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

23 March 2022

[redacted]

Kia ora [redacted]

Your Official Information Act request, reference: GOV-016937
Thank you for your email of 25/02/2022, asking for the following information under the Official Information Act 1982 (the Act):

I am seeking the information regarding these policies/procedures/processes that ACC have:

- *Criteria for work-related personal injury 'place of work' Policy; and*
- *Criteria for overriding injury classification Policy; and*
- *the process involved in 'Contact Client or Provider for Information at Lodgement'; and*
- *Eligibility of Late Claims Policy; and*
- *Cover criteria for Medical Misadventure Policy; and*
- *Receiving and streaming Treatment Injury Claim Policy (CHIPS); and*
- *A copy of the Claim intake form (manual claims process) and the policy / process around the use and criteria in completion of this by ACC.*

Attached are a copy of the requested policies
While we have included all of the requested policies, please note that in respect of your request for a copy of the *Claim intake form*, we are unable to provide this. The reason is because the manual forms are received from treatment providers and each treatment provider generates their own form as they are needed. Therefore, this information is refused reliant on section 18(e) of the Act as the requested information does not exist.

If you're concerned about this response, please get in touch
You can email me at GovernmentServices@acc.co.nz.

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

Ngā mihi

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

Criteria for Work-related Personal Injury 'Place of Work' v17.0

Summary

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

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

Owner [Out of Scope]

Expert

Procedure

1.0 Work-related personal injury - criteria

a Section 28 of the Accident Compensation Act 2001 provides the criteria used to determine a work-related personal injury (WRPI). An injury is clearly a WRPI when the injury occurs:

• at the physical place of employment, while the employee is there for the purposes of work, during normal work hours (this includes a place that moves or a place that the client moves through)

• while the employee is taking a break from work and remains on the work premises.

b The following 'guiding principle' will help you determine whether an injury is a WRPI.

NOTE Guiding principle

2.0 Complex cases

a In some cases, you may find it difficult to determine whether an injury has occurred at work, for example:

• employees who work in 'non-traditional' workplaces, ie clients who work from home or on assignment

• clients who work in a traditional place of work, but are out of town on business, en route to another workplace, or away from their usual place of work.

b When deciding whether cases like these fit the WRPI criteria, you must:

• determine the specific place the injury happened

• determine the purpose for being in that place

• apply the guiding principle.

non traditional work place decision flowchart.gif

3.0 Employee carparks and work-related injuries

a Several factors need to be considered when considering whether a carpark is considered as a place of employment if we are to understand if a work-related personal injury (WRPI) has occurred, or not

b When can a car park be considered as a place of employment?
In general, the carpark must be attached to the building where they work, be for employees only and have restricted access to the public. There would need to be internal access to the building from the car park. For further detail see business rule

c When can we consider a person has had a WRPI in that car park?
If the person was in that carpark for the purpose of employment, then we would consider any personal injury caused by accident to be work-related.

d Start and end of Shift
If the person is in that carpark as they start or end their shift for the day and they have a personal injury caused by accident, this will be considered a WRPI (see Section 4)

e Was the person there for the purpose of employment?

a. Purpose – for an injury to be work-related, an employee needs to be at the place of the injury for the purposes of employment.
Key considerations:
• Why was the employee in the carpark at the time of the accident?
• Was it for the purpose of employment?
And
Was the person at a place of employment

b. Place of employment – for an injury to be work-related, the injury should occur at the employee's place of employment.
Key considerations include:
• Where did the accident occur?
• Did it occur in an employee workplace carpark provided by the employer? (see "Employee carpark" business rule for start and end of shift).

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

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

- When a carpark is a place of employment at the start of a shift of an employee
- When a carpark is a place of employment at the end of a shift of an employee

4.0 Questions to consider to help you determine WRPI

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

NOTE Example:

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

NOTE Example:

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

NOTE Example:

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

NOTE Example

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

NOTE Example:

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

NOTE Example:

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

NOTE Example

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

NOTE Example:

NOTE Example:

NOTE Example:

NOTE Example:

6.0 Additional examples to help you determine WRPI

NOTE Example One:

NOTE Example Two:

NOTE Example Three:

NOTE Example Four:

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

a There will still be grey areas where it is difficult to determine whether a WRPI occurred – each claim will need to be determined on a case-by-case basis taking into consideration the specific facts of the case.

b Feel free to provide examples (via [Give Feedback] function on this page) of complex cases where you've found it difficult to determine WRPI. These examples can be included here to help others.

