27 July 2023

[redacted]

Kia ora [redacted]

Your Official Information Act request, reference: GOV-026458
Thank you for your review application of 12 July 2023. The following questions were forwarded to my team for response under the Official Information Act 1982 (the Act):

- *What investigation activities do ACC undertake to ensure that claims are valid and remain valid.*
- *Are there any checks made by ACC on employees pre-existing conditions before loading an injury to an employer.*

We have interpreted your first question as relating to how ACC verifies whether a claim is work related
We have attached processes and policies which demonstrate how ACC verifies this; including our processes for determining whether an injury is related to a pre-existing condition.

The following processes are attached as Appendix 1

- Criteria for Work-related Personal Injury 'Place of Work'
- Identify Client's Employer
- Contact Client or Provider for Information at Lodgement
- Cover criteria for pre-existing conditions Policy
- Work-related Gradual Process, Disease or Infection Policy
- Assess Claim for Cover: Simple PICBA Claim

As staff names were not requested, they have been deemed out of the scope of your request and removed.

Further information about how experience ratings are calculated is available on the ACC website

- https://www.acc.co.nz/for-business/your-work-levy-and-experience-rating/calculating-your-experience-rating/
- https://www.acc.co.nz/assets/business/experience-rating-for-businesses.pdf

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

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

Ngā mihi

Sara Freitag
Acting Manager Official Information Act Services
Government Engagement

GOV-026458

Criteria for Work-related Personal Injury 'Place of Work' v21.0

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

• an employment activity

• some activity reasonably connected with their employment.

2.0 Complex cases

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

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

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

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

• determine the specific place the injury happened

• determine the purpose for being in that place

• apply the guiding principle.


non traditional work place decision flowchart.gif

c 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. If you need assistance to determine this, please seek internal guidance.

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

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

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

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

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

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

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

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:**

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

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

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

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

NOTE **Example:**

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

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

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

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

NOTE **Example**

A client has finished work for the day and is walking to their car in the employee carpark located across the road from their workplace. While walking through the carpark, they trip and injure themselves.

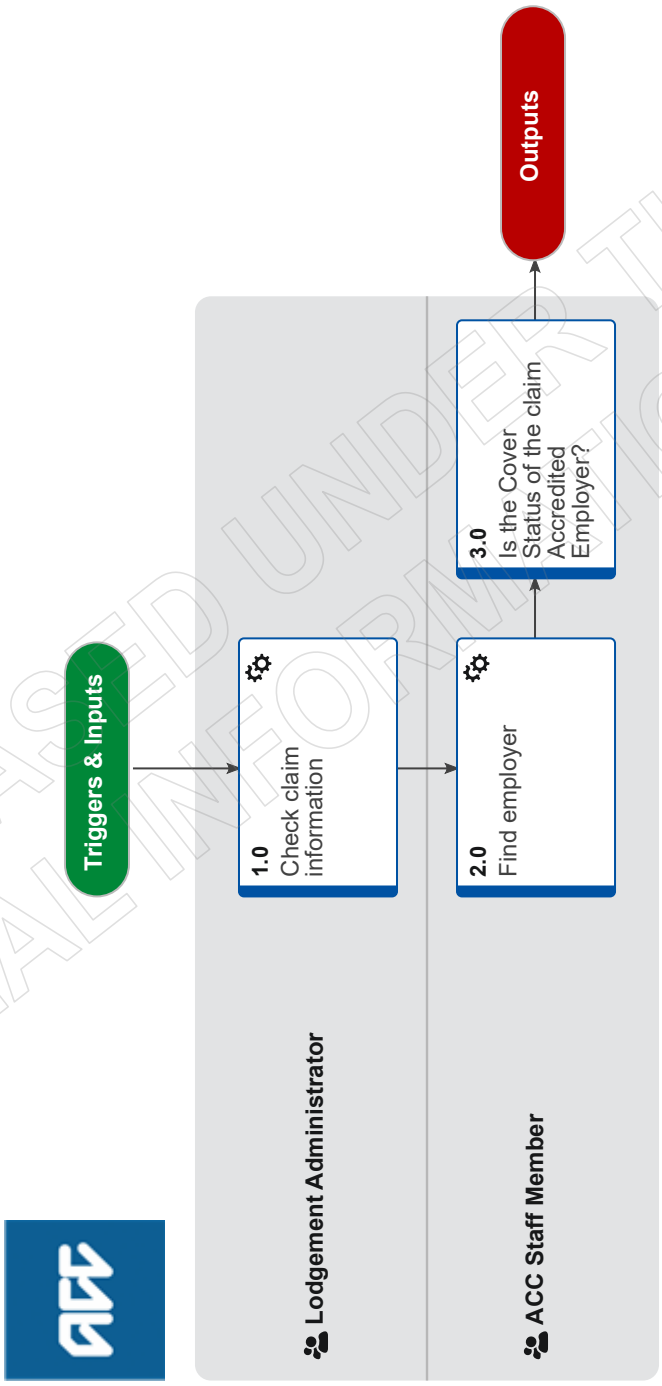
The carpark is owned by the employer and the client has a carpark pass to use the spaces. The carpark is intended for employees only and has prominent signage stating that cars without passes displayed will be towed, but there are no physical barriers to prevent members of the public parking in the space.

