteria?

NOTE What if the claims being compared meet all of the criteria above?

NOTE What if the claims being compared meet all the criteria listed except the last one (ie the employer is different)?

NOTE What if the claims being compared don't meet the criteria I sted?

c Contact the case owners of the claims and confirm it's okay to link them.

NOTE What if there's no case owner for the existing claim?

2.0 Link claims
ACC Staff Member

a Identify which claim is the master and which is the duplicate.

NOTE Which is the master claim?

b Link the claims, using the Add a Case Alias system steps below.

Add a Case Alias

c Close any open cover decision information requirements and the [Confirm Cover Decision] task if they're present on the claim.

3.0 Notify client
ACC Staff Member

NOTE Which letter should you generate?

a Generate the appropriate letter in Eos on the duplicate claim by manually entering the master claim number into this letter.

CVR44 Claim approve - duplicate claim - claimant

CVR70 Cover approve - add injury - claimant

Upload an Incomplete Electronic Document

b Print and sign a copy for the provider and client.

c Add the Working Together information sheet to the client's letter.

ACC255 Kōrero mai - Working together

d Complete a privacy check to ensure you are only sending information to the client and provider that is relevant to the claim.

NOTE Do you have to complete the privacy check yourself?

4.0 Move information from duplicate to master

ACC Staff Member

a Move any relevant information from the duplicate to the master claim which includes any dental injury tab data, additional diagnosis codes, providers, tasks, contacts and documents etc by using the system steps below.

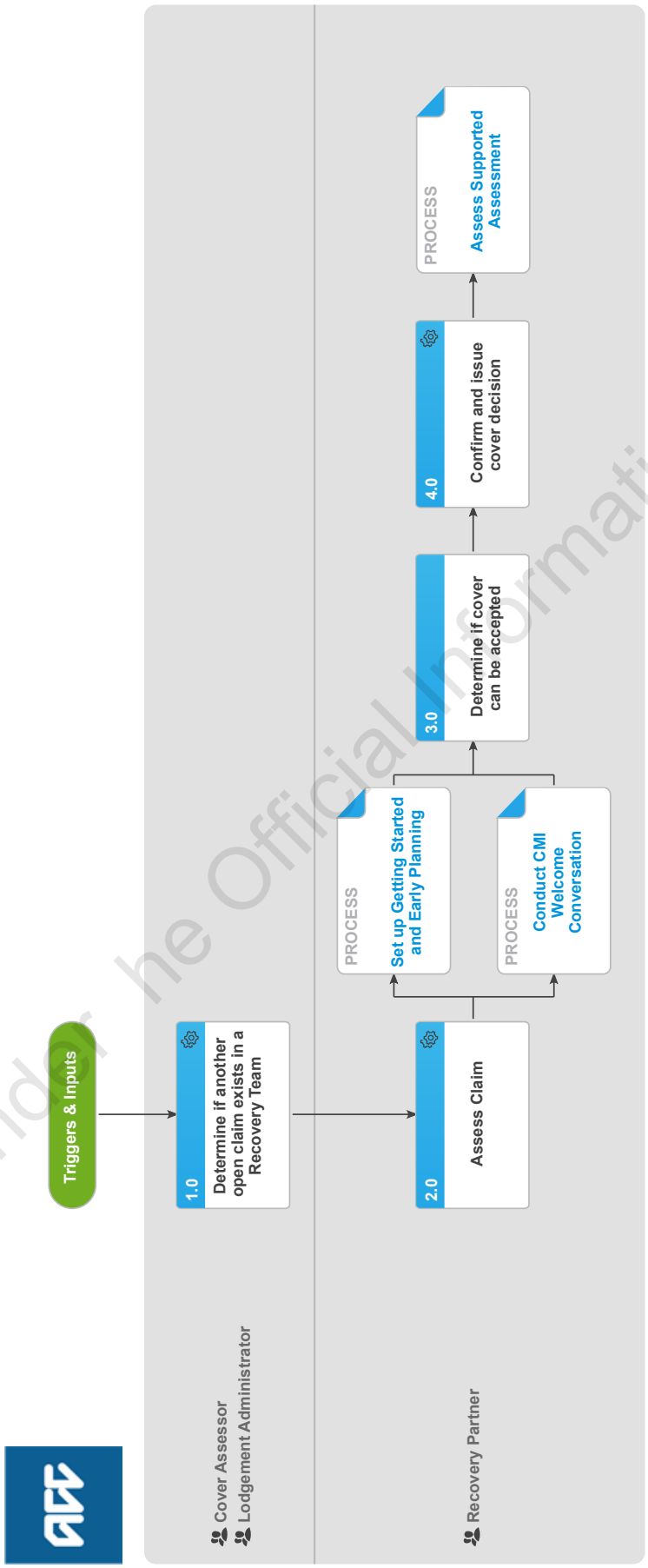
- Add an Injury Code
- Add a participant
- Move a Task
- Move a Purchase Order
- Move a contact from the claim
- Move a Document to Another Claim

NOTE Which Document should I leave on the Claim?

b Transfer the duplicate claim to the relevant actioned cases department queue, using the Move a claim to actioned cases system steps.

- Move claim to actioned cases (Eos Online Help)

Make Cover Decision for Mental Injury Caused by Sexual Abuse v12.0



Make Cover Decision for Mental Injury Caused by Sexual Abuse v12.0

Summary

Objective
To assess a claim for cover whether it's declined, held or accepted.

Owner [redacted]

Expert [redacted]

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?

NOTE What if there is an active managed claim?

2.0 Assess Claim
Recovery Partner

a In Eos, confirm this is the only single claim or if there are earlier claims all related to the same event with no other mental injury claims.

b Review the claim and determine the actions required to support a cover decision

NOTE What if an ISSC Engagement form has been received?

NOTE What if an ACC45 injury claim form has been received?

PROCESS **Set up Getting Started and Early Planning**
Recovery Partner

PROCESS **Conduct CMI Welcome Conversation**
Recovery Partner

3.0 Determine if cover can be accepted
Recovery Partner

a Review the material received via assessments, or information gathered that the assessor has stated that one or both of the diagnosed conditions was caused by the sexual abuse event, or that the event materially contributed to the development of the condition.

NOTE What should you be hecking for to determine cover?

NOTE What else should you be checking for in the Assessment or medical information?

NOTE What if the Assessor advises that there is more than one cause of the mental injury?

b Determine if internal guidance is required to assist in making a cover decision.

NOTE When should you seek internal guidance?

Mental Injuries Policy

c Determine eligibility for cover.

---

4 0 Confirm and issue cover decision
Recovery Partner

a Contact the client to discuss the decision using the Conduct Recovery Check-in process. Return to this process once the Recovery Check-in has been completed,

b In Eos, generate the MIS12 - Approve Mental Injury (Adult) or MIS24 - Approve Mental Injury (Guardian) and send via their preferred communication method.

NOTE What if the preferred method is via post?

NOTE What if they do not wish to progress with the claim at this stage?

NOTE What if the information available confirms there are injuries which are not caused by the event(s) the client experienced?

NOTE What if the decision is to decline cover?

c In Eos, in the General Tab, update Cover Status to 'Accept' and the 'Cover Status Reason'

d Add the accepted injury code and update the outcome status to 'Approved'.

- Standard Diagnoses and READ codes for Mental Injury
- Complex Mental Injury READ codes

e In Eos, in the Injury Tab, Sensitive Claims Sub-Tab, add the events linked to the injury. Refer to Schedule 3 Act to find the appropriate event code.

Select the frequency of the event (Multiple or Single)

Ener a 'Date From'. If exact dates are not known enter 01/01/xxxx

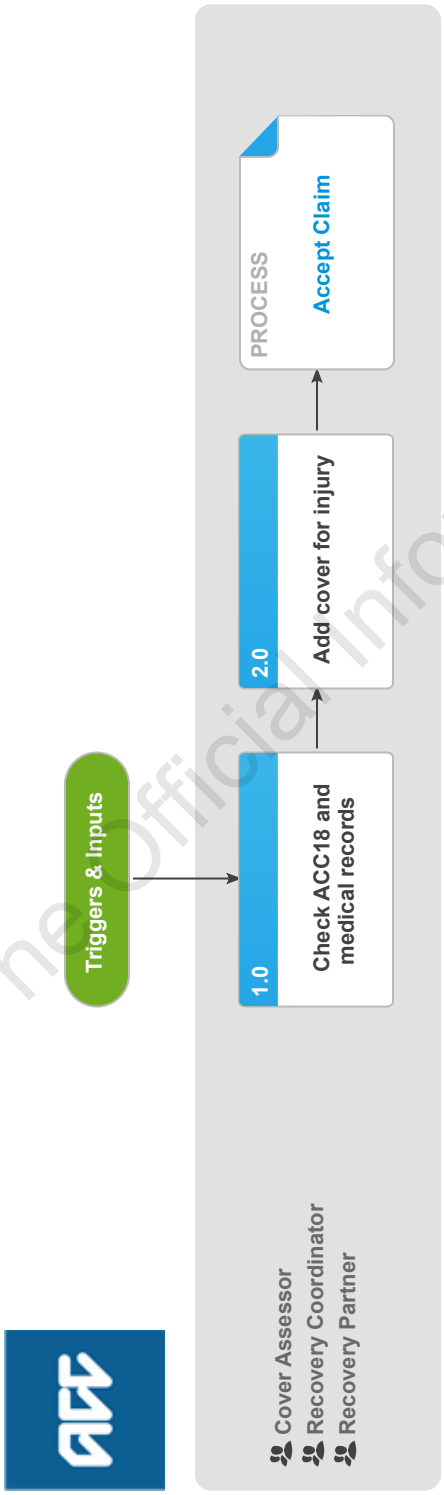
Enter a 'Date To'. If Multiple events have occurred, the date needs to be of the last event. If exact date are unknown use 31/12/xxxx

- Schedule 3 ACC Act 2001
  https://www.westlaw.co.nz/maf/wlnz/app/document?tocGuid=AUNZ_NZ_LEGCOMM_TOC%7C%7CI96e01026010711e18eefa443f89988a0&parentguid=AUNZ_NZ_LEGCOMM_TOC%7C%7CI8071216200f911e18eefa443f89988a0&epos=1&startChunk=1&tocDs=AUNZ_NZ_LEGCOMM_TOC&endChunk=1&isTocNav=true&ipuser=true&docguid=Id921f2703b3d11e18eefa443f89988a0&resultType=list

f Approve to progress to Support to Wellbeing. Go to Activity 3.0 of Assess Supported Assessment process.

PROCESS **Assess Supported Assessment**
Recovery Partner

Make Cover Decisions for Keloid and Hypertrophic Scars v1.0



Make Cover Decisions for Keloid and Hypertrophic Scars v1.0

Summary

Objective
To enable recovery team members to make cover decisions on keloid and hypertrophic scars 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 [redacted]

Expert [redacted]

Procedure

1.0 Check ACC18 and medical records

Cover Assessor, Recovery Coordinator, Recovery Partner

a Check that the ACC18 (available to GP/hospitals only) was received less than six months after the date of the injury.

NOTE What if the referring doctor has not used an ACC18 to request cover?

NOTE What if more than six months have elapsed between the date of injury and the request to add cover for scarring?

b Check that there is pre-existing cover for an open wound or a burn in the same location as the scar.

NOTE What if there is no pre-existing cover for an open wound or burn in the same location?

c Check the medical records for evidence of a plausible mechanism of injury for example evidence of a full thickness burn or open wound occurring to that area.

NOTE What if there is insufficient information?

d Check that there is sufficient clinical documentation of the open wound/burn within four weeks of the date of injury.

NOTE What constitutes sufficient clinical documentation?

e Continue to 2.0 Accept Cover for Injury if all the checks were positive in steps a to d.

2.0 Add cover for injury

Cover Assessor, Recovery Coordinator, Recovery Partner

a Add cover for the READ code specified on the ACC18.

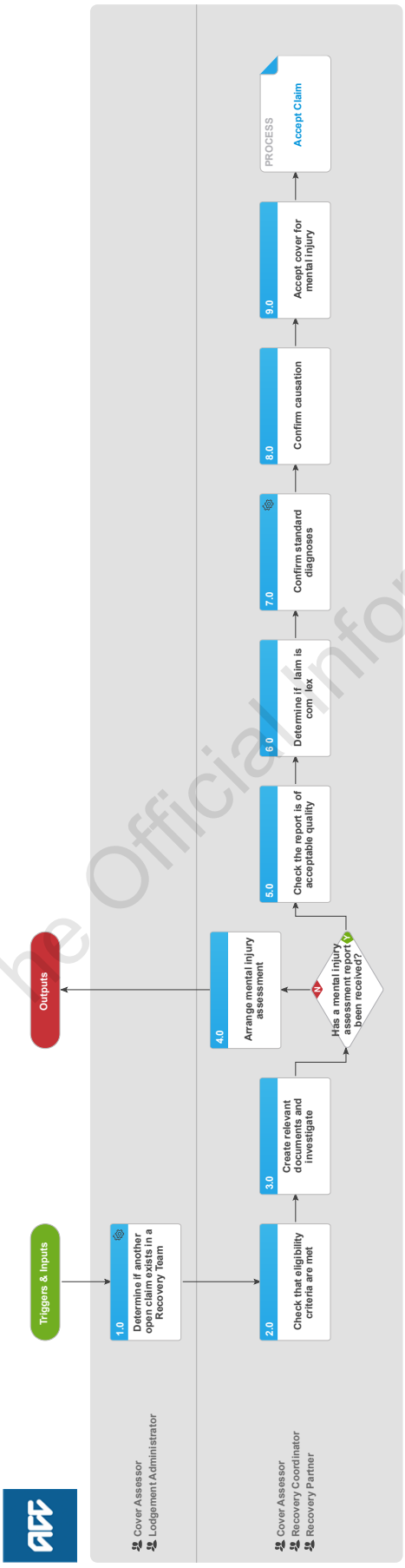
NOTE What if there is no valid READ code on the ACC18?

b Call the Clinical Advisor hotline on [redacted] for guidance if you are unsure.

PROCESS **Accept Claim**

Cover Assessor, Recovery Coordinator, Recovery Partner

Make Cover Decisions for Mental Injury Caused by Physical Injury v12.0



Make Cover Decisions for Mental Injury Caused by Physical Injury v12.0

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 [redacted]

Expert [redacted]

Procedure

1.0 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?

NOTE What is there is an existing open managed claim?

2.0 Check that eligibility criteria are met

Cover Assessor, Recovery Coordinator, Recovery Partner

a Check that there is a covered physical injury.

Cover Criteria for Personal Injury

b 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 and cover criteria policy to establish if the injury meets mental injury criteria.

Mental Injuries Policy

ACC45 ACC Injury claim.pdf

ACC54 Independence Allowance Lump Sum application

NOTE What if the injury does not appear to meet criteria for mental injury?

c Refer to Assessing a Claim for Mental Injury for general guidance on assessing claims for mental injury (including work-related mental injury).

Assessing a claim for mental injury (CHIPS)

3.0 Create relevant documents and investigate

Cover Assessor, Recovery Coordinator, Recovery Partner

a Determine if a decision can be made in the statutory timeframes. If not, send the client a CVR30 time extension letter.

CVR30 Tim Extension - advise - claimant

b Ask the clien 's GP to complete an ACC4245 form, if this has not already been received. Utilise form CVR14.

CVR14

ACC4245 Mental Injury Report

c Generate a new ACC1517 mental injury cover decision template form for the claim and populate with information from the ACC45 and other available clinical documents.

ACC1517 Determining cover for a mental injury claim

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

NOTE What information is relevant?

e 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.

Has a mental injury assessment report been received?
Cover Assessor, Recovery Coordinator, Recovery Partner

YES.... Continue

NO.... NEXT ACTIVITY

4.0 Arrange mental injury assessment
Cover Assessor, Recovery Coordinator, Recovery Partner

a Check the claim for any existing reports for evidence of a diagnosed condition that has previously been causally linked to the covered physical injury.

b Call the Psychology Advisor hotline for guidance on extension [redacted], in order to establish if a formal mental injury assessment is required If there is a clear and likely causative link described in an existing report.

c Ask the lodging provider to provide all mental health records and all relevant GP records from two years pre-injury onwards and make sure the client is aware of this and consents to ACC requesting this information.

NOTE What pre-injury GP records are relevant?