8.0 Link to legislation

Accident Compensation Act 2001, Section 28: Work-related personal injury
http://legislation.govt.nz/act/public/2001/0049/153.0/DLM100918.html

Criteria for Overriding Injury Classification Policy v7.0

Summary

Objective
Use the overriding injury classification criteria to determine whether the claim should be assigned to the Work Account or the Motor Vehicle Account.

1) Overriding injury classification: work-related personal injury
2) Example of a WRPI 'travelling to or from work'
3) Criteria for WRPI 'travelling to or from treatment for a previous WRPI'
4) Working vehicles
5) Overriding injury classification: motor vehicle injury
6) When the injury involves the driver of the vehicle
7) Links to Legislation

Background
Sometimes an injury could qualify as both a work-related personal injury (WRPI) and a motor vehicle injury (MVI). In these cases, we must assign the injury to the correct fund code.

Owner [Out of Scope]

Expert

Policy

1.0 Criteria for WRPI 'travelling to or from work'

a If the claim can meet the criteria of both work-related personal injury and motor-vehicle injury, use the following rule to determine whether the injury is a WRPI.

Overriding injury classification: work-related personal injury

2.0 Example of a WRPI 'travelling to or from work'

a A labourer for a civil engineering company is travelling as a passenger in a work van at the start of the working day. The van is being driven by their boss with two other passengers, all labourers. They are on their way from the work depot to a job site when it is struck from behind by another vehicle. The labourer suffers a broken collarbone.

- The labourer is a "passenger" in the work van.
- The work van is provided by and driven by the labourer's boss.
- The purpose of this travel is work related.
- They are travelling from the work depot to a job site at the start of their working day.

This meets the 'overriding injury classification' criteria for work-related motor vehicle accidents; the labourer is travelling as a passenger in a work vehicle. The work vehicle is being driven by their boss at the start of their working day, and from their place of employment to a job, therefore the injury is classed as work-related.

3.0 Criteria for WRPI 'travelling to or from treatment for a previous WRPI'

a A personal injury is work-related if the client was travelling between their place of employment and another place to obtain treatment for a WRPI, and:
- the person was travelling by the most direct, practical route
- the treatment was:
  - necessary for the WRPI
  - of the type that ACC can provide (even if it was not provided because of the new injury).

4.0 Working vehicles

a A vehicle can be a specific place for the purposes of employment. If a client is injured in a working vehicle, we classify this as a WRPI, not a MVI. The definition of 'motor vehicle injury' excludes injuries that occur during 'any use of a motor vehicle other than as a means of conveyance (Section 35 of the Accident Compensation Act 2001).

Example of working vehicles include:

- mowers, used for mowing the grass road verge
- roading equipment, such as steamrollers
- utility maintenance vehicles, such as cherry pickers.

NOTE Example 1

NOTE Example 2

5.0 Criteria to determine whether the injury is an MVI

a If the claim can meet the criteria of both work-related personal injury and motor-vehicle injury, use the following rule to determine whether the injury is a MVI.

Overriding injury classification: motor vehicle injury

6.0 When the injury involves the driver of the vehicle

a If the driver of the vehicle is injured, their injury could be a WRPI because they were at a place for purposes of their employment. However, as their injury is also a motor vehicle injury, this is the overriding classification.