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

5.0 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

Identify Client's Employer v26.0



Identify Client's Employer v26.0

Summary

Objective
To identify the correct parent company employer at the date of accident so that the new work-related claim can be assigned to an existing unique employer record on both new and existing claims.
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.
This process is also used to remove attribution from an incorrect employer and identify the correct employer for attribution
Work related claims for employees of an AEP participant are either managed by the employer or a third party administrator.

Owner [Out of Scope]

Expert

Procedure

1.0 Check claim information

Lodgement Administrator

a In Eos, check that the Accident Description accurately reflects the selection for the following fields:
- Did the accident happen on a road?
- Is it a Work Accident noted as 'Yes'?

The ACC45 features this question directly, but evidence to support this can also be found in Part B: Injury and Employment Details of the ACC45
- Does the Occupation field show a role (e.g Not 'Retired' or Pre-School child')
- Does the Occupation field make it a plausible work accident?
- Is there any conflict between Accident Description and employer that gives doubt to the accuracy of information?
- Does the Accident Description match the employment details (occupation and employer)?
- Earner status at date of accident?
- Is the claim for a Work Related Sensitive claim?
- Is the claim for a Work Related Mental Injury (MI)?
- Is the claim for a Work Related Gradual Process Disease Infection (WRGPDI)?
- Is the claim for a Work Related Hearing Loss Gradual Process?

NOTE **What if they don't match or you're unsure?**
If details are clearly incorrect, update as per the XML ACC45 form.

If this is unclear you must call the client or listed employer to clarify. Go to the Contact Client or Provider for Information at Registration process below to do this.

Example of situation to prompt query:
Accident description: Burnt hand taking tray of pies out of oven
Occupation: Retail Assistant
Employer: XYZ Hardware

The above details would raise doubt as it is it would be uncommon for this Occupation at this employer to be carrying out the described task. It would be appropriate to call the client to confirm their employer.

PROCESS Contact Client or Provider for Information at Lodgement

NOTE **What if you confirm the claim is not a work accident?**
If the claim is in intake, amend the claim to non work and leave a clear contact with all the information we have received to support making this change.

If the claim has gone through intake create task - Work Injury Inquiry – Request Investigation. Include details of change required and reasons in the task.
- Add a contact on the claim noting the information received and action required
- Transfer task to Hamilton SC - Quality Assurance (unless claim is sitting with a recovery team - then transfer task the recovery team).

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

• Obtain information to determine if the client was employed by a New Zealand company and that they were paying tax in New Zealand.
• If the client was not employed by a New Zealand company the employer cannot be attributed - add NFPROXY as the employer.
• If the client was employed by a New Zealand company, attribute the employer.

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

Use the Identifying WRPI vs MVA Claims information guides and the policies linked below to determine this.

- Motor Vehicle Account fund Policy
- Identifying Work-Related Personal Injury (WRPI) vs Motor Vehicle Accident (MVA) claims

NOTE **What if it is a Sensitive claim?**

Update the date of accident to the date of consultation and attribute 'NFProxy' and use the default CU '99999'

NOTE **What if the sensitive claim is for an Accredited Employer?**

Update the date of accident to the date of consultation and attribute the Accredited Employer as per the ACC45. This will generate a different transfer task for the relevant team to assess.

NOTE **What if the claim is for a work related Mental Injury?**

Attribute the employer as per the ACC45.

If unable to confirm employer from claim information, attribute NFProxy for the claim to be assess by relevant team.

NOTE **What if the claim is for a Work Related Gradual Process Disease Infection (WRGPDI)?**

Amend the Date of Accident to the Consultation Date (this will enable the management dates to be correctly calculated).

Attribute the employer as per ACC45
Add "Gradual Process" to the injury comments

See below notes for Work Related Gradual Process Hearing Loss claims.

NOTE **What if the claim is for a Work Related Gradual Process Hearing Loss?**

Amend the Date of Accident to the Consultation Date (this will enable the management dates to be correctly calculated).

Check the clients claim history for a previous Gradual Process Hearing Loss Gradual Process claim.

NOTE **What if the client does not have any previous Gradual Process Hearing Loss claims?**

If the Employer noted on the ACC45 meets any of the below criteria, attribute GPProxy as the employer and select the CU 99999 and allow claim to stream to the Hearing Loss queue for ACC to manage the claim:
Criteria:
• If the employer noted is not an Accredited Employer.
• If the Employment status is marked as "Self Employed."