NOTE Should you ask for more than two years of pre-injury GP records?

d Refer client for a mental injury assessment using the PSY11 request for mental injury assessment letter, and including the ACC4247 mental injury report template.

PSY11 Request for mental injury assessment - vendor

ACC4247 Mental Injury Assessment Report

NOTE What if there is no formal mental injury assessment but there is a previous report in which the client has been diagnosed with a mental health condition?

NOTE Should you refer to a psychologist or a psychiatrist?

NOTE How do I refer to a psychiatrist?

5.0 Check the report is of acceptable quality
Cover Assessor, Recovery Coordinator, Recovery Partner

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

NOTE What report checks should you complete?

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?

NOTE What if you need further guidance?

6.0 Determine if claim is complex
Cover Assessor, Recovery Coordinator, Recovery Partner

a Determine if the claim is complex.

NOTE What is a complex claim?

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 What if you need further guidance to determine if the claim is complex?

7.0 Confirm standard diagnoses
Cover Assessor, Recovery Coordinator, Recovery Partner

a In Eos, check within the mental injury assessment report that the assessor has only diagnosed one or two of the standard diagnoses.

NOTE What are the standard diagnoses?

NOTE What if there are diagnoses that do not appear as a standard diagnoses?

8.0 Confirm causation

Cover Assessor, 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?

NOTE What if the assessor indicates that the mental injury was caused by the event and not the physical injury or its consequences?

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

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?

9.0 Accept cover for mental injury

Cover Assessor, Recovery Coordinator, Recovery Partner

a Add cover for the READ code specified on the ACC18.

NOTE What if a READ code is not specified or does not align to the stated diagnosis?

List of all the READ codes
https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwik_rLp88zkAhXv7nMBHdy-DsQQFjABegQIAxAC&url=https%3A%2F%2Fwww.acc.co.nz%2Fassets%2Fprovider%2Fb32658ac9b%2Facc6343-read-codes.xls&usg=AOvVaw0Xb_0IpesrNB5IS5I-IvEt

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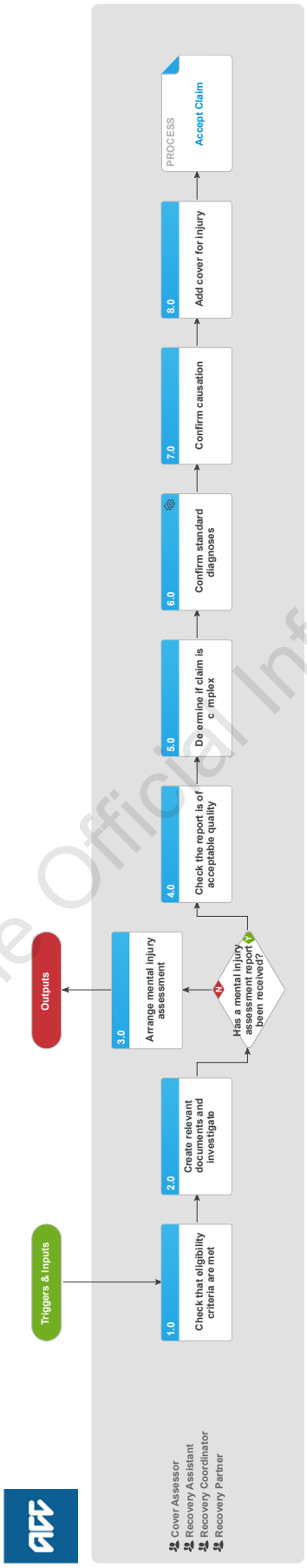
PROCESS **Accept Claim**

Cover Assessor, Recovery Coordinator, Recovery Partner

Make Cover Decisions for Work-Related Mental Injury Claims v8.0



Make Cover Decisions for Work-Related Mental Injury Claims v8.0

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 [redacted]

Expert [redacted]

Procedure

1.0 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.

- Work-related mental injury policy
- ACC45 ACC Injury claim.pdf
- ACC54 Independence Allowance Lump Sum application

b 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?

c 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?

NOTE What does ordinarily resident mean?

d Check that the client was at work at the time of the event

NOTE What constitutes being 'at work'?

e 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?

NOTE What constitutes a 'series of events'?

f 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?

NOTE What if you need further guidance?

2.0 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?

- CVR30 Time Extension - advise - claimant

b Generate a new ACC1517 Determining cover for a mental injury claim form and populate with information from the ACC45 and other available clinical documents.

- ACC1517 Determining cover for a mental injury claim

NOTE What information is relevant?

- ACC6300 Authority to collect medical and other records

c Ensure all documentation relevant on any physical files is copied and scanned to the claim. Ensure the documentation does not include sensitive information.

Has a mental injury assessment report been received?
Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

YES.... Continue

NO.... NEXT ACTIVITY

3.0 Arrange mental injury assessment
Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check the claim for any existing reports for evidence of a diagnosed condition previously linked to any covered physical injury or an existing covered mental injury.

NOTE What if there is existing cover for a mental injury?

b Refer client for a mental injury assessment using the PSY11 request for mental injury assessment letter, and including the ACC4247 mental injury report template.

ACC4247 Mental Injury Assessment Report

PSY11 Request for mental injury assessment - vendor

NOTE What if there is no formal mental injury assessment but there is a previous report in which the client has been diagnosed with a mental health condition, attributed to the workplace event?

NOTE Should I refer to a psychologist or a psychiatrist?

c Ask the lodging provider to provide all mental health records and all relevant GP records from two years pre-injury onwards. Make sure the client is aware of this and consents to ACC requesting this information. Make sure the assessor has access to these records when completing their assessment report.

NOTE What pre-injury GP records are relevant?

NOTE Should we ask for more than two years of pre-injury GP records?

4.0 Check the 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?

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?

NOTE What if you need further guidance?

5.0 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?

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 What if you need further guidance to determine if the claim is complex?

6.0 Confirm standard diagnoses
Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Eos, check within the mental injury assessment report that the assessor has only diagnosed one or two of the standard diagnoses.

NOTE What are the standard diagnoses?

NOTE What if there are diagnoses that do not appear as a standard diagnoses?

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?

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

8.0 Add cover for injury

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Add cover for the READ code specified on the ACC18.

NOTE What if a READ code is not specified or does not align to the stated diagnosis.

List of all the READ codes
https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwik_rLp88zkAhXv7nMBHdyDsQQFjABegQIAxAC&url=https%3A%2F%2Fwww.acc.co.nz%2Fassets%2Fprovider%2Fb32658ac9b%2Facc6343-read-codes.xls&usg=AOvVaw0Xb_0IpesrNB5IS5I-IvEt

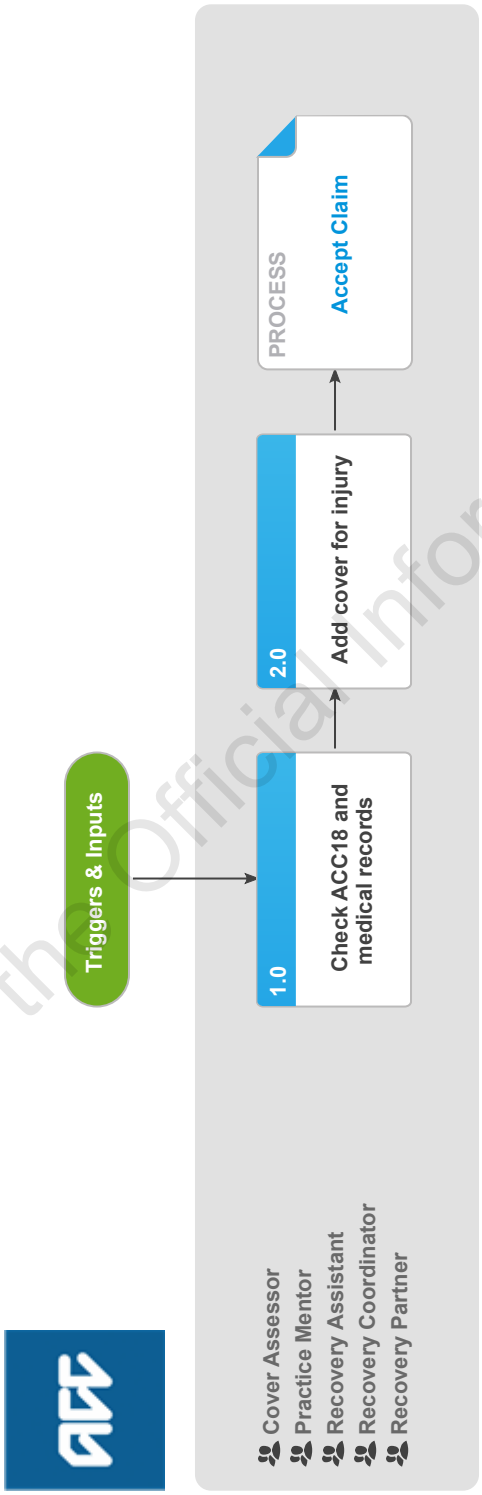
b Confirm the date from which the person is to be regarded as suffering mental injury is the date on which the client first received treatment for the injury.

Accident Compensation Act (2001) Section 36: Date on which person is to be regarded as suffering mental injury
https://www.westlaw.co.nz/maf/wlnz/app/document?docguid=I6790bbcfe03211e08eefa443f89988a0&&src=rl&startChunk=1&endChunk=1&snippets=true&originates-from-link=false&isTocNav=true&tocDs=AUNZ_NZ_LEGCOMM_TOC&extLink=false#anchor_I15aa023be03011e08eefa443f89988a0

PROCESS **Accept Claim**

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

Make Cover Decisions on Additional Diagnosis Requests for Rib Fracture v2.0



Make Cover Decisions on Additional Diagnosis Requests for Rib Fracture v2.0

Summary

Objective
To enable case owners to make cover decisions on requests for addition of rib fracture diagnosis 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 case owners to follow this process.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Check ACC18 and medical records

Cover Assessor, Practice Mentor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check that the ACC18 (available only to GP surgery or hospital) was received less than six weeks after the date of the injury.

b Check that the request was received from a medical practitioner or a nurse practitioner.

c Check the medical records refer to a single event involving a plausible mechanism of injury (e forceful, direct impact or blow to the outside of the chest).

NOTE Was the injury sustained via gradual process or internal force?

d Call the Clinical Advisor hotline on extension [redacted] for guidance if required.

e Continue to 2.0 Add Cover for Injury if all the checks were positive in steps a to c.

2.0 Add cover for injury

Cover Assessor, Practice Mentor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Adhere to general process for determining cover for additional injury or change in diagnosis.

Determining cover for an additional injury or change in diagnosis (CHIPS)

b Add cover for the READ code specified on the ACC18.

NOTE What if no READ code was specified on the ACC18 or what if the READ code provided does not align with the stated diagnosis?

List of Read Codes (CHIPS)

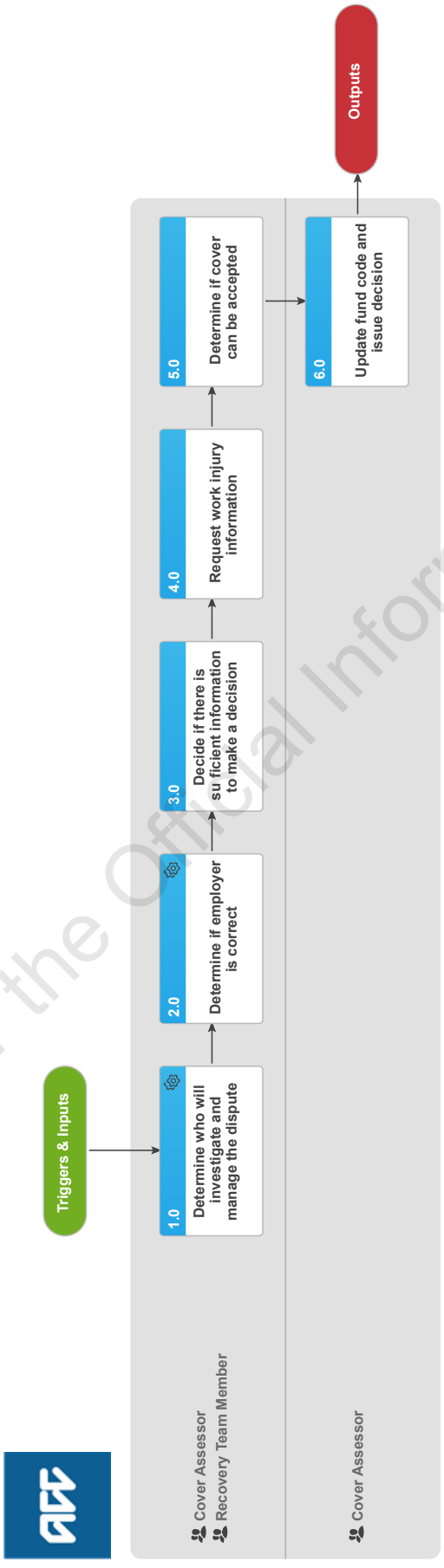
READ codes
http://thesauce/intra/groups/both_informe/documents/chips/wpc110180.doc

c Call the Clinical Advisor hotline on extension [redacted] or guidance if you are unsure.

PROCESS **Accept Claim**

Cover Assessor, Practice Mentor, Recovery Assistant, Recovery Coordinator, Recovery Partner

Manage a work injury dispute v19.0



Manage a work injury dispute v19.0

Summary

Objective
Where an employer or a client has disputed the circumstances of a claim, use this process to determine whether a workplace accident has occurred and/or who the liable employer for the claim is.

Background
When a decision has been made to accept a work related accident, the client's employer (where they were working when their accident occurred) must be loaded into the EOS ACC45 claim as the Default Employer. This is important to get right as the claim may affect the calculation of an employer's Experience Rating levy and for the employer to be advised of the decision to allow them opportunity to review that decision.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Determine who will investigate and manage the dispute
Cover Assessor, Recovery Team Member

a Confirm who is responsible for the work and assign it.

NOTE What if the claim is in actioned cases or with 'Enabled'?

EOS Online Help - Add a task
http://thesauce/team-spaces/eos-online-help/tasks/add-a-task/index.htm

2.0 Determine if employer is correct
Cover Assessor, Recovery Team Member

a In Eos, check if the liable employer details match the ACC45.

b Contact the employer and/or client to confirm the details

NOTE What if the employer details are incorrect?

c Notify the employer and/or client you will look into the work injury circumstances and issue a decision.

3.0 Decide if there is sufficient information to make a decision
Cover Assessor, Recovery Team Member

a Review information provided by the employer.

b Establish if there is sufficient information to confirm the injury is work-related.

NOTE What if there is sufficient information?

NOTE What if further information is required?

4.0 Request work injury information
Cover Assessor, Recovery Team Member

a Contact the client, employer or provider to request additional information and clarify areas of conflict or confusion.

NOTE What if you are contacting the employer?

NG Tool Employer Follow-up Conversation

NG Tool Employer Conversation

NG Guidelines Employer Conversation

NOTE What if you are obtaining the additional information using correspondence?

CVR06 ACC121 Pack - Work injury questionnaire request – client

CVR07 ACC122 Pack - Work injury questionnaire request - employer

NOTE What if you need to request information from a Provider?

5.0 Determine if cover can be accepted

Cover Assessor, Recovery Team Member

a Review the following policies to determine if cover can be accepted:

- Motor Vehicle Account fund Policy
- Work Account Fund Code Policy
- Criteria for work-related personal injury ‘place of work’ Policy

NOTE What if you are unsure if the client meets the criteria?

NOTE What if you have determined the client's injury does not meet the criteria for a work-related injury?

- Revoking Cover
  http://thesauce/team-spaces/chips/cover/cover-decision/process/revoking-cover/index.htm

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6.0 Update fund code and issue decision

Cover Assessor

a Based on the decision update the fund code details if required. Refer to the linked Fund Code to determine the correct code.

- Fund Code
  http://thesauce/team-spaces/chips/cover/fund-code/index.htm

b Check the fund code has been updated in the 'General' tab on the ACC45.

c Edit the accident details in the ACC45 Claim Injury Tab to reflect the correct cause of injury, including changing the accident to non-work, if necessary.

d Notify the employer of the work injury dispute decision.

NOTE What if it is the client's previous employer?

- CVR80 Work injury dispute - employer changed - employer

NOTE What if the it is a liable employer?