NOTE Example 1

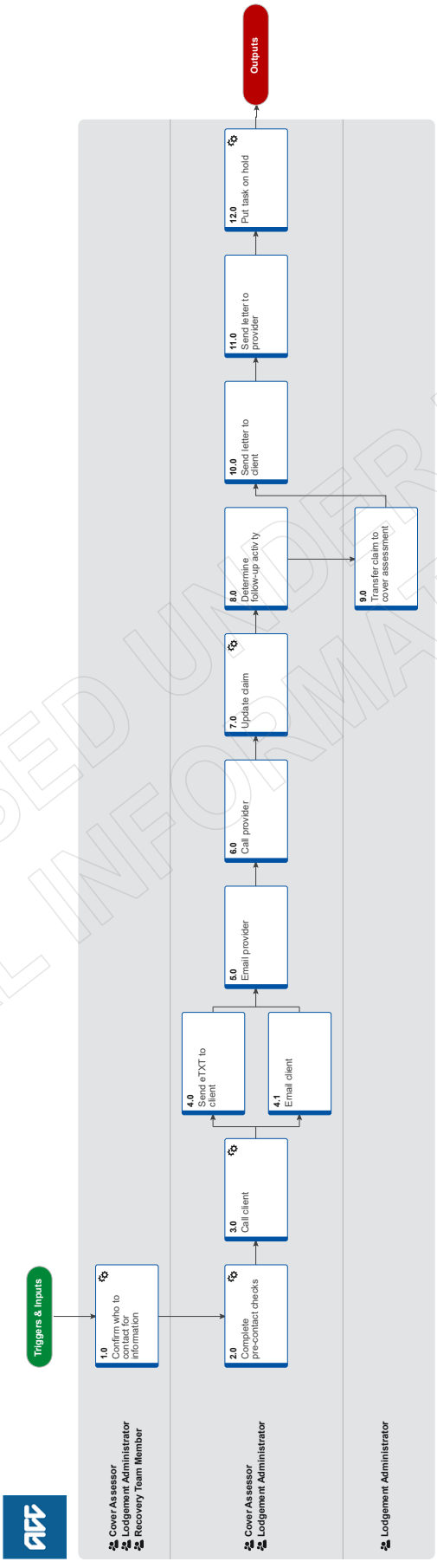
NOTE Example 2

7.0 Links to Legislation

Accident Compensation Act 2001, Section 28: Work-related personal injury
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100918.html

Accident Compensation Act 2001, Section 29: Personal injury that is both work-related and motor vehicle injury
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100925.html

Contact Client or Provider for Information at Lodgement v25.0



Contact Client or Provider for Information at Lodgement v25.0

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 [Out of Scope]

Expert

Procedure

1.0 Confirm who to contact for information
Cover Assessor, Lodgement Administrator, Recovery Team Member

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

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

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

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

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

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--pr

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

a Call the provider and request the information that you need. If necessary give them the client's NHI number and/or the ACC45 Number.

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

7.0 Update claim

Cover Assessor, Lodgement Administrator

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 I haven't confirmed the information I need?

8.0 Determine follow-up activity

Cover Assessor, Lodgement Administrator

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

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

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

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?

Eligibility of Late Claims v9.0

Summary

Objective
Use this guidance to help you determine cover for claims lodged more than 12 months after the date of injury.

1) Rules
2) Insufficient information

Owner [Out of Scope]

Expert

Policy

1.0 Rules

a If a claim that is lodged more than 12 months after the date of injury it may impact our ability to make a cover decision.

b To help us make a cover decision the client must provide:

• clear medical confirmation of the injury

• enough information to establish that they've met the criteria for cover. This includes:

- date of injury or treatment

- circumstances and cause of injury

- diagnosis of injury

- proof that the injury occurred in New Zealand or when the client was ordinarily resident in New Zealand

c We're responsible for contacting the provider where the client was treated to request written confirmation of the dates of injury, treatment and diagnosis, if applicable. See Cover criteria for personal injury.

Cover Criteria for Personal Injury

Cover for injuries suffered outside New Zealand Policy

2.0 Insufficient information

a If there is not enough information on file, and the client cannot obtain medical confirmation of the injury, we decline the claim under the Accident Compensation Act 2001, Section 53.

Accident Compensation Act 2001, section 53 Time for making claim
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100979.html

Cover Criteria for Medical Misadventure Policy v7.0

Summary

Objective
The medical misadventure legislation was replaced by treatment injury on 1 July 2005. For claims lodged before 1 July 2005 you must still use the medical misadventure processes, policies, forms, letters and information sheets.

The Treatment Injury Centre (TIC) only deals with the cover decision. Approved claims are managed by branches or short term claim centres (STCCs).

Medical misadventure claims are considered complicated claims. The timeframes that apply when making cover decisions on complicated claims are specified in the AC Act 2001, Section 57.