NOTE **What if there is no employer noted on the Gradual Process Hearing Loss claim form?**

If there is no employer noted on the ACC45, but the client has recent previous claims for an accredited employer - call the client to confirm employer at date of diagnosis.

If there is no reason to suggest they may be employed by an Accredited Employer - Attribute GPProxy

NOTE **What if the client does not have a previous Gradual Process Hearing Loss claim but the employer noted is an Accredited Employer?**

Call the client to confirm who they were employed by at the Date of Diagnosis.

If the client confirms their employer at the date of diagnosis as the Accredited Employer - Attribute employer and transfer claim to TPA for claim management.

If the client confirms the employer as a non-accredited employer or that they are no longer working/retired - attribute GPProxy as the employer and select the CU 99999

NOTE **What if the client has a previously Accepted Gradual Process Hearing Loss claim?**

Attribute "GPProxy" and allow claim to stream to the Hearing Loss queue for ACC to manage the claim.

NOTE **What if the client has a previously Declined Gradual Process Hearing Loss claim? Check the rationale for the Decline (will be noted on the general screen under cover status):**

If the decline was due to the questionnaire no yet returned or lack of information - Attribute GPProxy and allow claim to stream to the Hearing Loss queue for ACC to manage the claim.

If the decline is for any other rationale the claim needs to be treated as though there was no previous Hearing Loss claim and the above criteria for employer at date of diagnosis applies.

NOTE **What if the client has a previous Gradual Process Hearing Loss claim with an Accredited Employer attributed?**
Check whether the date of diagnosis on the new Hearing Loss claim is within the managed dates period found on the general screen of the previous claim.

NOTE **What if the new Gradual Process Hearing Loss claim is within the Managed Dates period of the previous AE Hearing Loss claim?**
Check the employer on the new claim:
• If the employer noted on the ACC45 is not Accredited - Attribute the previously accredited employer and transfer to the TPA for claim management.

• If the employer noted on the ACC45 is the same Accredited Employer OR a different Accredited Employer - Attribute the Accredited Employer noted on the new ACC45 and transfer to TPA for claim management.

NOTE **What if the Gradual Process Hearing Loss claim is outside of the managed dates period?**
Attribute "GPProxy" allow claim to stream to the Hearing Loss queue for ACC to manage the claim.

As the previously managed claim will be returned to ACC by the TPA for ACC to continue any claim management requirements.

- Criteria for overriding injury classification Policy
- Criteria for work-related personal injury 'place of work' Policy
- Work Account fund Policy

2.0 Find employer
ACC Staff Member

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

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

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

NOTE **What are E, S and D employer types?**
E (Employer) is someone who the client is directly employed by and they pay the client's PAYE (tax) directly to the IRD.

S (Self Employed) is someone who could be a contractor to another business in which they invoice for their services and own 100% of their business. Also included in this is when employers deduct With-holding Tax.
Most couriers, real estate agents and cricket players are self-employed but will list the company/team they contract to on the ACC45.

D (Shareholder employee) is someone who is an owner of the company and who is also employed by the company. They must be working for this company when they have their accident. Some people can own multiple companies so we need to confirm the name of company they were working for on the date of accident.

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

NOTE **What if you find a possible employer but want to confirm?**
Contact the employer to ask if the client was on their payroll at the date of accident. You must only give the client's name and not provide any details about the accident or other personal information.

NOTE **What if there are no possible matches?**
• Click view party to see the employer's alternative addresses
• Search using different variations of the employer name e.g. if employer is Mana Wahine O Te Wairoa, search for Mana Wahine.
• Search for the employer on alternative sites (See note below for a list of these sites)
• Call the client to ask for their employer at date of accident. Go to the Contact Client or Provider for Information process below to do this.

PROCESS Contact Client or Provider for Information at Lodgement

NOTE **What are the alternative sites to search?**

Check if the employer is a Subsidiary or Prime company in the Registration Reference Book and the Accredited Employer List.

Internal searches:
• First search using the Registration Reference Book

Use any of these tools in any order:
• ACC Employer Search Tool
• Accredited Employers list (for work-related claims only) in CHIPS
• In the client's previous claims on their Party Record
• JUNO Policy Centre

Internet searches:
• Google.co.nz - Can help for correct spelling, or phone numbers and addresses that can then be used in the ACC Employer Search Tool.
• WhitePages.co.nz - Can help with locating employers for farm workers who list the employers name and not the company/partnership name, from here a phone number of full address can be used in the ACC Employer Search Tool.
• COYS.co.nz - Provides a quick view of shareholding in company and can also provide a trading name or show a previous name(s) of a company.

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

• Start a new employer search in Eos using the NFPROXY or NSEPROXY.
• Choose the most appropriate Classification Unit (CU) based on the client's occupation. Use the CU tab in the Registration Reference Book below to find this.