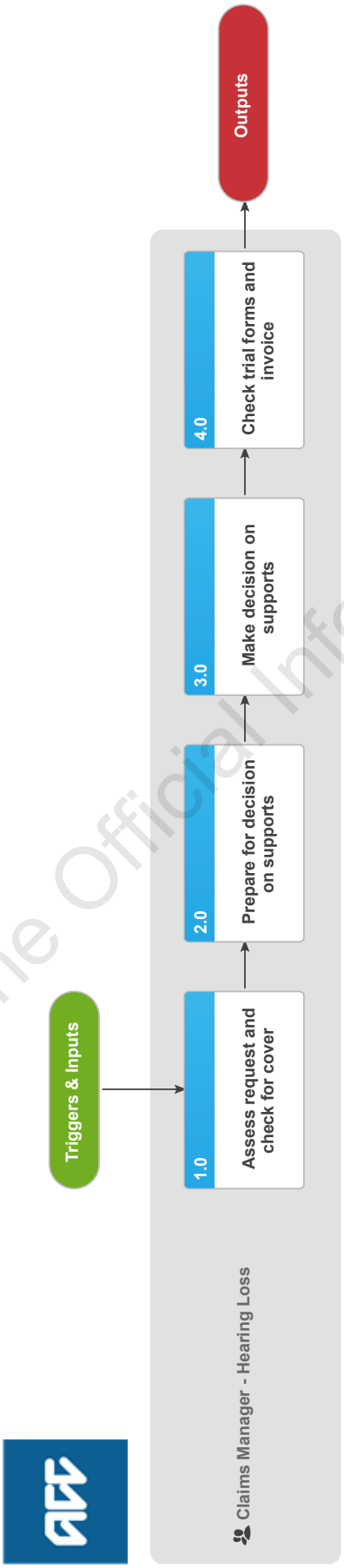
- CVR48 Claim approve - work injury - employer
- CVR46 - Claim approve - non-work - employer
- CVR85 Work injury dispute decision upheld - employer

e Notify the client of the dispute decision using the appropriate letter.

- RC01 Cover Decision - Revoke cover
- CVR45 - Claim approve- non-work injury - claimant
- CVR47 - Claim Approve - work injury - claimant
- CVR44 Claim approve - duplicate claim claimant

f Close the task and record the outcome.

Managing Hearing Loss Supports v6.0



Managing Hearing Loss Supports v6.0

Summary

Objective
To manage requests for hearing loss supports

Background
Covers requests for all for hearing aids and is governed by the Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010

Owner [redacted]

Expert [redacted]

Procedure

1.0 Assess request and check for cover
Claims Manager - Hearing Loss

a Ensure that it has been more than six years since the client last received funding under the Acciden Compensation (apportioning entitlements for hearing loss) Regulations 2010

Accident Compensation (apportioning entitlements for hearing loss) Regulations 2010
https://www.westlaw.co.nz/maf/wlnz/app/document?docguid=I3842f503e16a11e08eefa443f89988a0&tocDs=AUNZ_NZ_LEGCOMM_TOC&isTocNav=true

NOTE What if the client received funding less than six years ago?

HLS999 Hearing Loss cover decline - client

NOTE What if client is less than 18 years old?

b Create and authorise a purchase order 'HL01 Hearing assessment Report' allowing payment of completed audiometric report

NOTE What if request came in by phone call or letter from client?

c Transfer claim to your department queue

NOTE What if physical file exists?

d Add a hearing loss rehabilitation action plan

e Update the hearing loss indicator

NOTE What information requires updating?

f Review and confirm cover decision

NOTE What if cover is not yet confirmed?

2.0 Prepare for decision on supports
Claims Manager - Hearing Loss

a Check the ACC612 to determine whether the client has been in paid employment since they were last assessed by an ear, nose and throat (ENT) specialist

ACC612 Audiometric report for hearing loss

NOTE What if client hasn't been in paid employment since they were last assessed by an ear, nose and throat (ENT) specialist and the previous ENT report is not valid for attribution?

NOTE What if client hasn't been in paid employment since they were last assessed by an ear, nose and throat (ENT) specialist and the previous ENT report is valid for attribution?

NOTE What if the client's hearing loss hasn't changed enough to move them into a higher funding band?

b Contact client and complete ACC613 over the phone

NOTE What if the client doesn't wish to complete the ACC613 via the telephone?

ACC613 Hearing Loss Questionnaire

NOTE What if the client has indicated that workplace testing has occurred?

HLS08 Acknowledge ONIHL claim - employer

ACC725 Hearing loss report for employers

NOTE What if the ACC613 is incomplete or not returned within 28 days?

HLS10 Reminder Questionnaire - client

c On receipt of all requested information ask the ENT specialist to complete an assessment by sending them all the information obtained

- HLS26 Regs ENT assessment (ONIHL- appointment)
- HLS27 Regs ENT (ONIHL no appointment) - Vendor
- HLS28 Regs ENT assessment trauma - appointment - vendor
- HLS29 Regs ENT Specialist assessment (trauma - no appointment) - vendor

NOTE What if ACC723 Otolaryngologist report is not received within 28 days?

d Make client aware of ENT assessment

- HLS20 ENT assessment (ONIHL - appointment) - client
- HLS21 ENT assessment (ONIHL - no appointment)

3.0 Make decision on supports

Claims Manager - Hearing Loss

a Check that the information in the report appears factually correct and the level of hearing loss is what we would expect for this type of client, given the circumstances of the injury.

NOTE What if the ACC723 is factually correct but we don't agree with its findings?

NOTE What if the ACC723 is missing information or contains factual inconsistencies?

b Update the hearing loss indicator

NOTE What information should be updated?

- HLS76 Re-aiding entitlement approve - client

c Close necessary tasks and transfer claim to actioned cases queue

---

4.0 Check trial forms and invoice

Claims Manager - Hearing Loss

a Check that the ACC611 Hearing aid trial outcome report received from the client's audiologist has been completed correctly

NOTE What if the audiologist doesn't use e-billing?

- ACC611 Hearing aid trial outcome report

b Check the ACC611 to see if the trial was successful

NOTE What if trial was unsuccessful?

c Check all the information has been provided and is correct

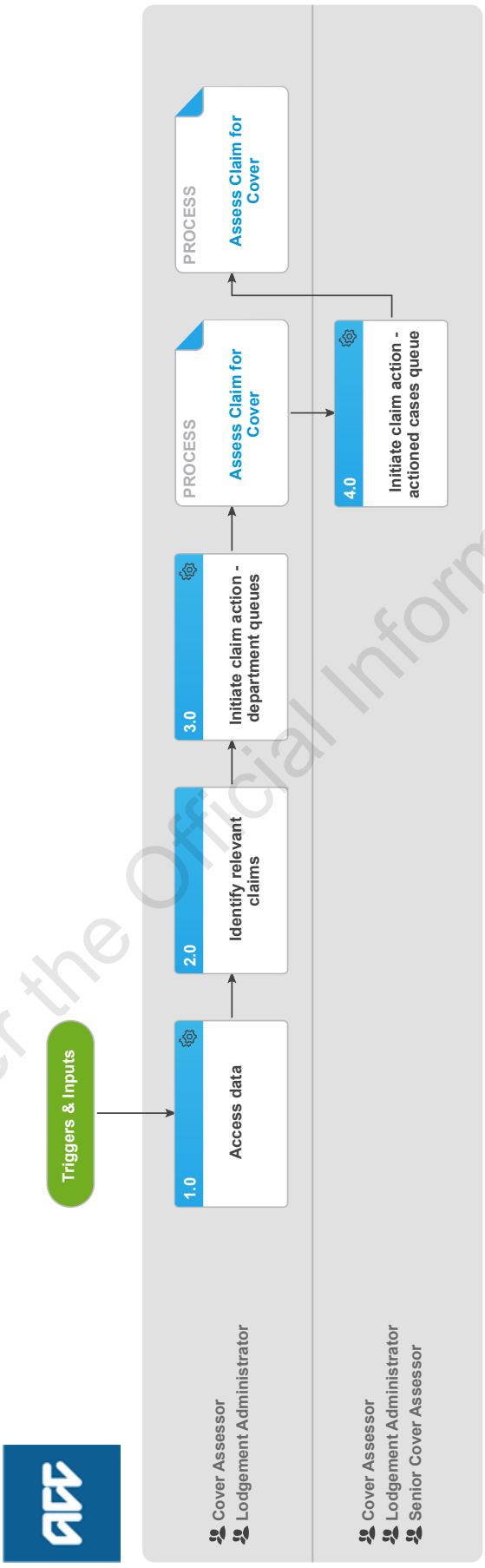
NOTE What information should be in receipt?

- ACC259 Hearing aid battery prescription

d Update the 'Aid Warranty Start Date' and 'Period of Warranty' fields in the hearing loss indicator

NOTE What if an ACC259 hearing aid battery prescription form has been supplied?

Monitor Cover Decision Timeframes :: Held Claim v5.0



Monitor Cover Decision Timeframes :: Held Claim v5.0

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 [redacted]

Expert [redacted]

Procedure

1.0 Access data
Cover Assessor, Lodgement Administrator

a Review the Policy information below about cover timeframes 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?

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

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

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

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?

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

4.0 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?

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

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

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

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?

c Make a cover decision. Go to the Assess Claim for Cover process below to do this

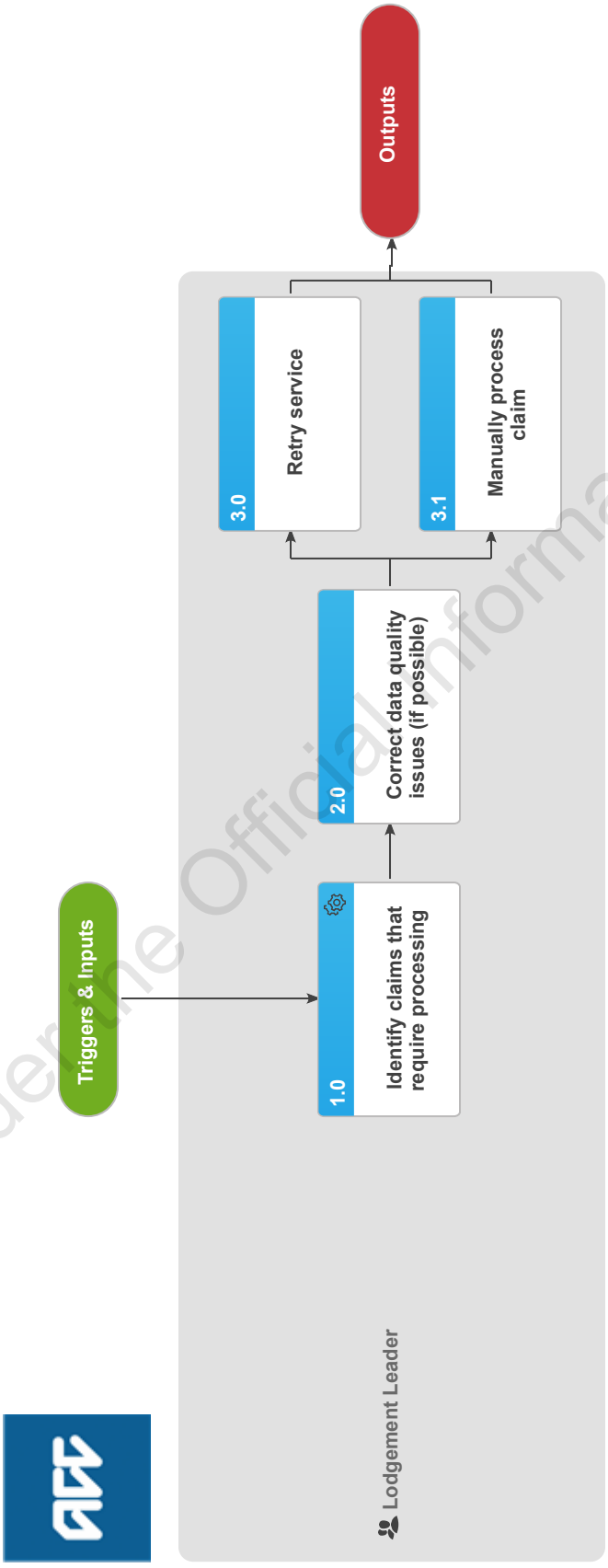
d Repeat steps a-c until all identified claims in the Actioned Cases list have been checked.

PROCESS

Assess Claim for Cover :: PICBA

Cover Assessor, Lodgement Administrator

Resolve Service Failure v5.0



Resolve Service Failure v5.0

Summary

Objective
To process claims that have failed to go through the automated Accident Description Service, Claim Type Service, and/or Cover Decision Service.

Background
There are two reasons why a claim can fail to go through the automated services:
1. The service is unavailable due to network failures
2. The service is available but the claim has data quality issues that prevent automatic processing

In both scenarios, Eos creates one or more of the following tasks to flag where the issue has occurred. These tasks are sent to a specific failure queue:
- Accident Description Service Unavailable
- Automation: Claim Type Service Unavailable
- Automation: Cover Decision Service Unavailable

Every day at 12pm and 6pm, the failure queue work performer is restarted in Eos. This clears the backlog of Claim Type Service Unavailable and Cover Decision Service Unavailable tasks that have been created due to network failures (scenario 1). These claims are returned to the automated processing workflow. The work performer restart does not fix claims that cannot be progressed due to data quality issues (scenario 2). These claims must be processed manually.

Note that it's not possible to re-try the Accident Description Service, so whenever an Accident Description Service Unavailable task is created, the accident codification must be done manually (this is true for both scenario 1 and 2).

This process needs to be completed every morning. At this time the majority of claims affected by network failures will have been returned to automatic processing in the 6pm failure queue work-performer restart, and he remaining tasks will be those prevented from progressing due to data quality issues.

Users who are completing this processing need to have the following Eos system access:
'Supervisor of" Work Performer Tasks
Secured Action: ACC_OPEN_LDGCLAIM_AUTOMATION

Owner [redacted]

Expert [redacted]

Procedure

1.0 Identify claims that require processing
Lodgement Leader

a In Eos, identify the tasks that have become stuck in the failure queue using the Accessing Failure Queues system steps below.

Accessing Eos Failure Queues

b Transfer these tasks into you My Tasks queue.

2.0 Correct data quality issues (if possible)
Lodgement Leader

a Open the first task (select Do Task).

NOTE What if it's an Accident Description Service Unavailable task?

b

c Check the claim for any straight forward data issues that may be preventing processing.

NOTE What if I can't identify or fix the data issue?

d Correct the data issue then go to step 3.0.

3.0 Retry service
Lodgement Leader

a Close the Claim Type Service Unavailable or Cover Decision Service Unavailable task – choose to re-try the service when prompted.

b Check the claim to ensure it's successfully progressed through automation.

NOTE What if automation wasn't successful?

c This process ends.

3.1 Manually process claim

Lodgement Leader

a Close the Claim Type Service Unavailable or Cover Decision Service Unavailable task – choose to manually process the claim when prompted.

b Manually process the claim.