Owner [Out of Scope]

Expert

Policy

1.0 Rules

a When making a medical misadventure cover decision you must consider all of the following:
- the client must have suffered a personal injury
- the treatment given or not given must have been the cause of the injury
- the treatment must have been provided by a registered health professional (RHP)
- the injury must be the result of medical mishap or medical error.

2.0 Failure by a health professional

a Medical error may occur if a health professional fails to:

- obtain a client's informed consent before they undertake any medical or surgical procedure, unless it is a life-threatening emergency

- use a reasonable standard of skill and care when diagnosing a client's condition

- give the client treatment within an appropriate timeframe.

For all cases involving medical misadventure, the RHP who initially provided the treatment alleged to have caused a personal injury must be given an opportunity to comment on the allegations before we make our decision.

3.0 Failure by an organisation

a Medical error may include the failure of an organisation to observe a standard of care and skill reasonably expected in the circumstances, if:

- the date the client first sought or received treatment for the personal injury occurred on or after 1 April 2002

- the error could not be readily attributed to a particular RHP involved in the provision of the treatment

- the treatment was being provided at the direction of, or under the management of, an organisation.

A medical error does not exist just because:
- the desired results were not achieved
- subsequent events showed that different decisions might have produced better results
- the failure in question consists of a delay or failure attributable to the resource allocation decisions of an organisation.

NOTE Example

b If the initial independent advisor raised the issue that there was a possibility an organisation could be involved in the error, the organisation must be given the opportunity to comment.

4.0 Claims resulting from treatment from a non-registered health professional

a There is provision under of the AC Act, Section 284(2) for reporting personal injury claims resulting from treatment from a non-registered health professional to the Health and Disability Commissioner and Director General of Health. See When to report medical misadventure.

- the AC Act, Section 284(2)
  https://www.westlaw.co.nz/maf/wlnz/app/document?docguid=I67906f62e03211e08eefa443f89988a0&isTocNav=true&tocDs
- When to report medical misadventure

5.0 Infection transmitted to family

a If a client has an accepted medical misadventure claim for an infection, that infection can subsequently be transmitted to the client's spouse, child or other third parties. When this happens, the spouse, child or other third party can lodge a claim for cover under the AC Act, section 32(7) for medical misadventure.

This provision is limited to the immediate spouse, child or third party infected by a person with a medical misadventure claim. For example, a third party who passes an infection on to another third party would not be eligible for cover.

- the AC Act, section 32(7)
  https://www.westlaw.co.nz/maf/wlnz/app/document?docguid=I67906e40e03211e08eefa443f89988a0&tocDs=AUNZ_NZ_L

6.0 Date of injury

a The date of injury under medical misadventure is the date the client first sought or received treatment for the personal injury.

7.0 Reconsidering cover decisions

a Claims under the 1992, 1998 and 2001 Acts are sometimes returned to the TIC with queries from branches about whether or not cover was correctly granted. Before asking the TIC to revisit a decision on a medical misadventure claim, the branch should provide:
- further medical reports
- a detailed explanation about why they believe the particular claim should not have cover as medical misadventure.

Processing a claim for cover for medical misadventure is complex and we must meet specific legislative criteria. Because the issues surrounding medical misadventure are so complex, delegation for revoking a decision on a medical misadventure claim remains with the TIC.

The TIC does not reconsider cover decisions for claims lodged under the 1972 or 1982 Acts. Branches are responsible for making decisions on medical misadventure under these Acts.

8.0 Review of ACC's decision regarding medical error

a If ACC accepted cover for a claim involving medical error, the health professional or organisation to which the error was attributed had the right to apply for a review of the decision.

9.0 Client contact

a When we received a medical misadventure claim, we had to notify the client within two working days that their claim had been received. We sent a treatment details report (TDR) to the client to complete and made a screening call to obtain essential information from the client regarding their claim.

10.0 No support could be provided until cover was approved

a The legislation did not allow ACC to provide any support to a client until a decision to accept the claim was made. The client was responsible for obtaining any assistance they needed until a decision was made to accept the claim.

11.0 Gathering information

a For medical misadventure claims we needed to determine if:
- there was a personal injury
- the treatment given or not given must have caused the injury being claimed for
- the injury was a result of medical mishap or medical error.

