

18 August 2023

[REDACTED]

Kia ora

Your Official Information Act request, reference: GOV-026841

Thank you for your email of 3 August 2023, asking for the following information under the Official Information Act 1982 (the Act):

Could you please provide me all the current policies, guidelines that relate to Long Term Service Support

Policies for claims requiring long-term support

We have identified the following policies as relating to claims that require long term support. Please find these attached as Appendix 1:

- Identify and Reassess a Client Requiring Long Term Social Rehabilitation Supports
- Assess and Set Up Long-term Residential Support
- Set up Long Term and Extended Nursing Supports
- Send a Permanent Injury Compensation application pack
- Process a Permanent Injury Compensation application

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

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

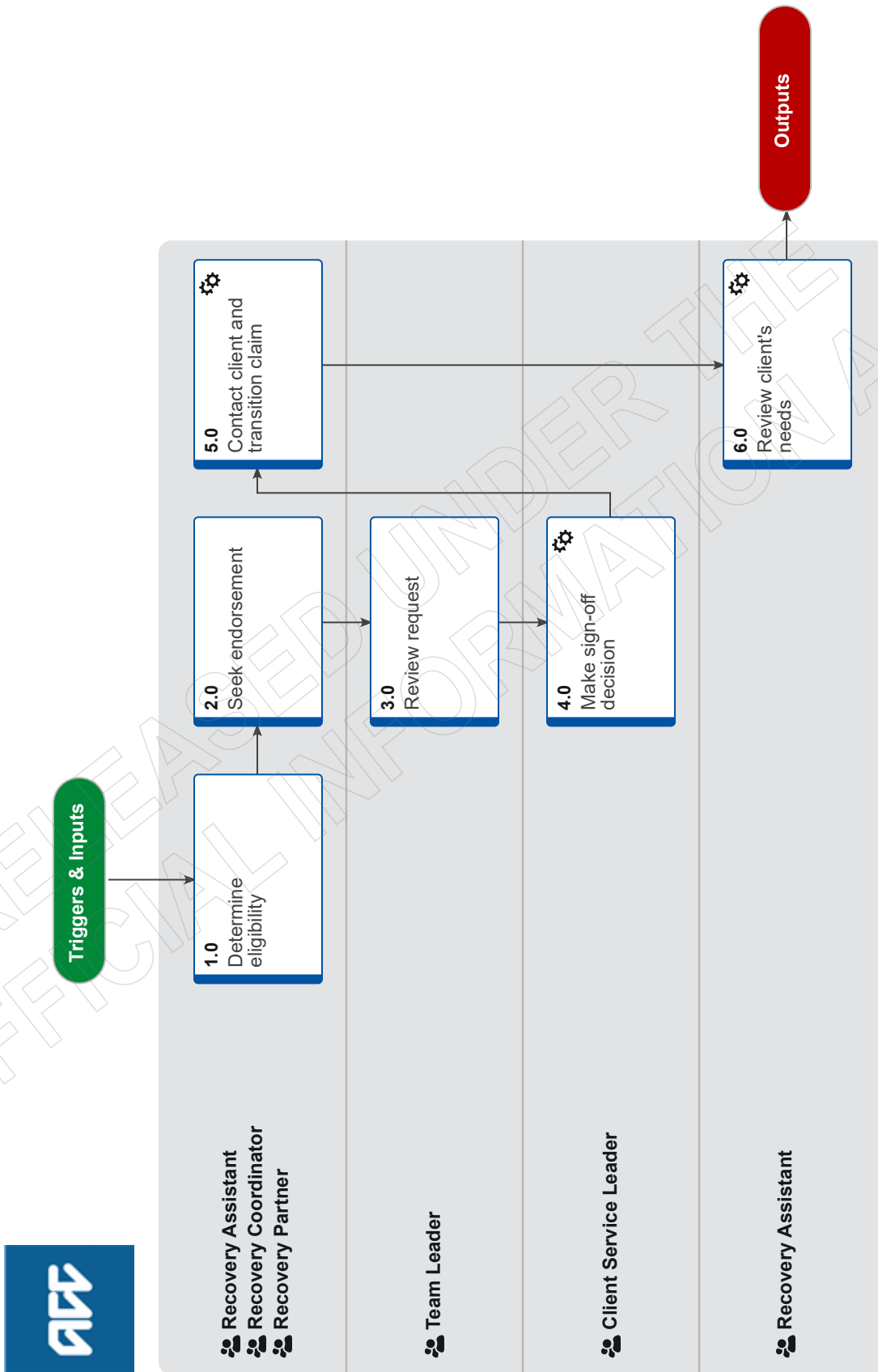
You can email me at GovernmentServices@acc.co.nz.