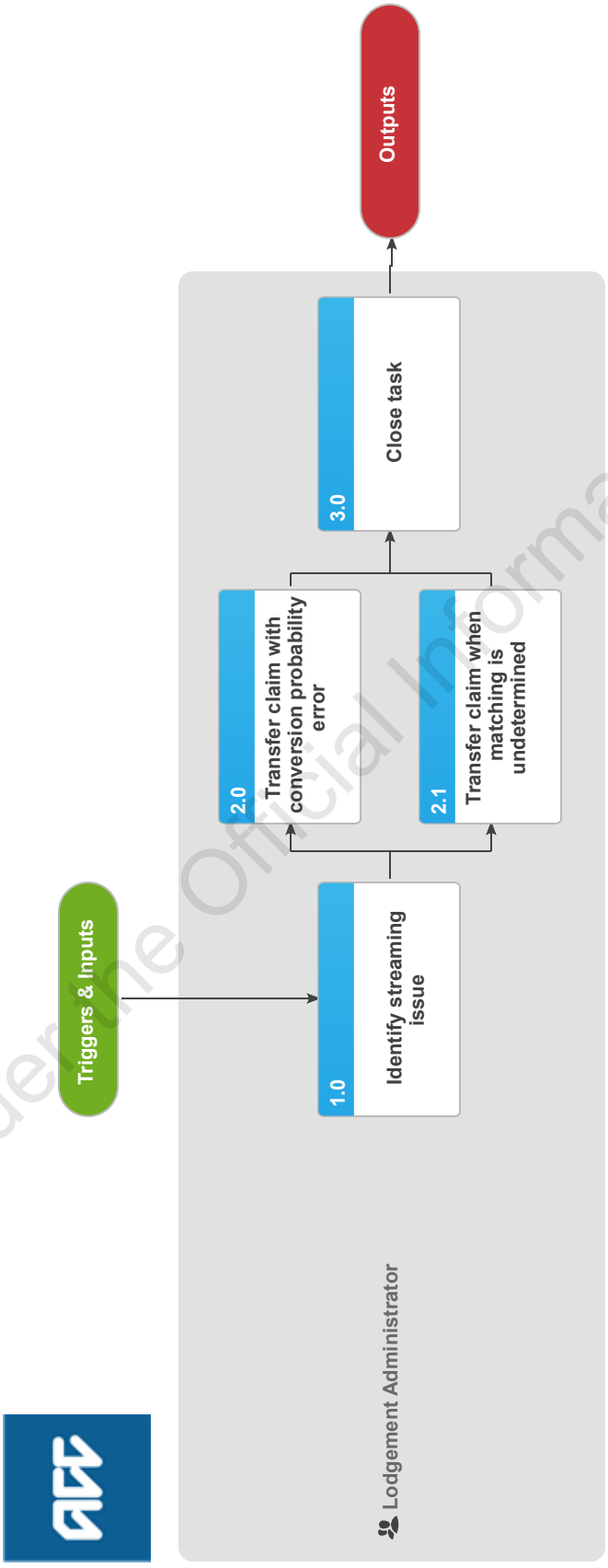
NOTE What if I need to make a cover decision for a PICBA claim?

NOTE What if I need to make a cover decision for a specialist claim?

NOTE What if I don't have delegation to decline a claim?

c Repeat steps 2.0 to 3.0 / 3.1 for all claims that you've transferred into your My Tasks queue.

Transfer Claim When Automatic Matching Fails v4.0



Transfer Claim When Automatic Matching Fails v4.0

Summary

Objective
To transfer a held or accepted claim to the appropriate department when automatic matching has failed.

Background
Eos has not been able to stream a claim and sends a task for someone to manually transfer the claim to the correct department. If the claim couldn't stream because:
• there was no Conversion Probability result, then a Conversion Probability Error task is created
• none of the streaming business rules were met, then a Streaming Undetermined task is created.

Future State: AppDynamics monitoring solution will monitor the Manual Streaming Required work queue and send an alert to a designated staff member when a task is sent to this queue, therefore removing the need for a person to periodically monitor this queue.

Note: 'Streaming' term has now been replaced by 'matching' as part of CCL but not all systems/documents/queues have been updated as yet. References to other items/teams that haven't been updated will still mention 'streaming'.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Identify streaming issue
Lodgement Administrator

a Monitor the Manual Streaming Required department queue for automatic matching failures.

NOTE This is a #Workaround procedure until AppDynamics is in place which will automatically monitor the queue send an alert to the designated staff member when a matching failure occurs.

b Go to the appropriate next step 2.0 or 2.1, depending on automatic matching error task.

2.0 Transfer claim with conversion probability error
Lodgement Administrator

NOTE A Conversion Probability Error task has been raised because Eos couldn't generate a conversion probability score for the claim. This score is used to determine whether an accepted earner claim should be streamed to the Service Needs Assessment team for further assessment, or to actioned cases.

Conversion Probability Threshold

a Confirm that cover status is 'Accept' and the client's earner status is 'Employed,' 'Self Employed' or Other'.

NOTE What if the above conditions are not met?

b Identify if the claim is likely to require further management and therefore should be matched to the Service Needs Assessment team.

NOTE Examples:

NOTE What if there's no indication that the claim needs further management?

Move claim to actioned cases (Eos Online Help)

c Transfer the claim to Service Needs Assessment department.

Transfer a claim (Eos Online Help)

2.1 Transfer claim when matching is undetermined
Lodgement Administrator

NOTE A Streaming Undetermined task has been created because none of the automatic matching business rules in Eos have been met and therefore Eos can't determine where to match the claim to.

a Identify the correct department to transfer the claim, using the Streaming criteria guides which are based on the automatic matching business rules.

Streaming criteria - accepted claims

Streaming criteria - held or accredited employer claims

b Transfer the claim to the department.

Transfer a claim (Eos Online Help)

Move claim to actioned cases (Eos Online Help)

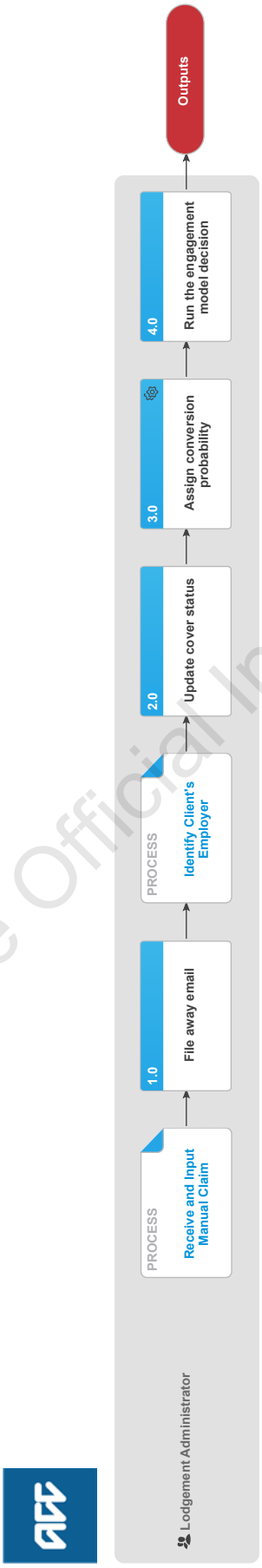
3.0 Close task

Lodgement Administrator

a Close the Conversion Probability Error or Streaming Undetermined task.

Close a Task

Action Returned Accredited Employer Claim v3.0



Action Returned Accredited Employer Claim v3.0

Summary

Objective
To manually run the conversion probability threshold in Eos on claims where this has not been automated, determining cover status and allocating the claim to the correct team.

Background
For all accredited employer (AE) claims Eos does not run the conversion probability threshold. There are situations where the acc e-dited employer has identified that the claim has been incorrectly allocated to them and return this to ACC to manage. To be able to allocate the claim appropriately the conversion probability threshold needs to be identified. Therefore, this task has now been up-dated for lodgement advisors to run manually.

Owner [redacted]

Expert [redacted]

Procedure

PROCESS **Receive and Input Manual Claim :: Email**
Lodgement Administrator

1.0 File away email
Lodgement Administrator

a Forward the email to your inbox and file away the email to the claim.

File an inbound email

b Before progressing with this process you will need to confirm the employer. Go to Identify Client's Employer. Once you have updated the employer you will need to return to this process

NOTE What if the claim is clearly for a work accident for that Accredited Employer (AE)?

PROCESS **Identify Client's Employer**
Lodgement Administrator

2.0 Update cover status
Lodgement Administrator

a Change the cover status to eithe held or accept by using the traffic light rules in the Registration Reference Book.

Registration Reference Book Spreadsheet

Update Cover Status

3.0 Assign conversion probability
Lodgement Administrator

a Go to the 'insights tab' in Eos and confirm that the conversion probability (CP) threshold has not been run. Follow the system steps below to direct you to the Insights tab.

Insights tab on claim record (Eos Online)

NOTE How do you know if the conversion probability threshold has not been run?

NOTE What if the conversion probability has already been run?

b Go to the 'add activity tab' and select 'Run Duration Conversion Probability'.

Conversion Probability Threshold

NOTE What if the cover status is set to Held?

4.0 Run the engagement model decision
Lodgement Administrator

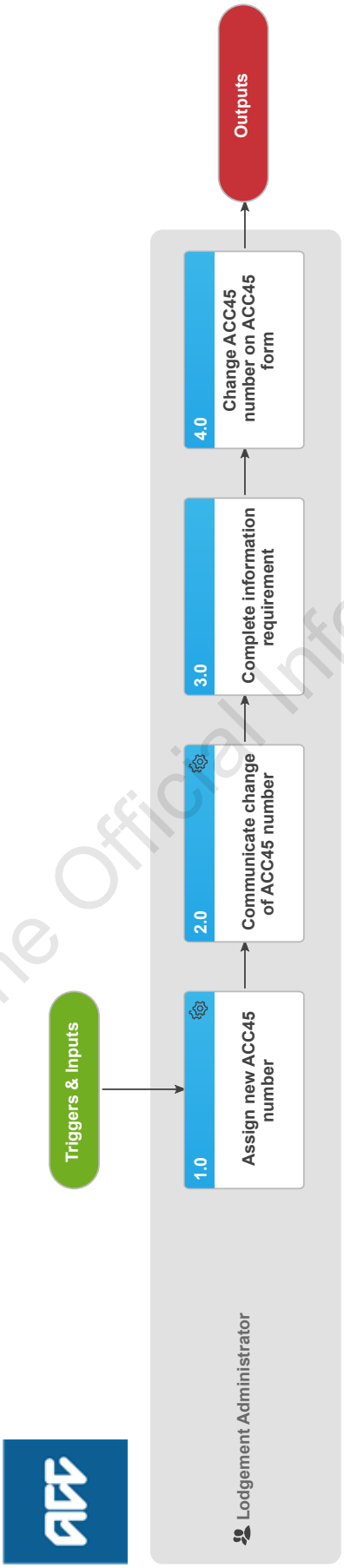
a Go to the 'add activity tab' and select 'Run Engagement Model Service'.

b Open the engagement model decision results from the documents tab and review to confirm who the claim needs to be ma-naged by.

NOTE What if the document does not direct where the claim should be managed?

C Go to the add activity tab and transfer the claim to Next Gen, choosing the department the document has confirmed.

Assign New ACC45 Number v12.0



Assign New ACC45 Number v12.0

Summary

Objective
To assign a new ACC45 number to the claim so that each claim has a unique ACC45 number identifier and advise the client and provider of the new number.

Background
Eos has checked the claim and identified that the ACC45 number on the newly registered claim has already been used for a different claim and/or client. It has raised an Assign New ACC45 Number information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Assign new ACC45 number
Lodgement Administrator

a Request a Dummy ACC45 number using the Request Dummy 45 tool.

NOTE What if the claim is an identical copy of the original claim with the same ACC45 number?

Request Dummy 45 spreadsheet

b In the Reason for request box, type 'ACC45 number already in use'.

c In the Case Alias tab in Eos, assign the new ACC45 number using the Assign a new ACC45 number system steps below (edit the existing number and replace it with the new number).

Assign a new ACC45 number

Registration Reference Book Spreadsheet

2.0 Communicate change of ACC45 number
Lodgement Administrator

a Add the EXR07 Change claim number - provider letter

NOTE System steps of letter for communicating about change of ACC45 number:

EXR07 Change of claim number - provider

b Check that the address details for both parties are valid.

NOTE What if the address is invalid?

3.0 Complete information requirement
Lodgement Administrator

a Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

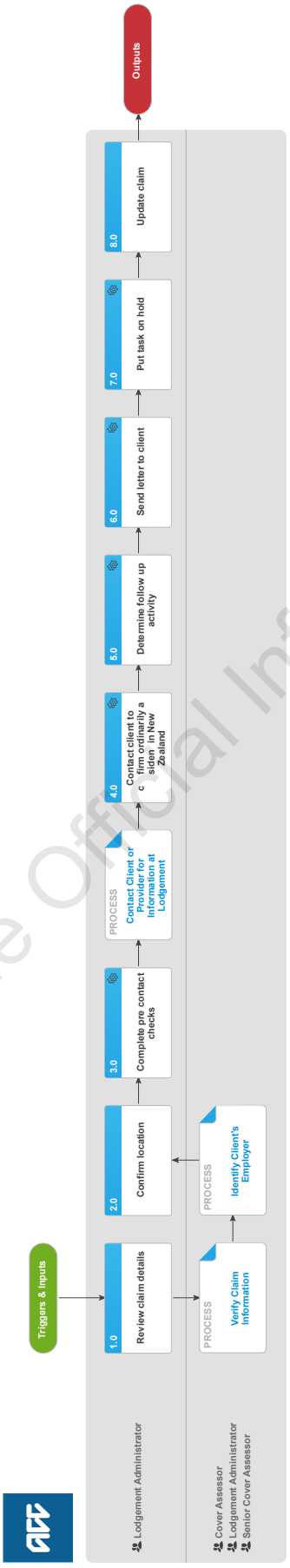
b Close the task.

4.0 Change ACC45 number on ACC45 form
Lodgement Administrator

a C oss out the old ACC45 number and noted the new ACC45 number on the page.

b Send the ACC45 form to DMT to upload.

Confirm Accident Location v7.0



Confirm Accident Location v7.0

Summary

Objective
To confirm accident location and/or whether a client is ordinarily resident in New Zealand so that a cover decision can be made.

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 3 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 requirement included in Missing information for Cover task:
• Accident Location is Invalid
• Accident Location is Missing

Information requirement included in Confirm Cover Decision task:
• Check Eligibility - Overseas

Owner [redacted]

Expert [redacted]

Procedure

1.0 Review claim details
Lodgement Administrator

a Open the claim and review the information requirements (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 diagnosed injury would mean that a Lodgement Administrator would not be able to accept the claim for cover? (ie not a green traffic light injury)

NOTE What if there are IRs present that do not relate to the accident location or client's residency at the time of the accident?

PROCESS **Verify Claim Information**
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

PROCESS **Identify Client's Employer**
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

2.0 Confirm location
Lodgement Administrator

a Use the information on the claim form to identify where the accident happened.

NOTE What if you can't confirm the accident location just by looking at the claim form?

b Update the intake form and progress claim if accident occurred in NZ.

NOTE What if the accident clearly occurred outside of NZ?

Contact Generator Spreadsheet

Add a client contact

3 0 Complete pre-contact checks
Lodgement Administrator

a Check the client's party record in Eos to make sure it's okay to contact the client.

View party details

NOTE What if the client is under 16 years old?

NOTE What if the client has a care indicator?

NOTE What if the client has a safe contact?

Contacting sensitive claims clients Policy

NOTE What if the client is not well enough to contact, eg they might be unconscious or under heavy medication?

NOTE Check the client has a valid phone number.

NOTE What if the client has an overseas phone number?

PROCESS

Contact Client or Provider for Information at Lodgement

Lodgement Administrator

4.0 Contact client to confirm ordinarily a resident in New Zealand

Lodgement Administrator

a Open the Contact Generator template and go to the Overseas & Allergy tab.

b Call the client and complete a security check to ensure you're talking to the correct person. Attempt a call to all numbers listed on their party until you speak with them, ie. home, work and cell phone. If you can't speak with the client ensure you leave messages, send eTXTs and send an email as detailed below.

NOTE What if the client does not have a recorded phone number, including cell phone number, in Eos?

NOTE What are the security check questions?

NOTE What if the client refuses to answer the security questions or doesn't believe you're from ACC?

NOTE What if you've tried to call the client and still can't contact them?

Contact Generator Spreadsheet

c Send an eTXT to the client saying:
Hi [Client], we've received your claim and need more details. Please ring ACC on 0800 101 996 ext [your extension/hunt group]. We are available from 7am to 7pm weekdays. Thank you
---
Replies cost up to 27c. If necessary review the eTXT Policy and Use information on the Sauce by following the link below.

eTXT Policy and Use (The Sauce)

Send an eTXT (The Sauce)

d If the client has a verified email address, email the client requesting the information that you need. If necessary, review the Email Policies by following the links below.

Email Policies

e If the client confirms that it was an overseas accident complete the Overseas Questionnaire in the Contact Generator template while you're on the phone with the client. Ensure the wording is correct for question 3; "In the 12 months before you left for your holiday had you been in NZ for 6 or more months?"

f Go to step 8.0

5.0 Determine follow-up activity

Lodgement Administrator

a Ensure two attempts have been made to contact the relevant person (or people) by phone/eTXT/email.

NOTE What if the first attempt has been unsuccessful?

NOTE What if the second attempt has been unsuccessful?

Contact Generator Spreadsheet

NOTE What if you are unable to contact the client by phone/eTXT/email or Letter (unable to leave a phone message and address is invalid?