Obtain information concerning the:
- health professional's actions or inaction and, where relevant, the organisation
- actions of other health professionals subsequently involved in the client's care
- any past medical history of relevance to the claim
- likely cause of the personal injury
- rarity and severity of the client's condition.

12.0 Letter templates for obtaining information

a We used the following process for obtaining information:
- take the names of the IHP/NIHP from the treatment details report
- write to involved health professional (MM06 Request for RHP report)
- write to the non-involved health professional (MM07 Report Request NIHP)
- seek any additional clinical records from hospital or GP, etc.

13.0 Timeframe for medical report

a Health professionals were asked to respond to requests for information within three weeks from the report request.

If they did not respond within three weeks, the MM08 Reminder 1 IHP (for IHP) or MM09 Reminder 1 NIHP (for NIHP) was sent with a request for a response within two weeks.

14.0 Refer for independent advice

a Independent advice had to be sought for all medical error claims. ACC asked the independent advisor the following key questions:

- Has the client suffered a personal injury as a result of the actions or inactions of an RHP?

- On the balance of probabilities, could the action or inaction of the RHP have caused the injury? (Is there a 'causal link'?)

- If the action or inaction of the RHP caused the injury, has the RHP failed to observe a standard of care and skill reasonably to be expected in the circumstances?

- If the error cannot be attributed to the actions of an RHP, is there a possibility it may be organisational error?

- If the above applied, then we also asked, 'Was the claim for a personal injury sustained on or after 1 April 2002?'

- If so, was the treatment in question being provided at the direction or under the management of an organisation, other than the Corporation?

- If so, was there a possibility of failure of the organisation to observe a standard of care and skill to be reasonably expected in the circumstances?

If the initial independent advisor raised the issue of organisational error the claim was sent to an organisational advisor for comment after further information has been gathered from the organisation involved.

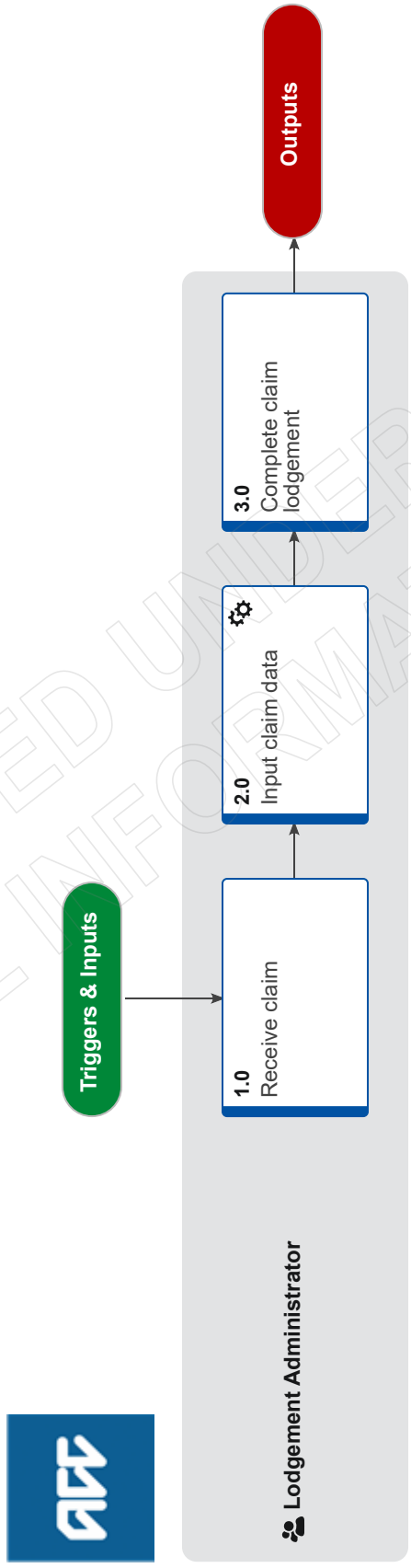
If the claim did not meet the medical error criteria, we would have considered whether the claim qualified as medical mishap, being a rare and severe adverse outcome of treatment.