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

NOTE **How do you identify the correct CU?**

Choose the most appropriate classification unit (CU) based on the client's occupation. Use the CU tab in the Registration Reference Book to identify this.

f Confirm whether the claim is for an accredited employer

NOTE **What if the claim is late lodged?**

If the claim is in intake, check management period for the accredited employer on the employer record in EOS, and confirm the Date of accident is still within the management period.
If the claim has gone through intake the management period will be on the general screen.

NOTE **What if the date of accident is outside of the accredited employers management period?**

The claim will stay with ACC to manage. Instead of attributing the accredited employer we will attribute NACproxy as the employer. If the claim has already gone through intake with the accredited employer status we will need to change the cover status to held, then generate a high priority general task advising that claim needs to be assessed as it is outside of the accredited employer's management period, this task will need to be transferred to the Registration Centre - Low Complex Dunedin queue.

g Amend the incorrect employer, if applicable.

NOTE **What if we have received notification that the incorrect employer has been attributed to the claim?**

Where confirmation has occurred with the client or employer that the incorrect employer has been attributed and the CVR48 has been issued to the incorrect employer the below steps can be followed.

NOTE **What if you need to remove an employer from the claim?**

• Remove the incorrectly attributed employer from the claim (SYSTEM STEPS Remove an Employer from a Claim).
• Issue and send the employer who has been removed a CVR80 letter.
• Issue and send end newly attributed employer a CVR48 letter.

Remove an employer from a claim

CVR80 Work injury dispute - employer changed - employer

CVR48 Claim approve - work injury - employer

Registration Reference Book Spreadsheet

Employer Search Tool
http://prod-ess.ds.acc.co.nz/

Accredited employers list (for work-related claims only)

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?**

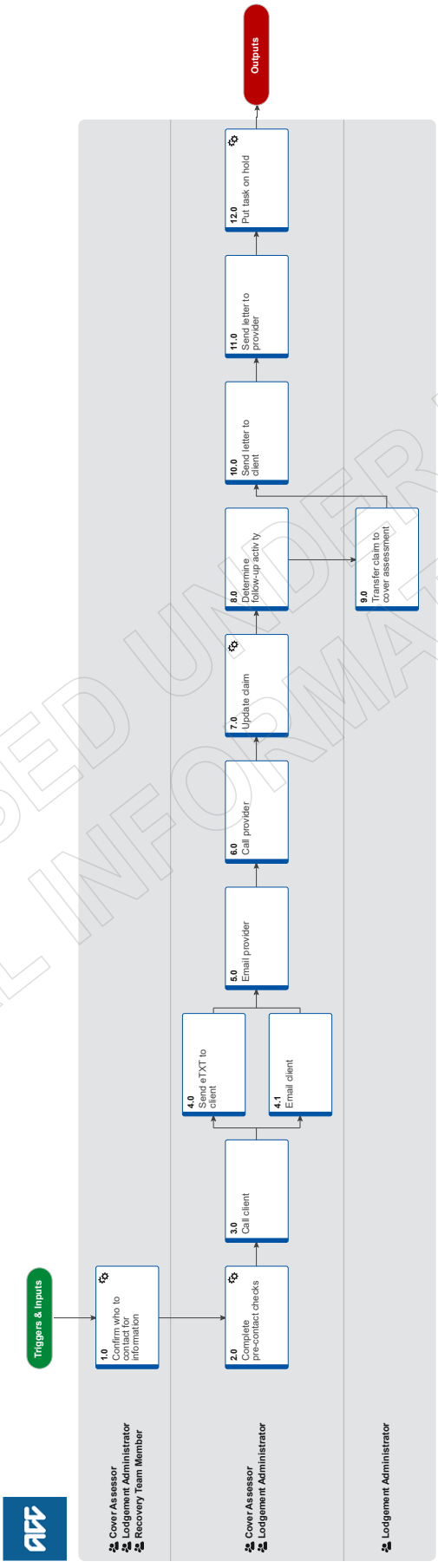
Transition the claim to an Accredited Employer using step 3.0 of the following process. This process ends.

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

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

Close the Generate AE Claim Transfer Notification task if applicable, resolve any other IR's, assess cover and stream the claim as appropriate. This process ends.

Contact Client or Provider for Information at Lodgement v28.0



Contact Client or Provider for Information at Lodgement v28.0

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?**
Ring the provider for a client contact number. Cell phone numbers are not always visible on ACC45s but can be held by providers.

NOTE **Who can contact the client about request for hernia cover?**
Cover Assessors contact the client and complete ACC6261 Cover assessment - initial call summary - hernia template with the client.

ACC6261 Cover Assessment – Initial Call Summary - Hernia

NOTE **What if it's more appropriate to contact the provider?**
Go to task 5.0

NOTE **What if the provider has not signed the ACC45?**
If the ACC45 requires a signature this can not be completed verbally with the provider. Either email the ACC45 to the provider (task 5.0) or send a letter with the ACC45 attached (task 11.0).