6.0 Send letter to client

Lodgement Administrator

a Ensure the client has a valid postal address.

NOTE What if the client's address is invalid?

b Generate CVR11 questionnaire to determine whether the client is ordinarily resident in NZ.

CVR11 Residency questionnaire request

c Ensure the date the questionnaire is due back is not a weekend or statutory holiday.

NOTE How do you determine if a over decision timeframe extension is required?

7.0 Put task on hold

Lodgement Administrator

a In Eos, edit the Missing Information for Cover or Confirm Cover Decision task to add today's date, and in the description field add any action you've taken.

b Put the task on hold by editing the target and hold dates with the time of 08:00am. If this is a first contact to client set priority to 'high'.

- Edit a task

c Transfer the task/claim as appropriate.

NOTE Where do you transfer the task to after a first contact attempt?

NOTE How long should you put the task on hold for?

NOTE Where do you transfer the claim to after a second contact attempt?

8.0 Update claim

Lodgement Administrator

a Update the claim and contact and continue to manage as appropriate if client has confirmed accident happened in NZ. The Confirm Accident Location process ends.

b If client confirms the accident occurred outside of NZ review the residency questions answers to determine if the client meets the residency criteria.

NOTE What answers mean the client meets residency criteria?

NOTE What if the client is a child younger than 6 months?

c Update claim and contact and see the Traffic Light tab in the Registration Reference Book spreadsheet to determine if a 'Green' cover decision can be made.

NOTE What if the client doesn't meet the residency criteria?

NOTE What if the claim is not able to be accepted for cover in accordance with the 'Green' injuries on the Traffic Light document?

NOTE What if you're unable to handshake the call to a staff member in the hunt group 85000 or the automation system is running slowly?

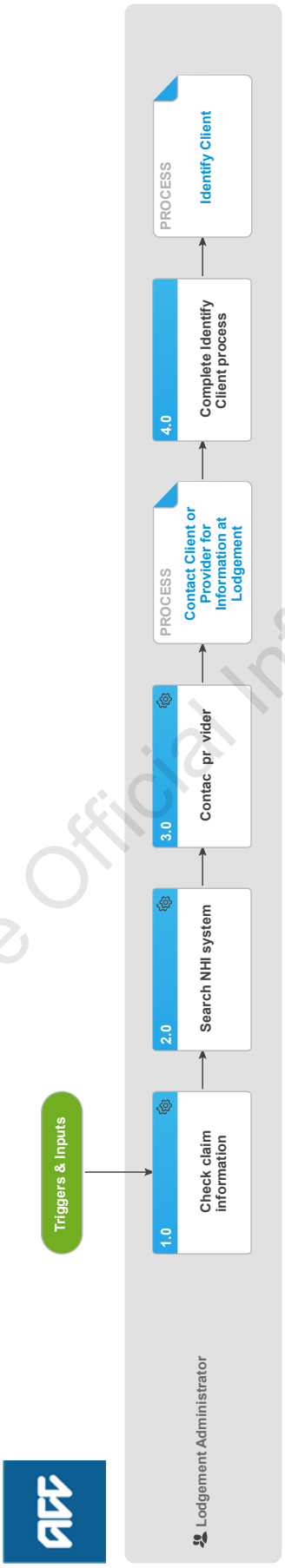
- Add a client contact
- Registration Reference Book Spreadsheet

d Make the cover decision by following the Assess Claim for Cover :: PICBA process below.

NOTE Assess Claim for Cover :: PICBA process

e Complete the Accident Location IR and all other outstanding Mandatory IRs as appropriate.

Confirm Gender v8.0



Confirm Gender v8.0

Summary

Objective
To confirm the correct gender for the client when it's missing from the claim form so a new client party record can be created.

Background
Eos is unable to find a unique party record for the client and the gender field on the claim form is blank. A Client Not Found information requirement has been raised for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Check claim information
Lodgement Administrator

a Check the claim for any personal pronouns (e.g. her, his, she, he) in the free text boxes.

NOTE What if I don't find any personal pronouns?

b Update the Gender field in Eos.

Edit claim intake form

c Click NEXT on the claim intake form to save the changes. Go to step 4.0.

2.0 Search NHI system
Lodgement Administrator

a Search for the client using the Ministry of Health NHI database.

NOTE What if the Ministry of Health NHI database isn't working?

NOTE What if I don't find the client in the NHI system?

b Update the Gender field in Eos to reflect the gender stated in the NHI system.

c Click NEXT on the claim intake form to save the changes. Go to step 4.0.

3.0 Contact provider
Lodgement Administrator

a Contact the provider who lodged the claim to ask if they have a record of the client's gender. Go to the Contact Client or Provider for Information process below to do this.

b If the provider is able to provide the information, then update the Gender field in Eos.

c Click NEXT on the claim intake form to save the changes.

NOTE What if the provider doesn't answer or asks for a written request?

Upload an Incomplete Electronic Document

CVR02 ACC45 information request - vendor

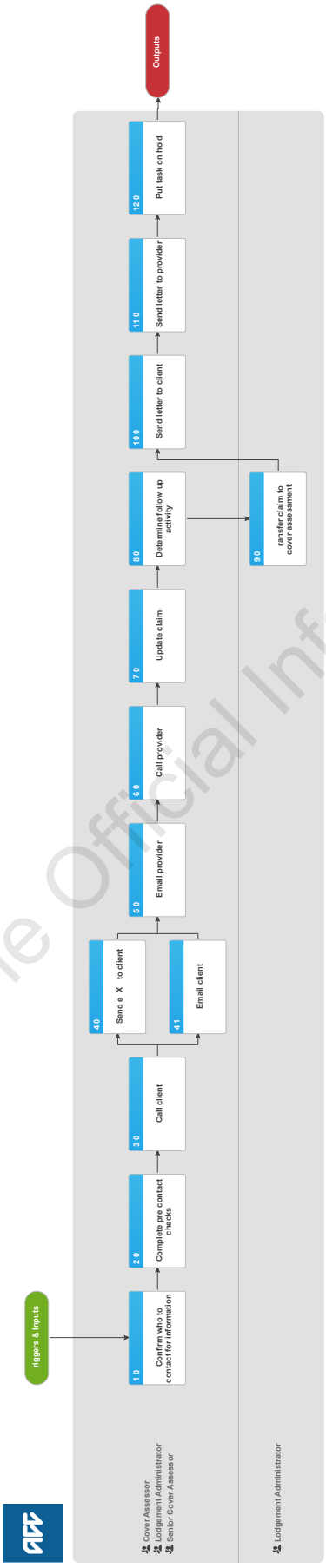
PROCESS **Contact Client or Provider for Information at Lodgement**
Lodgement Administrator

4.0 Complete Identify Client process
Lodgement Administrator

a Complete the Identify Client process to attribute an existing record or create a new client record.

PROCESS **Identify Client**
Lodgement Administrator

Contact Client or Provider for Information at Lodgement v21.0



Contact Client or Provider for Information at Lodgement v21.0

Summary

Objective
To contact a client or provider for information about a claim.

Background
Someone needs to contact either the client or provider for information about a claim so that a cover decision can be made.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Confirm who to contact for information

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Ensure the client is the appropriate person to contact for the information.
In general, it's best to contact the client for personal information and the provider who lodged the claim for medical information.

NOTE What if the client does not have a recorded phone number, including cell phone number in Eos?

NOTE Who can contact the client about request for hernia cover?

ACC6261 Cover assessment - initial call summary - hernia

NOTE What if it's more appropriate to contact the provider?

NOTE What if the provider has not signed the ACC45?

2.0 Complete pre-contact checks

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Check the client's party record in Eos to make sure it's okay to contact the client.

View party details

NOTE What if the client is under 16 years old?

NOTE What if the client has a care indicator?

NOTE What if the client has a safe contact?

Contacting sensitive claims clients Policy

NOTE What if the client is not well enough to contact, e.g. they might be unconscious or under heavy medication?

b Check the client has a valid phone number.

NOTE What if there's no phone number for the client?

NOTE What if the client has an overseas phone number?

3.0 Call client

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Call the client and complete a security check to ensure you're talking to the correct person. Attempt a call to all numbers listed on their party until you speak with them, ie. home, work and cell phone

NOTE What are the security check questions?

NOTE What if the client refuses to answer the security questions or doesn't believe I'm from ACC?

NOTE What if I've tried to call the client and still can't contact them?

b Request the information you need. Go to activity 7.0

4.0 Send eTXT to client

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a If necessary, review the eTXT Policy and Use information on the Sauce by following the link below.

eTXT Policy and Use
http://thesauce/how-to/technology/applications-and-systems/send-an-etxt/etxt-policy-and-use/index.htm

b Send an eTXT to the client saying:
Hi [Client], we've received your claim and need more details. Please ring ACC on 0800 101 996 ext [your extension/hunt group]. We are available from 7am to 7pm weekdays. Thank you
---
Replies cost up to 27c

Send an eTXT
http://thesauce/how-to/technology/applications-and-systems/send-an-etxt/index.htm

NOTE Can I name the client in the eTXT?

c Go to activity 7.0

4.1 Email client

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a If necessary, review the Email Policies by following the links below.

Email Policies

b Email the client requesting the information that you need.

c Go to activity 7.0

5.0 Email provider

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Check that the provider's email address is a general one for the practice or for the individual provider at that practice. See the Verifying and Re-Verifying an Existing Vendor, Provider or Facility Work Email Address process below if necessary.

Verifying and Re-Verifying an Existing Vendor, Provider or Facility Work Email Address
http://thesauce/team-spaces/chips/providers-vendors/provider--vendor-registration/process/verifying-an-existing-vendor--provider-or-facility-work-email-address/index.htm

NOTE What if I don't have the email address I need?

b Email the provider to request the information that you need.

NOTE What if the provider doesn't want to email the information?

c Go to activity 7.0

6.0 Call provider

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Call the provider and request the information that you need. If necessary give them the client's NHI number.

NOTE What if the provider doesn't want to provide information over the phone?

7.0 Update claim

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Update the claim with the information you've received (if applicable).

b Add a contact in Eos stating the action you've taken.

Add a client contact

c If you've contacted the client or provider and confirmed the information you need, this process ends.

NOTE What if haven't confirmed the information I need?

8.0 Determine follow-up activity

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a If appropriate, try contacting an alternative person for the information (e.g. if you've tried contacting the client, try the provider instead). Go back to task 1.0 to do this.

NOTE What if it's not appropriate to contact another person?

NOTE What if I've tried contacting all appropriate people but haven't been successful?

b Ensure that two attempts have been made to contact the relevant person (or people) by phone/eTXT/email.

NOTE What if only one attempt has been made?

c If you're a Lodgement Administrator, go to activity 9.0 to transfer the claim before generating the appropriate letter.

NOTE What if I'm not a Lodgement Administrator?

9.0 Transfer claim to cover assessment

Lodgement Administrator

a Remove the lodging provider ID from the claim and add the default provider ID J99966. This will ensure the claim is given a Held status.

b Add any other default information required to bypass the mandatory data fields.

c Click NEXT on the claim intake form to save the changes.

d Close the Missing Information for Cover task, this will trigger the claim to re-run validations and be sent to the Cover Decision Service where it will be given a Held status.

e Open the claim.

f Remove default information that you added and replace with information received on the claim form.

g If you're sending a letter to the client, go to activity 10.0.

NOTE What if I'm sending a letter to the provider?

10.0 Send letter to client

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Ensure the client has a valid postal address.

NOTE What if the client's address is invalid?

b Generate the appropriate letter to the client requesting the information that you need ensuring that that date it is required by is not a weekend or statutory holiday.

NOTE Which letter should you generate?

- CVR01 ACC45 information request - claimant
- CVR06 ACC121 Pack - Work injury questionnaire request – client
- CVR08 Activity questionnaire request - claimant
- CVR09 Late lodgment info request - claimant
- CM04 Advise claimant that you were unable to reach them by phone

NOTE What if I'm a Lodgement Administrator and I'm sending a letter for a PICBA claim?

NOTE What if I'm a Lodgement Administrator and I'm sending a letter for a specialist claim?

c 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?

d Send the letter to the client.

e Go to task 12.0

11.0 Send letter to provider

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Generate the appropriate letter to the provider requesting the information that you need.

NOTE Which letter should you generate?

- CVR02 ACC45 information request - vendor
- CVR03 ACC45 diagnosis request - vendor
- MD09a Further info – consultation notes – vendor

NOTE What if you're a Lodgement Administrator and I'm sending a letter for a PICBA claim?

NOTE What if I'm a Lodgement Administrator and I'm sending a letter for a specialist claim?

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

NOTE Do I have to complete the privacy check myself?

c Send the letter to the provider.

12.0 Put task on hold

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a In Eos, edit the Missing Information for Cover or Confirm Cover Decision task to add today's date, and in the description field add any action you've taken.

b Put the task on hold by editing the target and hold dates, and set priority to "high".

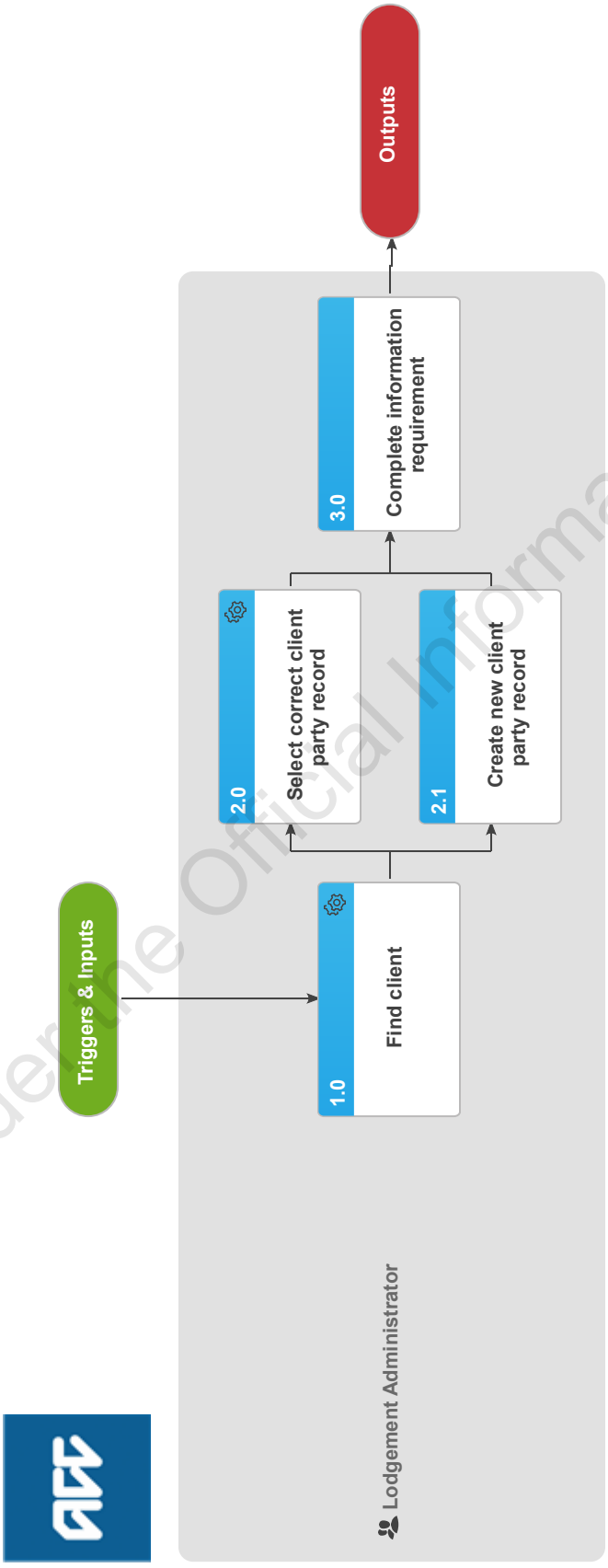
NOTE How long should I put the task on hold for?

- Edit a task

c If it's a Missing Information for Cover task, transfer task to the Registration Centre - Information Required queue.

NOTE What if it's not a Missing Information for Cover task?

Identify Client v16.0



Identify Client v16.0

Summary

Objective
To identify the correct client so that the new claim can be assigned to an existing unique client record or a new client record.