15.0 Making the cover decision

a ACC was ready to make a cover decision when the medical reports on file covered details of:
- treatment given by an RHP
- personal injury and any pre-existing conditions
- investigation of any error issues in relation to an RHP
- rarity and severity criteria
- investigation of error issues involving the organisation, if relevant.

We considered all the following criteria as part of the decision making process:
- The circumstances around the claim related to the intervention of a RHP.
- The client suffered a personal injury.
- The treatment caused the personal injury.
- A medical error was attributed to the RHP, or a medical mishap occurred.

Receive and Input Manual Claim :: Paper v26.0



Receive and Input Manual Claim :: Paper v26.0

Summary

Objective
To capture ACC45, ACC46 and ACC46N manual claim forms received as a paper version into Eos on behalf of the provider and then prepare the forms for further document management..

Background
A Provider has submitted a claim form to ACC manually by:
- posting it to the Mailhouse
- the client delivering the form completed by the provider into an ACC branch.

Manual claims are completed in a priority order of:
1. Sensitive & Treatment Injuries
2. Time Off/Helds
3. Overseas
3. Work/Accredited Employers
5. Dental

Owner [Out of Scope]

Expert

Procedure

1.0 Receive claim
Lodgement Administrator

a Prepare paper forms for data input.

NOTE The Mailhouse will sort the paper claim forms into the following groups:

NOTE What if the ACC45 has previously been used?

NOTE What if it's an ACC42 Dental claim form?

NOTE What if this is a manual claim and there is no claim uploaded?

Complete claim intake form

2.0 Input claim data
Lodgement Administrator

a In Eos, attribute the client. Go to the Identify Client process by following the link below. Once you have completed this you will need to return to this process.

Identify Client

b Enter the remaining information on the claim form into the relevant fields.

NOTE What if I can see information or inconsistencies on the claim form that I can correct now so that they don't trigger an IR?

View or maintain party address details

Complete claim intake form

c

NOTE What if the claim form was lodged with ACC (i.e. received) prior to the date of claim intake?

NOTE What if the answer to "Is this a work related gradual process, disease or injury?" is Yes?

NOTE What if there is no accident description listed on the claim form?

NOTE What if the Provider hasn't signed the claim form? (E.g. they've stamped the form instead).

NOTE What if the provider has signed the form, however there are no other provider details?

NOTE When is it appropriate to use the Default Provider (J99966) ID?

NOTE What if there is missing information on the claim form and it is a Treatment Injury/Sensitive Claim?

NOTE What if the accident occurred overseas?

NOTE What should I do if I have forgotten to input time off/restricted work duties?

NOTE What if I am concerned about a client that is under 18?

NOTE What if more than one ethnicity has been selected on the claim form?

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

NOTE What if the accident date isn't completed in full?

NOTE If the accident description states the accident was an MVA

NOTE What if the ACC45 is for a Sensitive Claim?

NOTE What if the client has not given consent for the claim to be lodged?