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?**
- If the client's parent or guardian is listed on the claim, call them instead. Use the instructions in task 3.0 to do this.
- If the client's parent or guardian is not listed on the claim, contact the provider. Go to task 5.0 to do this.

NOTE **What if the client has a care indicator?**
Look up their management plan or speak with a leader or manager before proceeding.

NOTE **What if the client has a safe contact?**
Follow the policy on Contacting Sensitive Claims Clients below.

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?**
Contact the provider instead. Go to activity 5.0 to do this.

b Check the client has a valid phone number.

NOTE **What if there's no phone number for the client?**
Look at the most recent phone number history to see if there's a recent valid number on file you can call. If there isn't one, call the provider to obtain the client's number.

NOTE **What if the client has an overseas phone number?**
Check if the client has a verified email address.
- If they do, then request the information via email. Go to task 4.1 to do this.
- If they don't then contact the provider. Go to activity 5.0 to do this.

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?**
See 'Identity Check Policy' below for the standard security questions

Identity Check Policy

NOTE **What if the client refuses to answer the security questions or doesn't believe you're from ACC?**
You can:
- Give the client their provider's name to reassure them you're from ACC
- Suggest the client calls you back on your work number – 0800 101 996 [your extension]

NOTE **What if you've tried to call the client and still can't contact them?**
If it's a cell phone number and either:
• the voicemail states and matches the client's first name,
• there is no voice mail identifying any name, or
• if it's a home or work phone number and the voicemail states the client's first AND last name, then:

• Leave a voice message to call you back. Don't leave any information about the reason for the call or the claim number, simply say: "Hi it's [your first name] from ACC, please call me back on 0800 101 996 [your extension]. We're available from 7am to 7pm weekdays. Thank you."

• If there's a cell phone number, go to activity 4.0 to send an eTXT, and
• If there's a verified email address, go to task 4.1 to send an email.

Make a contact using the Contact Generator template to record the call attempt.

b Request the information you need. Go to activity 7.0

Sending eTxts

4.0 Send eTXT to client

Cover Assessor, Lodgement Administrator

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

Etxt Policy

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

Creating and sending eTxts

NOTE **Can you name the client in the eTXT?**
If the mobile number is verified the clients first name can be used. If the mobile number isn't verified the clients name is not to be stated 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.

Verify an Existing Provider, Vendor or Facility Email Address

NOTE **What if you don't have the email address I need?**
Call the provider instead. Go to activity 6.0 to do this.

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

NOTE **What if the provider doesn't want to email the information?**
If the provider is happy to confirm the information over the phone, then call them directly. Go to activity 6.0 to do this. Otherwise ask for provider to send the information in writing.

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?**
Depending on what you're requesting either:
• ask the provider to email the information or send it in writing, then go to task 7.0
• send the provider the appropriate letter requesting the information. Go to task 10.0 to do this.

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 you haven't confirmed the information you need?**
Go to task 8.0

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?**
Go to task b below.

NOTE **What if you've tried contacting all appropriate people but haven't been successful?**
Go to task b below.

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?**
Go to activity 12.0 to put the task on hold. When the task is released from hold a second attend must be made to contact the person by phone/eTXT/email.

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?**
Go to activity 10.0 to send a letter to the client or activity 11.0 to send a letter to the provider.

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 you're sending a letter to the provider?**
Go to activity 11.0.

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?**

- If the address is verified but invalid, it's okay to send a letter.
- If the address is not verified and invalid, then do not send a letter.
- If the claim is to clarify Residency Criteria send eTXT to client if cell number is available (see activity 4.0) and add questions into contact using the Contact Header Generator.

If not able to send letter or eTXT the client, the claim may need to be declined due to a lack of information. Follow the Decline Claim process below to do this or talk to your manager if you're unsure whether this is appropriate. If you don't have delegation to decline the claim then transfer it to the appropriate queue to be declined.

PROCESS Decline Claim

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 if requesting missing information on the claim form
- CVR06 questionnaire to determine whether the injury is work-related
- CVR08 questionnaire to determine what activity the client was undertaking when they were injured
- CVR09 for further information on a late lodged claim
- CM04 if you want to advise the client that you were unable to reach the client by phone.

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 you're a Lodgement Administrator and you're sending a letter for a PICBA claim?**

If you're unlikely to receive a response before the cover decision due date, then extend the due date. Go to the Extend Cover Decision Timeframe process below to do this. Include the CVR30 timeframe extension along with the letter requesting the outstanding information to the client.

PROCESS Extend Cover Decision Timeframe

NOTE **What if you're a Lodgement Administrator and you're sending a letter for a specialist claim?**

Contact the specialist team to explain the action you've taken on the claim. Alert them if the cover decision due date is close to being reached so that they can extend the timeframe if necessary. This process ends.