Background
Eos has attempted to match the new claim to an existing unique client record or create a new client record and is unable to. It has raised a Client Not Found information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Find client
Lodgement Administrator

a Search for the client in Eos using the existing business rules and guide below.

- Matching client record to a claim record when no NHI number – system and manual lodgement
- Matching client record to a claim record when NHI number – manual lodgement
- Matching client record to a claim record when verified NHI number – system lodgement
- Matching client record to a claim record when non-verified NHI number – system lodgement
- Client searches

NOTE You must compare the client matches returned in Eos to all the de ails on the claim before assigning the client party record. Look at the information for common mistakes, eg: middle name and first name together.

NOTE What if you find possible duplicate client party records?

NOTE What if there are no matches?

2.0 Select correct client party record
Lodgement Administrator

a Select the correct client record and attribute it to the claim using the Edit claim intake form system steps.

- Edit claim intake form

NOTE What if I accidentally select the wrong client?

b Ensure the client's address, phone number title, gender and ethnicity on the claim form matches the information on their party record in Eos.

NOTE What if this information doesn't match?

NOTE What if there is a ariation in the client's name or the spelling is different?

- Edit Party Details

NOTE What if there is a parent/guardian for client?

c If you've made any changes to the claim intake form, click [Next] to save the changes.

2.1 Create new client party record
Lodgement Administrator

a Check that the gender has been entered on the claim.

NOTE What if the Gender field is blank?

b Create a new party record and attribute it to the claim.

- Add a person party

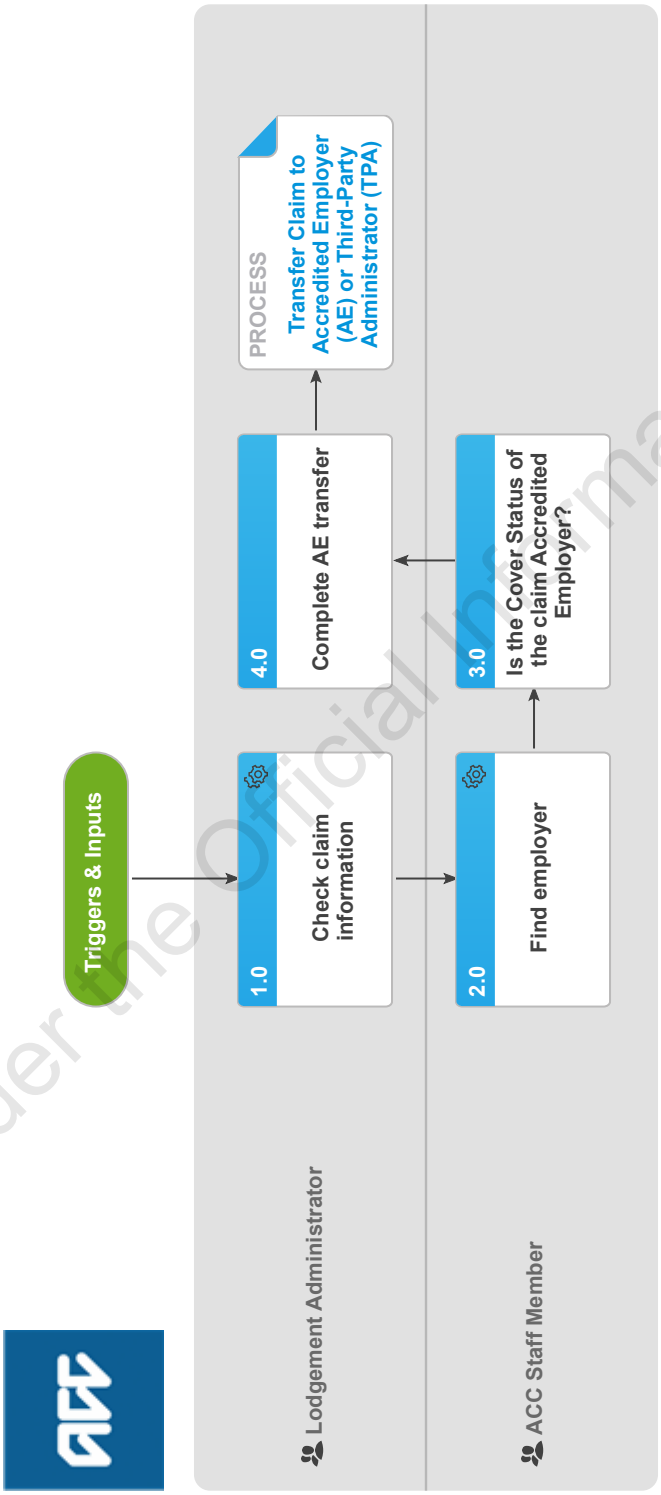
3.0 Complete information requirement
Lodgement Administrator

a Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

b Close the task.

Identify Client's Employer v14.0



Identify Client's Employer v14.0

Summary

Objective
To identify the correct parent company employer so that the new work-related claim can be assigned to an existing unique employer record.
When an employer for a work related injury is identified as an AEP participant this needs to be transitioned from ACC to be managed by an AE Administrator or Third Party Administrator for the employer.

Background
Eos has identified that a claim is for a work-related injury and raised an Attribute Employer information requirement for a person to manually attribute the employer to the claim.
Work related claims for employees of an AEP participant are either managed by the employer or a third party administrator.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Check claim information
Lodgement Administrator

a In Eos, check that the Accident Description accurately reflects the selection for the follow ng fields:
- Did the accident happen on a road?
- Is it a work accident?
- Does the Occupation field make it a plausible work accident?
- Earner status at date of accident?
- Is this a Work Related Gradual Process Disease or Infection (WRGPDI) claim?

NOTE What if they don't match or I'm unsure?

NOTE What if I confirm the claim is not a work accident?

NOTE What if the claim states it's a work accident but the accident occurred overseas?

NOTE What if it's a WRGPDI claim?

NOTE What if I'm not sure whether the claim is for a work related personal injury (WRPI) or a motor vehicle accident (MVA)?

- Motor Vehicle Account fund Policy
- Work Account fund Policy
- Criteria for work-related personal injury ‘place of work’ Policy
- Criteria for overriding injury classification Policy
- Identifying WRPI vs MVA claims

2.0 Find employer
ACC Staff Member

a Is the claim for Hearing Loss or a Gradual Process Injury?

NOTE Check the client's claim history for a previous Hearing Loss or Gradual Process injury claim.

b Search for the employer in Eos using the trading name listed on the claim form. If self-employed, use the client's name

c Confirm which Employer ID number to use (always use the Prime company)

d Choose the correct Employer Account Number type (E, S or D)

NOTE What are E, S and D employer types?

e Compare the employer name and address in Eos against the claim form to confirm you've found a correct match

NOTE What if I find a possible employer but want to confirm?

NOTE What if there are no possible matches?

NOTE What are the alternative sites to search?

NOTE What if the client doesn't answer, or I have spoken with them and still cannot locate the Employer ID?

f Are there multiple Classification Unit's (CU's) for the employer or selecting a PROXY employer ID?

NOTE How do I identify the correct CU?

- Registration Reference Book Spreadsheet
- Employer Search Tool
  http://prod-ess.ds.acc.co.nz/

Accredited employers list (for work-related claims only)
http://thesauce/team-spaces/chips/employers/accredited-employer-claims/reference/accredited-employers-list/index.htm

Add an Employer to a Claim

3.0 Is the Cover Status of the claim Accredited Employer?

ACC Staff Member

NOTE What if the cover status of the claim is Accredited Employer and the employer is an AE?

NOTE What if the cover status of the claim is Accredited Employer and the employer isn't an AE?

4.0 Complete AE transfer

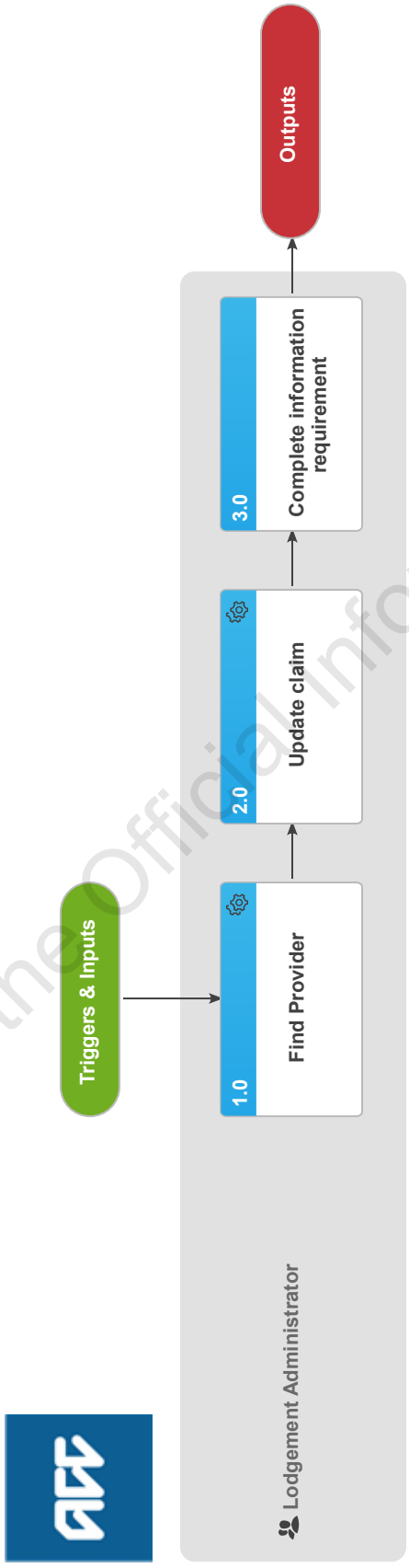
Lodgement Administrator

a Transition the claim to an Accredited Employer using the below process via Web Link, go to step 2b.

PROCESS **Transfer Claim to Accredited Employer (AE) or Third-Party Administrator (TPA) Service**

Lodgement Administrator

Identify Client's Provider v11.0



Identify Client's Provider v11.0

Summary

Objective
To identify the correct provider so that the new claim can be assigned to an existing unique provider record.

Background
Eos has attempted to match the new claim to an existing unique provider record and is unable to because the ID is blank or does not exist. It has raised a Provider Status Invalid information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Find Provider
Lodgement Administrator

a Identify the provider's name from the Provider Details section (Section F) on the claim form and any free text fields for provider information

NOTE What I can't identify who the provider is from the information on the claim form?

b Use the information found and the resources below to find the correct Provider ID:
- MFP
- InFact
- Commonly Used Provider IDs information sheet

Commonly Used Provider IDs

NOTE What if the location is a prison?

2.0 Update claim
Lodgement Administrator

a Search for the correct provider using the Provider ID number in Eos.

b Select the correct provider record and attribute it to the claim using the Edit claim intake form system steps.

Edit claim intake form

c Click NEXT on the claim intake form to save the changes.

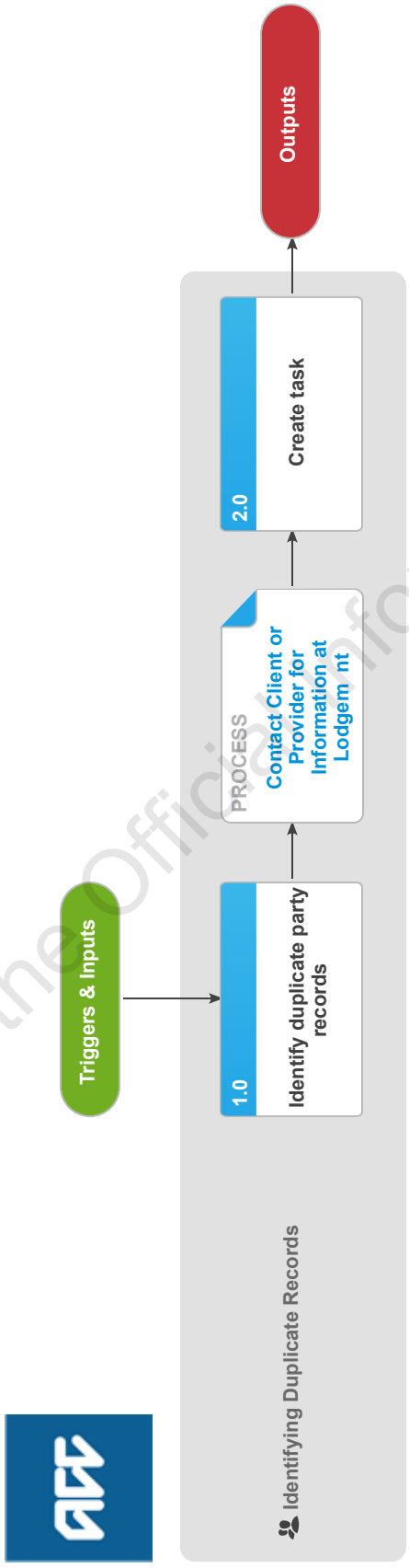
3.0 Complete information requirement
Lodgement Administrator

a Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

b Close the task.

Identify Duplicate Party Record v4.0



Identify Duplicate Party Record v4.0

Summary

Objective
To determine if two or more client party records are duplicates, identify which record should be the master and notify the appropriate team to request the records to be merged.

Background
At times, two or more client records will be created for the same client in Eos. It's important for ACC to only have one unique party record for a client, as a client's history ensures that they receive the most appropriate treatment and entitlements. Clients also have the right to request all their information that ACC has on file and it's possible that we won't comply with this if we're unaware of mul tiple records.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Identify duplicate party records
Identifying Duplicate Records

a Determine whether the two or more client party records could be duplicates by comparing the following fields in Eos:
- Full Name
- Preferred Name
- Date of Birth
- NHI Number
- IRD Number
- Claim Histories
- Address Histories
- Phone Numbers.

b Contact the client to confirm whether the records are duplicates. Go to the Contact Client or Provider for Information process below to do this

c Confirm with the client that the two or more party records are duplicates.

NOTE What if the client confirms they aren't duplicate records?

d Update the party records with the client's correct phone and address details if needed.

Edit Party Details

e Add a contact at party level, noting the conversation and any updates made.

PROCESS **Contact Client or Provider for Information at Lodgement**
Identifying Duplicate Records

2.0 Create task
Identifying Duplicate Records

a Determine which client party record is the master. Use the Determine master party record guide below to do this.

Determine Master Client Party Record

b Add an Action Client Duplicate task on the master record.

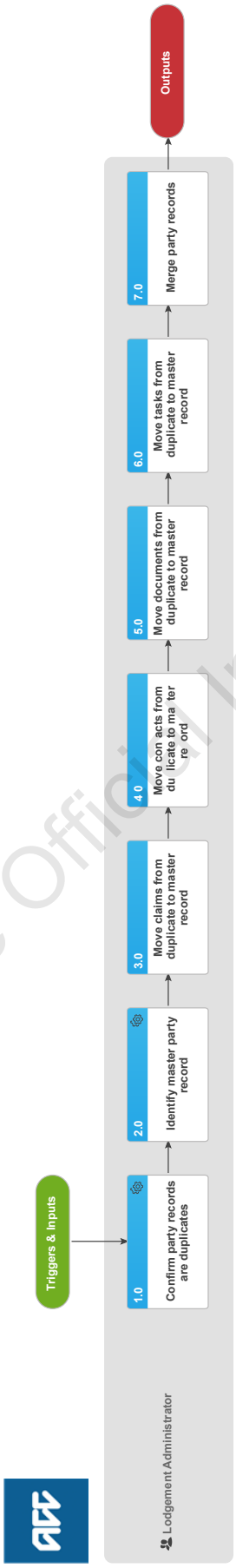
Edit a task

c Complete all the fields on the e-form.

d Add a comment explaining which details are correct and incorrect on the different party records.

e Select Next on the task. Eos will automatically transfer the task to the Registration Centre - Duplicate Client queue.

Merge Duplicate Party Records v12.0



Merge Duplicate Party Records v12.0

Summary

Objective
To merge duplicate client party records onto the master record so that the client has one unique record for future claims to be managed on.

Background
When a user has identified and confirmed two (or more) duplicate party records, an Action Client Duplicate task is sent to be resolved.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Confirm party records are duplicates
Lodgement Administrator

a Open the Action Client Duplicate task on the Additional Info Tab in Eos and check that the statement Confirmed with client that this is a duplicate client record' is set to Yes.