Ngā mihi



Sara Freitag
Acting Manager Official Information Act Services
Government Engagement

Identify and Reassess a Client Requiring Long Term Social Rehabilitation Supports v2.0



Identify and Reassess a Client Requiring Long Term Social Rehabilitation Supports v2.0



Summary

Objective

To identify a client who has reached a point in their recovery where they have ongoing social rehabilitation support needs and will not achieve full independence or no longer entitled to weekly compensation.

When the criteria is confirmed, the client can then be transitioned to, or stay in the Assisted Recovery Team. This is to ensure that the client will continue to be managed effectively and appropriately.

Background

A client may reach a point in their recovery where they have ongoing social rehabilitation support needs and will not achieve full independence.

To meet the criteria, you need to ensure that:

- the ongoing need for support is due to a covered personal injury
- treating medical opinion (including internal) indicates the client requires ongoing social supports
- all rehabilitation options have been explored.

And one or more of the following apply:

- A medical report or assessment (SRNA or for SI clients an SNA) that indicates a decrease in the client's functionality, recommending supports in place to maintain their condition/level of independence.
- With the assistance of rehabilitation, the client has not been able to achieve their identified goals ie Training for Independence.
- NASC assessment identifies a combination of injury and non-injury issues requiring supports.
- Over 85 years of age (consider the appropriateness of pursuing ongoing social rehabilitation and supports).
- A non-earner or is no longer in receipt of weekly compensation.

If the client is in Supported or Partnered Recovery and is eligible, they can be considered for transition to Assisted Recovery for on-going management.

If the client is in Assisted Recovery, then they can remain here and managed as required.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine eligibility

Recovery Assistant, Recovery Coordinator, Recovery Partner

- Review the claim and any information available to determine if the client meets the eligibility criteria.

NOTE What are the eligibility criteria?

To meet the criteria, you need to ensure that:

- the ongoing need for support is due to a covered personal injury
- treating medical opinion (including internal) indicates the client requires ongoing injury related social rehabilitation supports
- all social rehabilitation options have been explored.

And one or more of the following apply:

- A medical report or assessment (SRNA (Social Rehabilitation Needs Assessment) or for SI clients an SNA (Supports Needs Assessment) that indicates a decrease in the client's functionality, recommending supports in place to maintain their condition/level of independence.
- With the assistance of rehabilitation, the client has not been able to achieve their identified goals ie Training for Independence.
- NASC (Needs Assessment Service Co-ordination) assessment identifies a combination of injury and non-injury issues requiring supports
- Over 85 years of age (consider the appropriateness of pursuing ongoing social rehabilitation and supports).
- A non-earner or is no longer in receipt of weekly compensation.

NOTE What if the client does not meet the eligibility criteria?

Follow the rehabilitation/medical options and recommendations on the claim.

The process ends.

NOTE What if there is a vulnerable indicator on the claim?

Continue with management of the claim. The claim is to remain with the current Recovery Team.

The process ends.

NOTE What if you are unsure and need internal advice to determine if rehabilitation options have been addressed or what you do next?

Go to Seek Internal Guidance process.

The process ends.

PROCESS Seek Internal Guidance

2.0 Seek endorsement

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Create an email, copy and paste the following template and fill out the required information (keep in mind that the client has access to this information).

NOTE Email template:

Client Details

- Client name:
- Claim number:
- Client age:

Cover

- Mechanism of Injury:
- Covered injuries - Confirm cover is correct with no outstanding cover investigations pending:

Criteria met (and reasoning)

-

Supporting information

- Summary of social rehabilitation:
- Summarise any outstanding social rehabilitation/recommendations for social rehabilitation the client has not yet received/completed (SRNA/SNA):
- Summary of any non-injury conditions/considerations (including any natural supports who are assisting):
- Summarise any outstanding treatment/recommendations for treatment the client has not yet received/completed:
- Summarise last Clinical/Technical advice/comment:
- Other:

Recovery Team Member name/date:

Endorsement Team Leader

- Endorse: Yes / No (select)
- Comments:
- Name/Date:

Decision CSL (Client Service Leader)

- Decision:
- Comments:
- Name/Date:

b Email the completed template to your Team Leader.