3.0 Complete claim lodgement

Lodgement Administrator

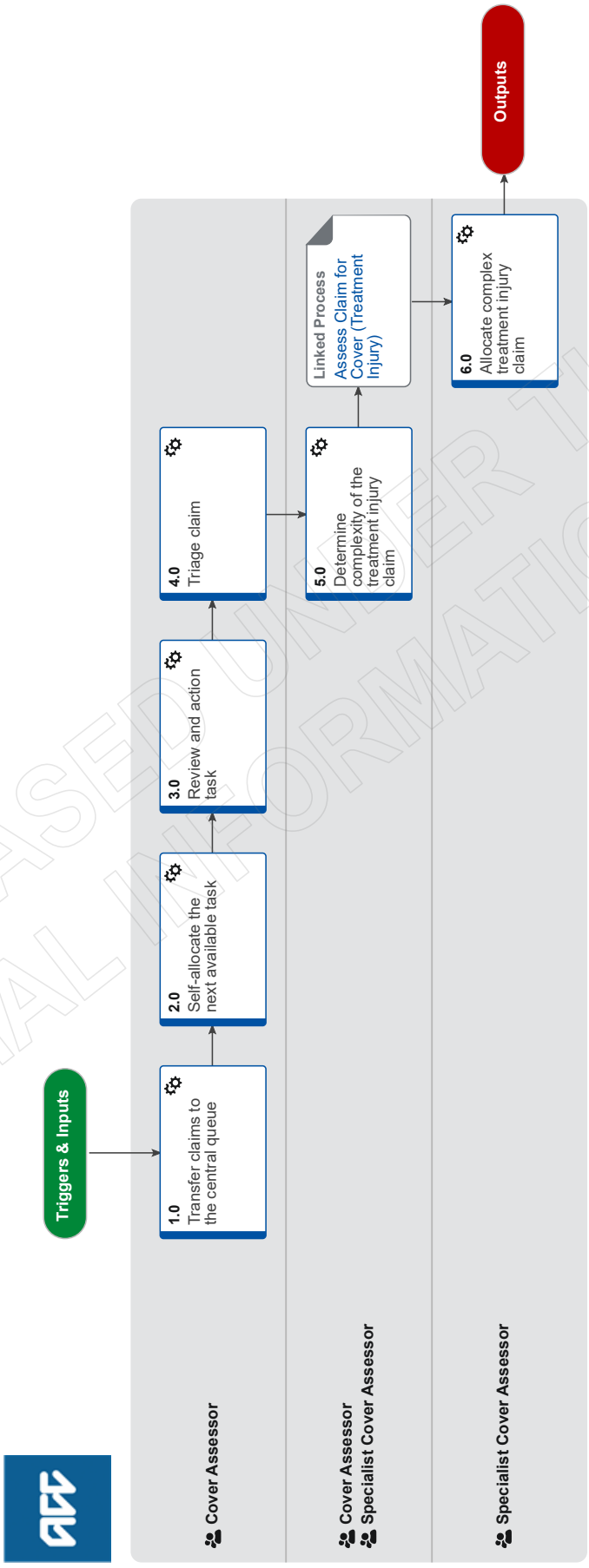
a Once the claim has progressed through automation, check there is no Missing Information for Cover task.

NOTE What if there is a Missing Information for Cover task?

b Place the paper claim form in the appropriate scanning folder.

NOTE How often do we deliver the registered claim forms for document management

Triage and Allocate Claim (Treatment Injury) v27.0



Triage and Allocate Claim (Treatment Injury) v27.0

Summary

Objective
To identify claims that require a critical decision and to decide on the claim's complexity, so that the person with the right skill set can begin cover assessment at the right time.

Background
The process starts from a Cover Assessor self-allocating the next available task. When you have self-allocated 'Confirm Cover Decision', this means there is a new claim that needs to be triaged, allocated and then assessed against cover criteria.

The 'triage' of the claim allows to classify the claim in terms of criticality, so we can make any tasks on the claim a 'high priority'. Complex claims get self-allocated and assessed by Specialist Cover Assessors, while straightforward and moderate can be assessed by Cover Assessor.

Owner [Out of Scope]

Expert

Procedure

1.0 Transfer claims to the central queue
Cover Assessor

a In Eos, transfer new claims from Treatment Injury Centre department queue to TIC-Administration department queue.

2.0 Self-allocate the next available task
Cover Assessor

a In Eos, 'View Tasks', set 'Choose Role' to 'TIC-Administration'

b Use 'Get Next Task' to self-allocate the next available task.

Get next department task (Eos Online Help)

3.0 Review and action task
Cover Assessor

a In Eos, open the claim by clicking on the claim number on the task.

b Check the other tasks on the claim to identify if you can action those tasks as well ie if more than one alert you have mail task exists you can action these at the same time. Close tasks that you have been able to take action on.

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

c Review injury diagnosis, accident description, client and provider consent. Cross check client information on the ACC45/42 matches the information in their EOS party record.

NOTE What if the injury diagnosis is unclear?

d Check the claim is not an accredited employer or duplicate and record this in a contact

NOTE What if the claim is for a personal injury caused by treatment for a WRPI managed by an accredited employer?

NOTE What if the claim is a duplicate?

e Confirm claim is for treatment injury.

NOTE What is considered treatment injury?

NOTE What if the treatment was received while overseas?

Assess Claim for Cover (Treatment Injury)

Cover Criteria for Treatment Injury Policy

NOTE What if the claim is for mental injury consequential on covered treatment injury?