NOTE What if the statement 'Confirmed with client that this is a duplicate client record' is set to No?

b Open the multiple client party records noted on the task.

NOTE What if the client is considered a high profile client or staff member?

c Determine whether the two or more client party records are duplicates by comparing the following fields in Eos:
- Full Name
- Date of Birth
- NHI Number
- IRD Number
- Claim Histories
- Address Histories
- Phone Numbers
- Preferred Name.

NOTE What if I'm unsure if they're duplicate client records?

2.0 Identify master party record
Lodgement Administrator

a Using the Determine master party record guide below, determine which party record should be the master.

Quick Reference Guide

NOTE What if one of the records has active payments?

NOTE What if there is merged tab?

NOTE What if I'm unsure which record should be the master?

b Once you've confirmed which record should be the master party record, make sure you have your screens set up so you don't edit the wrong one.

c Edit the address on the duplicate party record to show "Do not use - Duplicate ID".

3.0 Move claims from duplicate to master record
Lodgement Administrator

a Move all ACC45 claims using the Shift claims from the duplicate ID to the master ID.

NOTE Quick Steps

Shift claims from the duplicate ID to the master ID

NOTE What if there's a Party Case Role of Authority to Act (ATA) for the client that you're completing a merge for?

NOTE What if there's a claim with an old claim number format, eg: ********001?

b Check that you've moved each claim across individually to the master party record and that the duplicate party record is blank.

NOTE What if I get an error message that the claim is work-related when trying to move a claim to the duplicate record?

NOTE What if there is already an Employer – Default attributed to the claim?

4.0 Move contacts from duplicate to master record

Lodgement Administrator

a Once you have opened the Contacts tab, ensure you click the "Clear" button so that all contacts are viewable.

b Move all contacts using the Shift contacts from the duplicate ID to the master ID system steps.

NOTE Quick Steps

Shift contacts from the duplicate ID to the master ID

c Check that the Contacts tab is now blank.

NOTE What if there's some contacts left?

5.0 Move documents from duplicate to master record

Lodgement Administrator

a Move all documents using the Shift document from the duplicate ID to the master ID system steps.

NOTE Quick Steps

Shift Documents from the Duplicate ID to the Master ID

b Check that the Documents tab is now blank.

NOTE What if there are some documents left?

Merge Blurb

6.0 Move tasks from duplicate to master record

Lodgement Administrator

a Move all open tasks using the Shift tasks from the duplicate ID to the master ID system steps.

NOTE Quick Steps

Shift Tasks from the Duplicate ID to the Master ID

b Check that the Tasks tab is now blank.

NOTE What if there's some tasks left?

Claims (tasks) you are unable to move

7.0 Merge party records

Lodgement Administrator

a Complete the merge using the Merge or de- duplicate client IDs system steps.

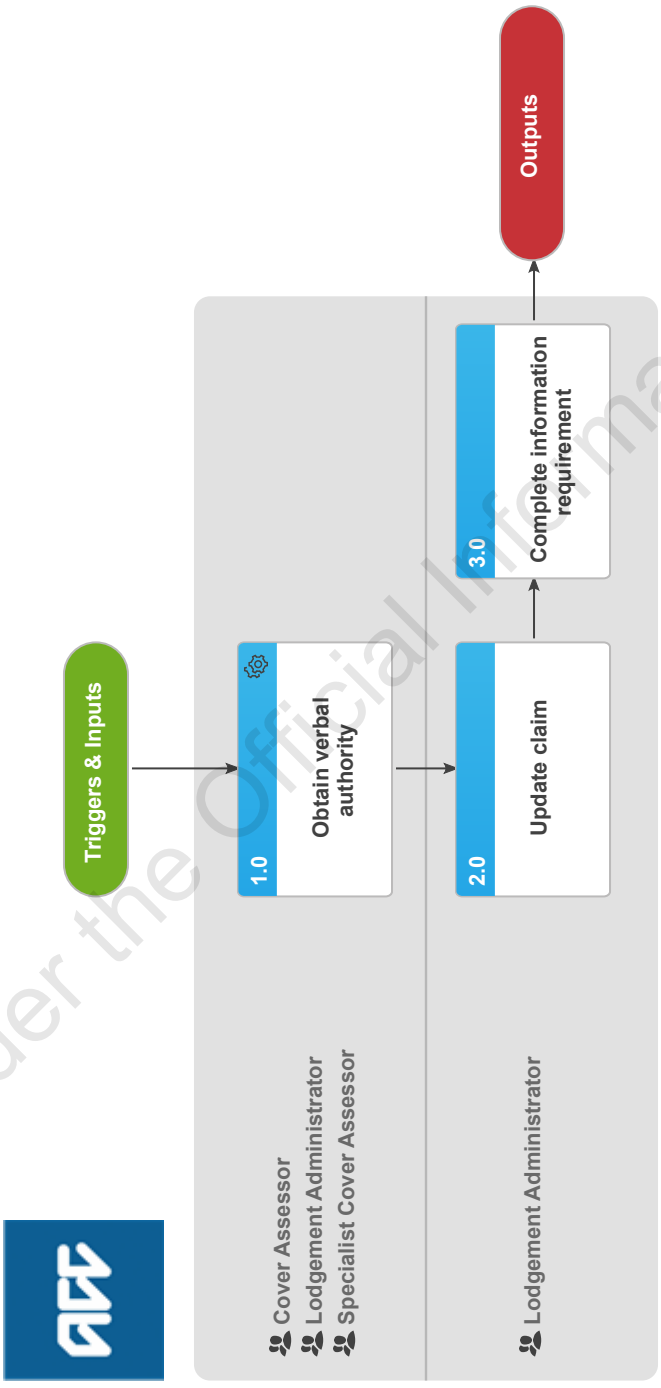
NOTE Quick steps

Merge or De-duplicate Client IDs

b If any claims are open on the party records and are being managed by a staff member, send them a General task or email to let them know.

c Close the Action Client Duplicate task.

Obtain Client Authority for Claim Registration v13.0



Obtain Client Authority for Claim Registration v13.0

Summary

Objective
To obtain verbal authority or a signature from the client on a manual claim form when it's missing so that a cover decision can be made.

Background
Eos has checked the claim and identified that the signature is blank on the paper form. It has raised a Client Signature Missing information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Obtain verbal authority

Cover Assessor, Lodgement Administrator, Specialist Cover Assessor

a If you are a Lodgement Administrator lodging a Treatment Injury or Sensitive claim, refer to the Receive and Input Manual Claims process. For any other claim type, contact the client to request their verbal authority to lodge the claim. Go to the Contact Client or Provider for Information process below to do this.
If you are a Cover Assessor or Specialist Cover Assessor with a Treatment Injury claim, please go to step 1.b.

Contact Client or Provider for Information at Lodgement
https://go.promapp.com/accnz/Process/0a2df950-84d0-4489-bcf7-3663fed855b8

NOTE What if the client is unable to provide authority?

NOTE What if I can't get a hold of the client on the phone?

Verifying and Re-Verifying an Existing Vendor, Provider or Facility Work Email Address
http://thesauce/team-spaces/chips/providers-vendors/provider--vendor-registration/process/verifying-an-existing-vendor--provider-or-facility-work-email-address/index.htm

b Read out the verbal authority statement below to the client, ensuring they have understood what you've said and have agreed to it:

"We noticed the form that's been filled in to lodge your claim with ACC doesn't have your signature on it, so we want to request your verbal authority to progress your claim.

To make our initial cover decision, we may need to talk to people, such as your GP, other health providers, or your employer. That will mean collecting and sharing information about you.

Some examples of the information we may need are:
• Details of your accident
• Medical information relevant to your claim
• Your work details if the accident happened at work.

We will follow the law when collecting, using, and sharing your information, and we will keep your information safe. You can ask us at any time for information we hold about you, and tell us if you think there's something wrong. You can read our privacy notice on our website at www.acc.co.nz for more information about your rights and our responsibilities.

Are you happy to provide authority for us to complete the claim in our system and collect any relevant information necessary to make an initial cover decision?"

[Delete one] Yes / No
Date obtained: [DD/MM/YYYY]

NOTE What if the client doesn't agree to provide verbal authority?

NOTE What if the client doesn't agree to give authority at all?

c Add a Contact and copy and paste the verbal authority statement in to show the day they provided verbal authority.

2.0 Update claim

Lodgement Administrator

a Update the 'Has the Claimant/Representative signed the form?' radio button to Yes.

Edit claim intake form

b Click NEXT on the claim intake form to save the changes.

3.0 Complete information requirement

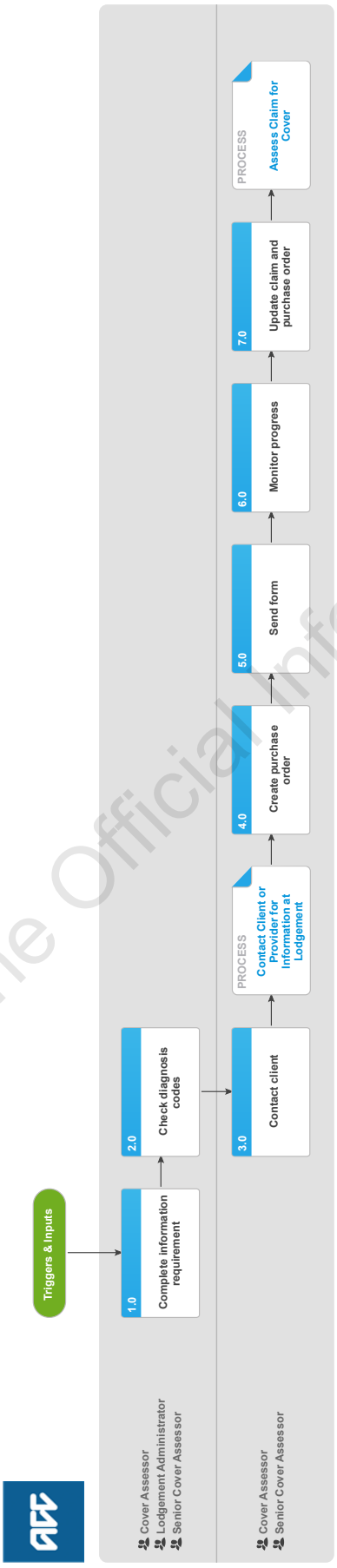
Lodgement Administrator

a Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

b Close the task.

Resolve Provider Competency Issue v9.0



Resolve Provider Competency Issue v9.0

Summary

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 cover decision can be made.

Background
Eos has checked the claim and identified that the provider who lodged the claim is unable to submit the Read code(s) on the claim. It has raised a Provider Competency Failed information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 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 other information requirements outstanding?

b Close the Confirm Cover Decision task.

c This process ends.

NOTE What happens once I have closed the task?

2.0 Check diagnosis codes
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Remove the default provider ID as a Participant on the claim and replace it with the lodging provider ID listed on the contact.

b Open the provider's party record and confirm their provider type

c Review the diagnosis codes on the claim.

d Open the 'Who can lodge claims for different injuries' webpage below and search using the provider type and Read Code.

Who can lodge claims for different injuries?
https://www.acc.co.nz/for-providers/lodging claims/who-can-lodge-claims

e If you can't find the Read Code under the provider type, then the provider competency has failed.

NOTE What if the Read Code is in the list?

3.0 Contact client
Cover Assessor, Senior Cover Assessor

a Contact the client and explain that their lodging provider is unable to diagnose the injury they have submitted. Advise that they need to see their GP, who must fill in the ACC125 Additional information on diagnosis form and return it to ACC before the claim can continue to be considered for cover. Go to the Contact Client or Provider for Information process below to do this.

NOTE What if the client doesn't answer after two attempts?

b Confirm whether they want to have the ACC125 Additional information on diagnosis form emailed or posted to them. Check that their postal address is valid and that they have a verified email address on file so it can be sent.

c Add a contact to note the conversation and to advise if the form is being emailed or posted.

Add a client contact

PROCESS Contact Client or Provider for Information at Lodgement
Cover Assessor, Senior Cover Assessor

4.0 Create purchase order
Cover Assessor, Senior Cover Assessor

a Create a purchase order for the future GP to invoice ACC using the system steps below. Use the default vendor ID (J99966) for this purchase order.

Create a purchase order

b Add the relevant document to the purchase order.

Generate a purchase order document

5.0 Send form

Cover Assessor, Senior Cover Assessor

a Add the CVR04 Diagnosis questionnaire request letter in Eos.

Upload an Incomplete Electronic Document

CVR04 Diagnosis questionnaire request - claimant

b Edit the form and letter with the relevant information, including a return email address. Ensure that you've specified they must see their GP and not their original lodging provider.

c Mark the letter as Complete in Eos.

d Print and send the letter with a pre-paid envelope.

NOTE What if the client asked for the form to be emailed?

6.0 Monitor progress

Cover Assessor, Senior Cover Assessor

a 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 the task.

NOTE What if the information I've requested can't be provided before the cover decision due date?

NOTE What if there's no contact from the client and the form isn't returned within 21 days of the claim lodgement date?

7.0 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.

NOTE What if the provider is not able to lodge the Read codes(s) on the form?

b Upload the ACC125 form to the claim.

File an inbound email

c Add the new provider as a participant on the claim.

Add a participant

d Update the purchase order by replacing the default vendor ID with the new provider's vendor ID number so they can invoice for the appointment.

Edit a party within a purchase order

e If needed, update the claim with any new information such as other Read codes.

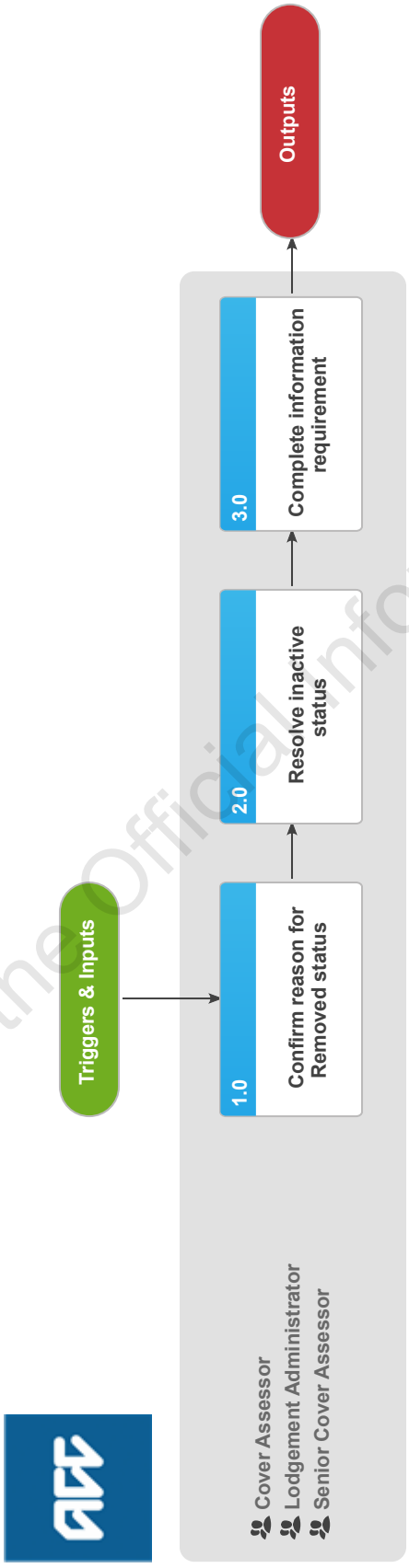
Edit claim details - general

f Make a cover decision. Go to the Assess Claim for Cover: PICBA process below to do this.

PROCESS **Assess Claim for Cover :: PICBA**

Cover Assessor, Senior Cover Assessor

Resolve Provider, Vendor or Facility Status Issue v7.0



Resolve Provider, Vendor or Facility Status Issue v7.0

Summary

Objective
To resolve the provider, vendor or facility status when its status is Removed.

Background
Eos has identified that a provider, vendor or facility has a Removed status and has raised an information requirement for someone to resolve. Possible information requirements are:
- Provider Status Invalid
- Vendor Status Invalid
- Facility Status Invalid

Owner [redacted]

Expert [redacted]

Procedure

1.0 Confirm reason for Removed status
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Search for the provider, vendor or facility in MFP.

NOTE What if the provider ID is blank or it does not exist in MFP?

b View the profile information to confirm that the provider has been inactive for the previous 12 months.