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

NOTE **Do you have to complete the privacy check myself?**

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

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 if request is for missing information on the claim form
- CVR03 if request for missing diagnosis when Z-code has been used on claim form
- MD09A if request for consultation notes (hernias).

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 you're sending a letter for a PICBA claim?**

If you're unlikely to receive a response before the cover decision due date, then extend the due date. Go to Extend Cover Decision Timeframe process.

PROCESS Extend Cover Decision Timeframe

NOTE **What if you're a Lodgement Administrator and you're sending a letter for a specialist claim?**

Check if the cover decision due date is within the next 2 days. If it is then contact the specialist team to explain the action you've taken on the claim and alert them of the pending cover decision due date so that they can extend the timeframe if necessary. This process ends.

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

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

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 you put the task on hold for?**
• if you're waiting for a response to a phone call, text message or email, update the target and hold dates to 2 days from the date of your call
• If you're waiting for a response to a letter, extend the target and hold dates by 14 days
• If the new target date will be beyond the date the cover decision is due, insert the extension paragraph into the letter and amend the target and hold date to the appropriate new target date. The extension paragraph can be found here: W:\Public\RAWC\REG Cover Clarification team\CC Blurbs

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?**
Ensure the claim and task are in the appropriate queue for the held claim to be managed:
• If the claim is PICBA and hasn't been allocated to a cover assessor yet, transfer the claim to the Registration Centre - Low Complex Cover queue (the Confirm Cover Decision task will follow the claim).
• If you're managing the claim, leave the claim and task in your own queue.

Cover criteria for pre-existing conditions Policy v10.0

Summary

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

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

Owner [Out of Scope]

Expert

Policy

1.0 Taking a person as they are

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

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

2.0 Aggravation or acceleration of pre-existing damage

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

3.0 Obtaining medical information

a When obtaining medical information you must:

- establish the cause of injury, to determine whether the injury is the result of an accident
- get a description of any significant pre-existing condition.

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

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

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

4.0 Adjacent Segment Disease

a Adjacent Segment Disease (ASD) is a term describing pathology that has become symptomatic following a spinal fusion. When a person has one or more levels of their spine fused surgically to treat disc pathology caused by a covered back injury, the adjacent disc level above or below the fused segment may be subject to extra load and stress because those levels are now the lowest remaining mobile segments.

b Only spinal fusion surgery has the potential to cause adjacent segment disease. The way in which disc prolapses contribute to ASD is not scientifically well established.

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

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

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

5.0 Examples of pre-existing conditions

a Example 1

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

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

b Example 2

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

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

c Example 3

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

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

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

d Example 4

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

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

e Example 5

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

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

f Example 6

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

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

g Example 7

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

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

Work-related Gradual Process, Disease or Infection Policy v11.0

Summary

Objective
Refer to this guidance to determine ACC cover for injuries caused by a work-related gradual process, disease or infection (WRGPDI).

Background
ACC covers injuries caused by a work-related gradual process, disease or infection (WRGPDI), including:

- asbestos-related diseases
- occupational diseases listed in Schedule 2
- other occupational diseases and infections
- musculoskeletal injuries, such as prepatellar bursitis, carpal tunnel syndrome or tendinitis.

Owner [Out of Scope]

Expert

Policy

1.0 Cover for WRGPDI

a ACC covers injuries caused by a work-related gradual process, disease or infection (WRGPDI), including:

- asbestos-related diseases
- occupational diseases listed in Schedule 2
- other occupational diseases and infections
- musculoskeletal injuries, such as prepatellar bursitis, carpal tunnel syndrome or tendinitis.

b We accept a personal injury that meets all the criteria set out in the AC Act 2001, Section 30 for cover as a work-related injury.

c We treat work-related hearing loss differently at the cover stage. See Criteria for hearing loss claims.

Criteria for Hearing Loss Claims Policy

d There are different criteria for claims lodged between1 July 2010 to 29 October 2022.

2.0 Key cover criteria

a The key criteria for cover for WRGPDI are:

- the person's employment task or environment must have a particular property or characteristic that caused, or contributed to the cause of, the personal injury.

- the particular property or characteristic is present in both the person's employment tasks or environment and non-employment activities or environment, it is more likely that the person's personal injury was caused as a result of the employment tasks or environment rather than the non-employment activities or environment.

- a claim can be declined if it can be shown that the risk of suffering the personal injury is not significantly greater for persons who –
(a) perform the employment task than it is for persons who do not perform it; or
(b) are employed in that type of environment than it is for persons who are not

b We must be able to decide that it's more than likely that the identified property or characteristic caused, or contributed to the cause of, the personal injury.

c If a personal injury has a short duration, ie a few days but never more than four weeks, you must consider whether the claim meets the criteria for personal injury caused by accident.

d We must accurately identify the specific property or characteristic in the client's workplace.

Cover Criteria for Personal Injury

e The property or characteristic does not have to be present through the whole day or the whole of the person's employment.

f We may decline a claim where it's clear that the risk of sustaining this form of personal injury is not significantly greater for people who do this particular type of employment task or work in that environment, than for people who do not.