NOTE What if the claim is for personal injury caused by accident (PICBA)?

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

NOTE What should be written in the contact?

g In Eos, select 'Add Sub-Case' and then select 'Recovery Plan'. This will auto-generate a ' NGCM - Client Welcome Conversation' task.

h In Eos, open the ' NGCM - Conduct welcome conversation' task and click 'Cancel'. Select from the 'Reason' drop box the 'Original Task Inappropriate' option.

4.0 Triage claim

Cover Assessor

a Determine if a client requires a critical decision.

NOTE When would a client require a critical decision?

Issues Alert Template

NOTE What if the client requires a critical decision?

NOTE What if the client has a rapidly deteriorating condition and / or is at risk of passing away soon?

5.0 Determine complexity of the treatment injury claim

Cover Assessor, Specialist Cover Assessor

a Generate and edit the appropriate acknowledgment letter (excluding fatal claims). This letter must include the first-time extension reasoning and date. Remove the paragraph stating when we expect to receive the requested information by and will remind the provider if necessary and add the time extension paragraph as outlined in the FLIS TI01 Acknowledgement and Extension combined - claimant.doc

b

TI01- Acknowledge and Extension combined- claimant.doc

TI02 - Acknowledge claim - parent

TI03 - Acknowledge claim - parent (deceased child)

TI04 - Acknowledge claim - next of kin

TI05 - Acknowledge birth injury claim - parent

NOTE Types of acknowledgement letters and their attachments

NOTE What should you write in the document description when generating an acknowledgement letter?

NOTE What if there is a request for treatment on the claim, ACC18, ARTP, weekly compensation request or other requests ie dental treatment, hearing aids, prosthesis and district nursing care? (Depending on the urgency of the request for support consider putting the task on high in the case ownership you if you cannot make the decision and the injury meets the criteria for a Specialist Cover Assessor to assess. If the client is being supported by the DHB for example home help this may not meet the criteria for upstreaming. Please use your judgement or discuss with your leader.)

c Upload any necessary attachments to be sent with the acknowledgement letter to the claim as a PDF.

NOTE How to upload PDF attachments to a claim

ACC6248 Voice of the family - questionnaire

ACCDIS01-How we can help after someone dies from an injury.doc

Health & Disability Commissioner - Learning from Complaints

ACC21 Advice of accidental death

ACC7118 Support for whanau of children injured at birth.pdf

d If acknowledgment letter is generated, create 'NGCM - Send Letter' task.

NOTE How to create the 'NGCM - Send Letter' task and how to link the necessary attachments.

e Review the complex and non-complex treatment injury - claims criteria.

complex and non-complex treatment injury - claims criteria.docx

NOTE What if it is a complex claim?

NOTE What if the injury is not on the 'Complex and non complex treatment injury-claims criteria' list?

NOTE What if the claim is on the non-complex list, and can therefore be assessed by a Treatment Injury Cover Assessor?

f In Eos, in the 'Treatment Injury' sub-tab, in the 'Injury' tab, tick the correct 'Claim Stream' and fill out the required fields. A claim stream is considered complex if identified in 5(a) Complex and non-complex treatment injury-claim criteria. If the claim is not considered complex stream as straightforward.

NOTE What if you can't fill out all required field?

g In Eos, change the target date of the 'Confirm Cover Decision' task to five business days prior to cover decision due date.

h In Eos, close 'AUTO Alert 1 - New Claim' task and leave the corresponding claim in TIC-Administration. Go to 'Assess Cover for Treatment Injury Claim' process.

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

Cover Assessor, Specialist Cover Assessor

6.0 Allocate complex treatment injury claim

Specialist Cover Assessor

a In Eos, in 'View Tasks' section, set 'Choose Role' to 'TIC-Case Ownership'.

b In Eos, click on 'Get next task'. You'll be allocated a 'Follow-up cover' task for a claim that requires assessment.

c Transfer the claim corresponding to the task to your name.

NOTE How to transfer a claim to your name.

NOTE How often should you be getting new claims for assessment?

d Close 'Follow-up cover' task.

e Ensure all tasks on a claim have been transferred to you.