NOTE What if the provider's annual practising certificate has been suspended, or they've been removed from the register?

2.0 Resolve inactive status
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Contact the provider to confirm that they still work at their current p actice.

NOTE What if the provider works at a different practice or their contact information has changed?

b Contact the Provider Vendor Registration team to ask them to reactivate the provider's status.

NOTE What if I need to get the claim registered quickly?

c Add a reminder task to follow up with the Provider Vendor Registration team in 5 days time if necessary.

Edit a task

d Attribute the provider, vendor or facility to the claim once you've received confirmation that they've been reactivated. Use the Edit claim intake form system steps to do this.

Edit claim intake form

e Click NEXT on the claim intake form to save the changes.

3.0 Complete information requirement
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Check that there are no other information requirements outstanding.

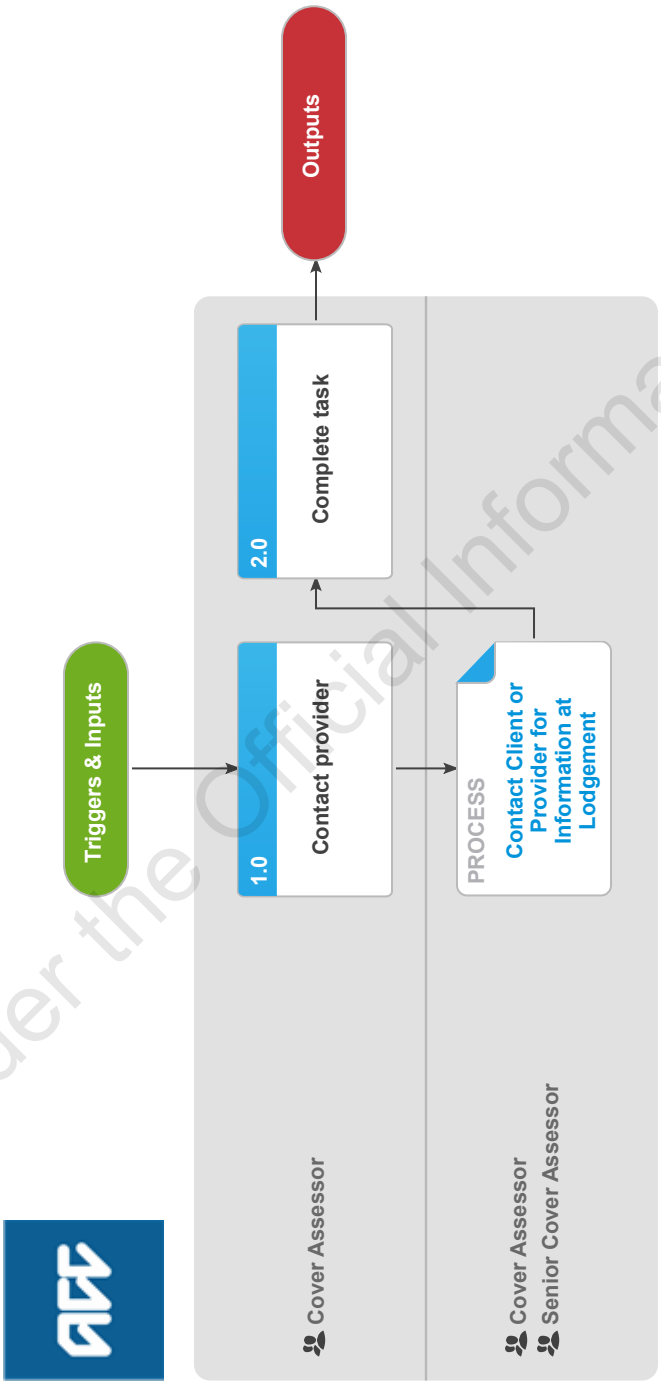
NOTE What if there are other information requirements outstanding?

b If you have resolved a Provider Status Invalid information requirement, then close the task.

NOTE What if I've resolved a Vendor Status Invalid or Facility Status Invalid information requirement?

Complete information requirement

Respond to Provider Request for Contact v4.0



Respond to Provider Request for Contact v4.0

Summary

Objective
To contact the provider if they have ticked the Contact Provider indicator on the claim form.

Background
Eos has identified that the provider has ticked the Contact Provider indicator on the claim form and has raised a Contact Provider task for someone to action.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Contact provider
Cover Assessor

a Contact the provider to find out why they ticked the checkbox. Go to the Contact Client or Provider for Information process below to do this.

b Resolve the query.

NOTE What if I can't resolve the query?

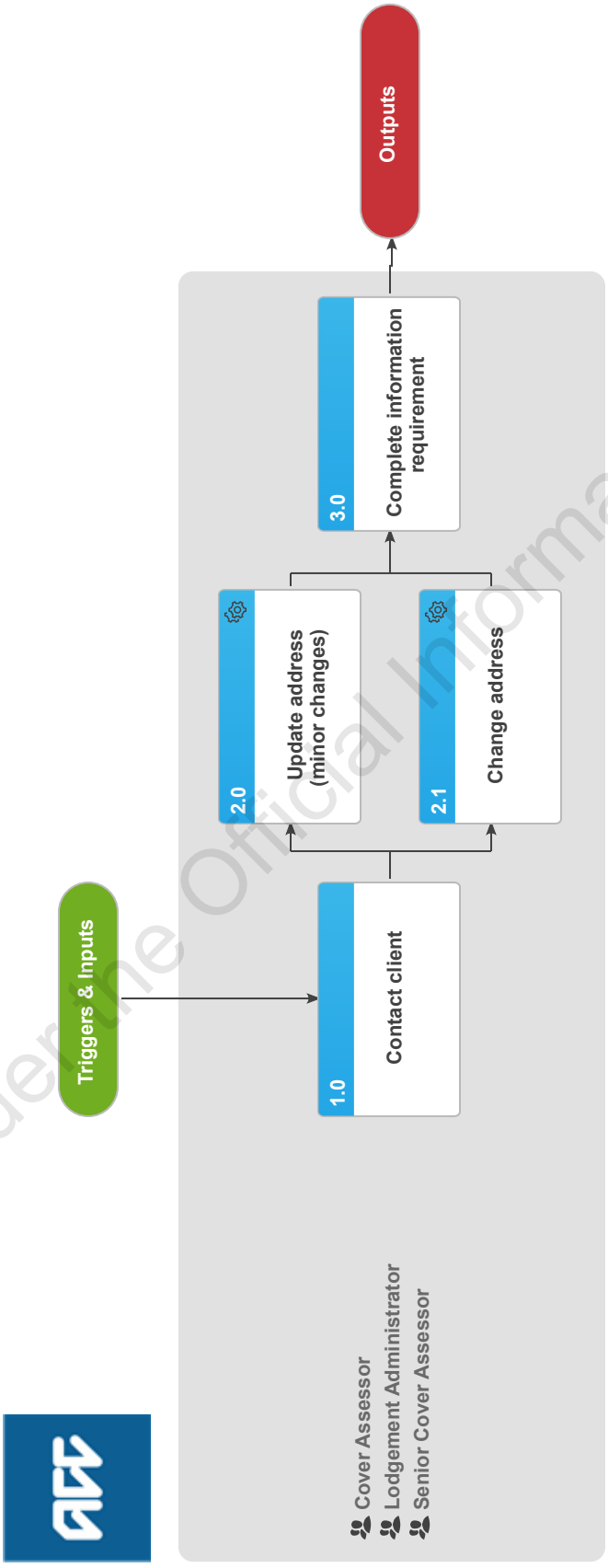
PROCESS **Contact Client or Provider for Information at Lodgement**
Cover Assessor, Senior Cover Assessor

2.0 Complete task
Cover Assessor

a Close the task.

Close a Task

Update Client Address v6.0



Update Client Address v6.0

Summary

Objective
To correct the client's address so we can send information to them by post.

Background
Eos has been unable to validate the client's address and has raised an information requirement for someone to resolve. There are four possible information requirements that can result from different address validation issues:

• Client address matches previous home address
• Client already has an address starting today
• Client already has a post address starting today
• Address is 'invalid'.

*Note: The Address is Invalid information requirement is raised when the Address Line 1 and/or Town field is blank not when the address has been marked as 'Invalid'

Owner [redacted]

Expert [redacted]

Procedure

1.0 Contact client

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Contact the client to confirm client's correct home or alternate address.

NOTE How do you contact a client?

b Go to next step to either update address (minor changes) or change address (new address).

2.0 Update address (minor changes)

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Edit the address in the client's party record in Eos.

Update and verify an address

Add or edit alternate address

b Validate the new address using QAS Pro address accuracy tool.

NOTE What do you need to check when looking up an address?

NOTE What if the tool cannot find a valid address eg new sub division?

Privacy Check Before Disclosing Information Policy

2.1 Change address

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Change the address in the client's party record in Eos.

Update and verify an address

NOTE What if you can't change the address because it's already been changed today?

Edit a task

NOTE Why can't you edit the address instead of changing it so you can do it immediately?

b Validate the address using QAS Pro address accuracy tool.

NOTE What do you need to check when looking up an address?

NOTE What if the tool cannot find a valid address eg new sub division?

Privacy Check Before Disclosing Information Policy

3.0 Complete information requirement

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Update the relevant address information requirements to [Complete].

Complete information requirement

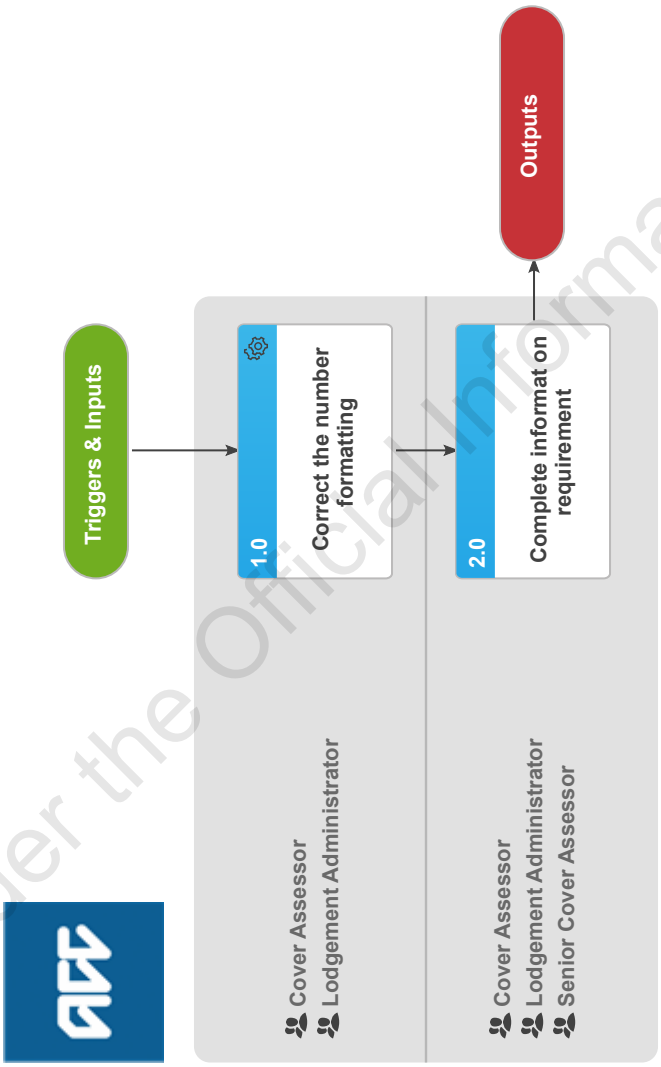
NOTE What if you need to release the CVR40 accept cover letter now that you've confirmed the client's correct address?

b Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

c Close the task.

Update Client Phone Number v5.0



Update Client Phone Number v5.0

Summary

Objective
To collect and update the client's correct phone number so that we have correct contact details for the client on file.

Background
Eos has checked the claim and identified that the phone number listed on the client's party record is an invalid number or the fields are blank. It has raised a Phone Number Verification information requirement for someone to resolve.

Owner [redacted]

Expert [redacted]

Procedure

1.0 Correct the number formatting
Cover Assessor, Lodgement Administrator

a Look at the phone number(s) on file and check that there's a simple area code error, eg: +6427 or blank.

NOTE What if the client has an overseas phone number?

NOTE What if there's too many or too few numbers to be a valid phone number (i.e. less than 8 characters or more than 9 characters long)?

b Update the phone number field in Eos with the correctly formatted number.

Edit Party Details

c Add to note the updates to the claim.

Add a client contact

2.0 Complete information requirement
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a Update the Phone Number Verification information requirement to Complete.

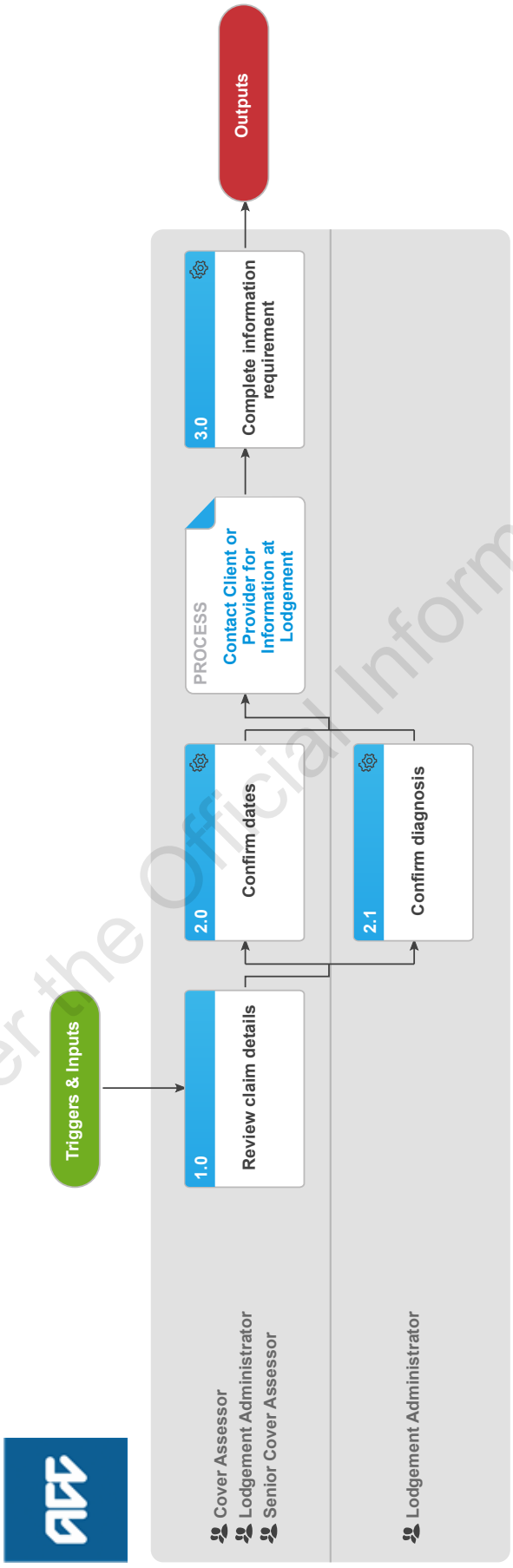
Complete information requirement

b Check that there are no other information requirements outstanding.

NOTE What if there are other information requirements outstanding?

c Close the task.

Verify Claim Information v16.0



Verify Claim Information v16.0

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 [redacted]

Expert [redacted]

Procedure

1.0 Review claim details

Cover Assessor, Lodgement Administrator, Senior Cover Assessor

a 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?

NOTE What if the information requirement is about the injury diagnosis?

NOTE What if the information requiremen is about location or work injury status?

NOTE What if I'm assessing a claim for cover and there's an outstanding Check Eligibility - Overseas IR

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?

NOTE What if ve received a claim for a client who's marked as deceased in Eos?

NOTE What if I've received a Date of Signing is Invalid information requirement because the provider hasn't signed the claim?

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?

b Replace z-code on treatment injury or sensitive claim (if applicable).

NOTE Which code should I replace the z-code with?

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?

NOTE When should I contact the provider?

NOTE What if the provider says there's no injury?

NOTE SNOMED Code

PROCESS **Contact Client or Provider for Information at Lodgement**
Cover Assessor, Lodgement Administrator, Senior Cover Assessor

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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 ?

NOTE What if I need to make a cover decision on a held claim?

b Close the Missing Information for Cover task.