3.0 Conditions not covered

a Personal injury caused by a WRGPDI does not include:

- non-physical stress
- hearing loss for which compensation has been paid under the Workers' Compensation Act 1956
- conditions caused wholly or substantially by a non-covered gradual process, disease or infection, or ageing.

4.0 Non-work activities

a We will accept a claim for cover if the injury is more likely to be the result of the employment task or environment than the non-work task or environment.

Non-work exposure would only exclude someone for cover if it was enough to actually cause the disease or condition in its own right.

5.0 Pre-existing condition

a We do not cover a pre-existing non-covered condition, or its worsened symptoms, if a person's employment aggravates the symptoms. The person's employment has not created the condition.

We do cover additional physical damage where the person's employment has created the additional damage.

The client may not be eligible for entitlements, or may be eligible for a short time only, depending on the effects of the additional damage for which we have accepted cover.

6.0 Pain

a Pain must be connected to a physical injury. We must investigate a diagnosis of pain in a particular body site to work out whether it's a symptom of a physical injury that meets our cover criteria.

7.0 Date of injury for work-related gradual process, disease or infection

a The date of injury for personal injury caused by a WRGPDI is the earlier of:

- the date the condition was first treated by a medical practitioner or nurse practitioner as an injury for which we provide cover
- the date the injury first results in a person's incapacity

See the Accident Compensation Act 2001, Section 37.

Accident Compensation Act 2001, Section 37
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100954.html

8.0 Criteria from 1 July 2010 to 29 October 2022

a Claims for WRGPDI lodged between 1 July 2010 and 29 October 2022 must be assessed under the relevant legislation, either:

b The amendments made by the Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Act 2022, do not apply to a certain group of claims.
These are claims which have been:
- Lodged before the commencement of Section 9 Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Act 2022; or
- Decided before, and resubmitted on or after the commencement of Section 9 Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Act 2022
For claims that meet either of the two criteria above, Section 30 Accident Compensation Act 2001 would apply as it was immediately before the amended legislation (Section 9 Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Act 2022) commenced on 30 October 2022.

the Accident Compensation Act 2001, Section 30.
http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100926.html

Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Act 2022, Section 9
https://legislation.govt.nz/act/public/2022/0051/latest/LMS564299.html

9.0 Key criteria 1 July 2010 to 29 October 2022

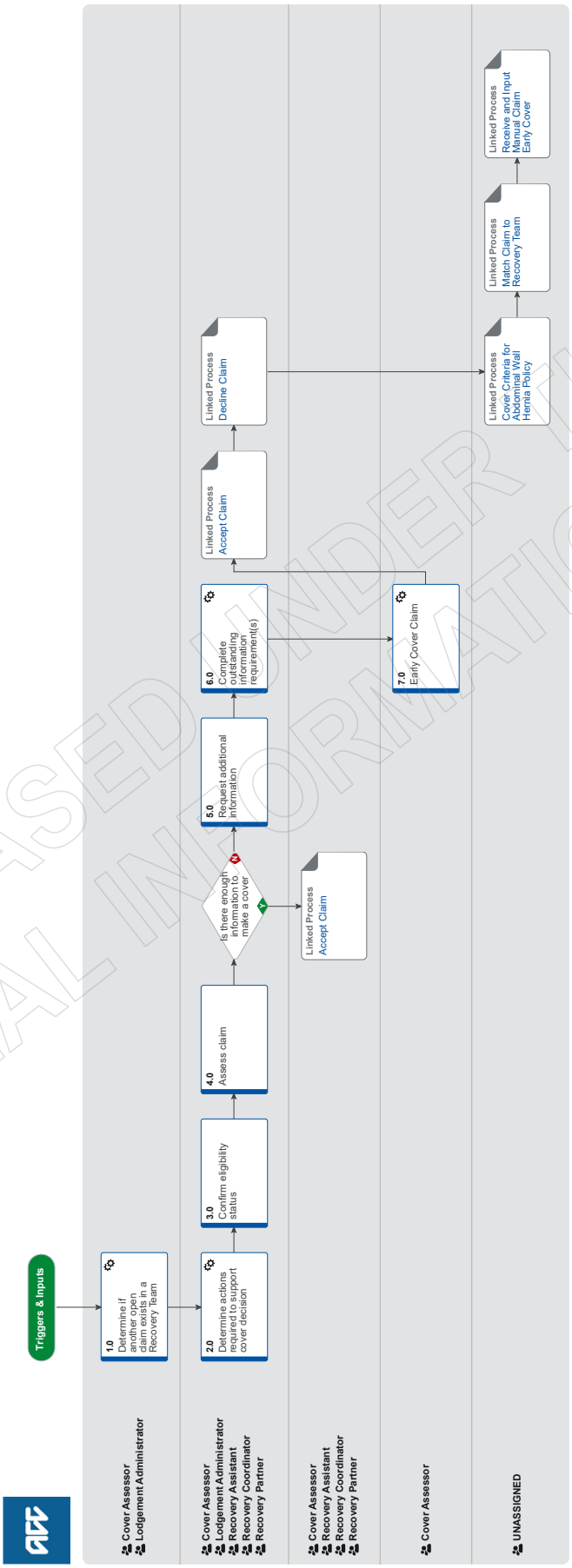
a the person's employment task or environment must have a particular property or characteristic that caused, or contributed to the cause of, the personal injury.
- the property or characteristic is not materially present in the client's non-work activities or environment.
- the risk of sustaining this form of personal injury is significantly greater for people who do this particular type of employment task or work in that environment, than for people who do not.

10.0 Determining a WRGPDI

a Use the Assessing cover for WRGPDI claim process to determine the type of work-related gradual process, disease or infection (WRGPDI) claim.

Assessing cover for WRGPDI claim

Assess Claim for Cover :: Simple PICBA claim v35.0



Assess Claim for Cover :: Simple PICBA claim v35.0

Summary

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

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

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

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

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

Global Process Owner [Out of Scope]

Global Process Expert [Out of Scope]

Variation Expert [Out of Scope]

Procedure

1.0 Determine if another open claim exists in a Recovery Team

Cover Assessor, Lodgement Administrator

a In Eos, check for any open claims.

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

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

PROCESS Match Claim to Recovery Team

NOTE **If there is an active Maternal Birth Injury (MBI) claim, transfer to MBI queue.**

2.0 Determine actions required to support cover decision

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

a Open the [Confirm Cover Decision] task.

Do a task with information requirements

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

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

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

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

Provider Spreadsheet

NOTE **What if the claim is for a hernia?**

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

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

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

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

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

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

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

ACC6261 Cover Assessment – Initial Call Summary - Hernia

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

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

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

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

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

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

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

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

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

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

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

PROCESS Resolve Provider Competency Issue

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

If after or during assessment it is determined that the claim type tick needs to be changed or added - please follow - http://thesauce/team-spaces/eos-online-help/how-to/working-with-claims/claims/add-or-edit-claim-type/index.htm

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

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

NOTE **What is claim is an Early cover Application via Early Cover Inbox**
Go to step 7.0

NOTE **What if claim is a Maternal Birth Injury PICBA claim?**
If this is a Maternal Bith Injury claim, transfer it to MBI queue.

3.0 Confirm eligibility status

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

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

NOTE **What if one or both of these information requirements are outstanding?**
They must be completed before you continue with this process. Go to the Verify Claim Information process below to do this.

PROCESS Verify Claim Information

NOTE **What if you've completed the information requirements and determined that the client is not eligible for cover?**
If the client is not eligible for cover, then you must decline the claim. Go to step 6.0 Complete outstanding information requirements to complete the information requirements and then decline the claim.

4.0 Assess claim

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

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

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

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

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

- TOOL - Add or change diagnosis decision traffic light
- Complex Regional Pain Syndrome (CRPS)
- Guidelines for accepting cover for Concussion

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

NOTE **What if the claim is for a hernia?**
Contact the client and complete the ACC6261 Cover Assessment - Initial Call Summary - Hernia document

PROCESS Cover Criteria for Abdominal Wall Hernia Policy

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

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

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

Is there enough information to make a cover decision?
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

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

NO.... Continue

5.0 Request additional information
Cover Assessor, Lodgement Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

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

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

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

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

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

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

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

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

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

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

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

- Timeframes to determine cover Policy

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

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

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

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

6.0 Complete outstanding information requirement(s)

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

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

Complete information requirement

b Clear Information required Tab in EOS and associated tasks

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

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

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

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

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

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

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

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

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

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

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7.0 Early Cover Claim

Cover Assessor

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

Traumatic Brain Injury Residential Rehabilitation (TBIRR) Service Overview Service Page
https://au.promapp.com/accnz/process/fc562909-fc94-49ae-b98d-0921f978338f

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

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

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

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

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

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

Example:

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

Thanks

Or

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

Thanks

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

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

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

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

ACC7422 Early cover application form

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

NOTE **What if the claim has already been registered?**
File away the early Cover application form & name documents on EOS i.e. CT Scan / Ambulance Reports

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

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

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

NOTE **What if the claim hasn't been registered and no claim form is attached to the request?**
Email the provider back, marked as high priority asking them to provide Relevant Information, ACC45 – as well as CT Scans / ACC18 / Ambulance information / ED notes etc. Note Some staff who complete the Early Cover forms at the hospitals are unable to access full notes so medical notes request will need to be actioned (Assess claim for cover – PICBA – Marked as Urgent)

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

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

Client searches

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

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

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

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

PROCESS **Match Claim to Recovery Team**
UNASSIGNED

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