3.0 Review request

Team Leader

a Review the email including the completed template.

NOTE What if the template is not complete?

Return the email to the Recovery Team Member and discuss your findings.

NOTE What if you are unsure if the template has been completed correctly?

Contact the Practice Mentor hotline.

PROCESS Seek Internal Guidance

NOTE What if you don't endorse the request?

Ensure you add a comment to explain and send back to the Recovery Team Member.

The process ends.

b Send email template with your endorsement to your Client Service Leader.

4.0 Make sign-off decision

Client Service Leader

- a Receive and review the completed email template.
- b Ensure the client meets the eligibility criteria and the client can be transitioned or can remain in Assisted Recovery.

NOTE What if you decide that the client does not meet the eligibility criteria?

Record the outstanding recommendations/options to be considered. Advise the Recovery Team Member of your decision.


The process ends.

- c Record your approval decision in the email template and send to the Recovery Team Member.
- d In Eos, activate the Long Term Service Claim indicator (LTSC) on the General screen.

5.0 Contact client and transition claim


Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive and review the CSL's response and then file it away.
- b Contact the client to discuss the decision.
- c Confirm you are speaking with the right person by asking ACC's identity check questions. If this is not the client, ensure there is a Authority to Act on file.

 Identity Check Policy

NOTE What if the client requests that the Recovery Team Member speaks with another person?

Go to Obtain Authority to Act (ATA).

 **PROCESS** Obtain Authority to Act (ATA)

- d Check the client has provided consent to collect and share information.

 View Client Consent

NOTE What if the client has not provided consent?

Go to Obtain Client Authority to Collect Information.

 **PROCESS** Obtain Client Authority to Collect Information

- e Explain the outcome of the decision and what this means for the client, including the main points.

NOTE What are the main points you need to cover in the conversation?

- How their claim will be managed
- What supports are in place and will continue
- Expectations regarding further reassessments, ie we can or may need to arrange further assessments and seek guidance in the support we're paying for
- Expectations regarding obtaining further medical opinion, if required.

- f In Salesforce, record details of the conversation with the client as a Contact action and update the life areas.
- g Create a Recovery Check-in to check on the clients needs/circumstances and set the date to be in line with the end date of the social supports.
- h Create a reminder task to obtain a Social Rehabilitation Needs Assessment (SRNA) for every two years.
- i Transition the claim to Assisted Recovery.

NOTE What if you are in Assisted Recovery?

Transition the claim to the Assisted Recovery queue.

6.0 Review client's needs

Recovery Assistant

- a Review the claim and any information available to determine if the client needs/circumstances have changed.

NOTE When would this be triggered?



- Recovery Check-in identifies a change in the client's circumstances
- Medical/rehabilitation/exception report identifies a change in the client's needs
- Medical Certificate identifies a request for social supports
- Obtaining an SRNA report every 2 years
- Contact from ATA/family outlining a change in the client's circumstances ie moved into rest home.

NOTE What if there is no change in client need/circumstances?

Continue management on the claim in Assisted Recovery and set next Recovery Check-in to be in line with the end date of the social supports.

This process ends.

b Contact the client or ATA to discuss the change and how this is impacting the client.


-  View Client Consent
-  Identity Check Policy

c In Salesforce, record details of the conversation with the client as a Contact action and update the life areas.

d Refer for a SRNA.

NOTE How do you refer for an SRNA?

Go to the Arrange Social Rehabilitation Assessment process link below.

-  **PROCESS** Arrange Social Rehabilitation Needs Assessment

NOTE What if the client is SI?

Determine the most appropriate assessment, either an SRNA or a Support Needs Assessment (SNA). If you are unsure seek guidance from the Practice Mentor Hotline.

-  **PROCESS** Seek Internal Guidance

e Reset the reminder task to obtain a Social Rehabilitation Needs Assessment (SRNA) every 2 years.

NOTE Why do you arrange a SRNA every 2 years?

It will determine the client's ongoing injury related need, identifying that they require supports long term.


f Consider whether to obtain updated medical notes.

NOTE When is it appropriate to obtain medical notes?

If there has been a significant change in circumstances or there are questions about whether the client's ongoing need is injury related.

NOTE How do you request medical notes?

Refer to Request Clinical Records process.

-  **PROCESS** Request Clinical Records

g Determine if the client should be continued to be managed in Assisted Recovery.

NOTE What if the client's needs/circumstance have changed and Assisted Recovery is not the appropriate Team to continue ongoing management?

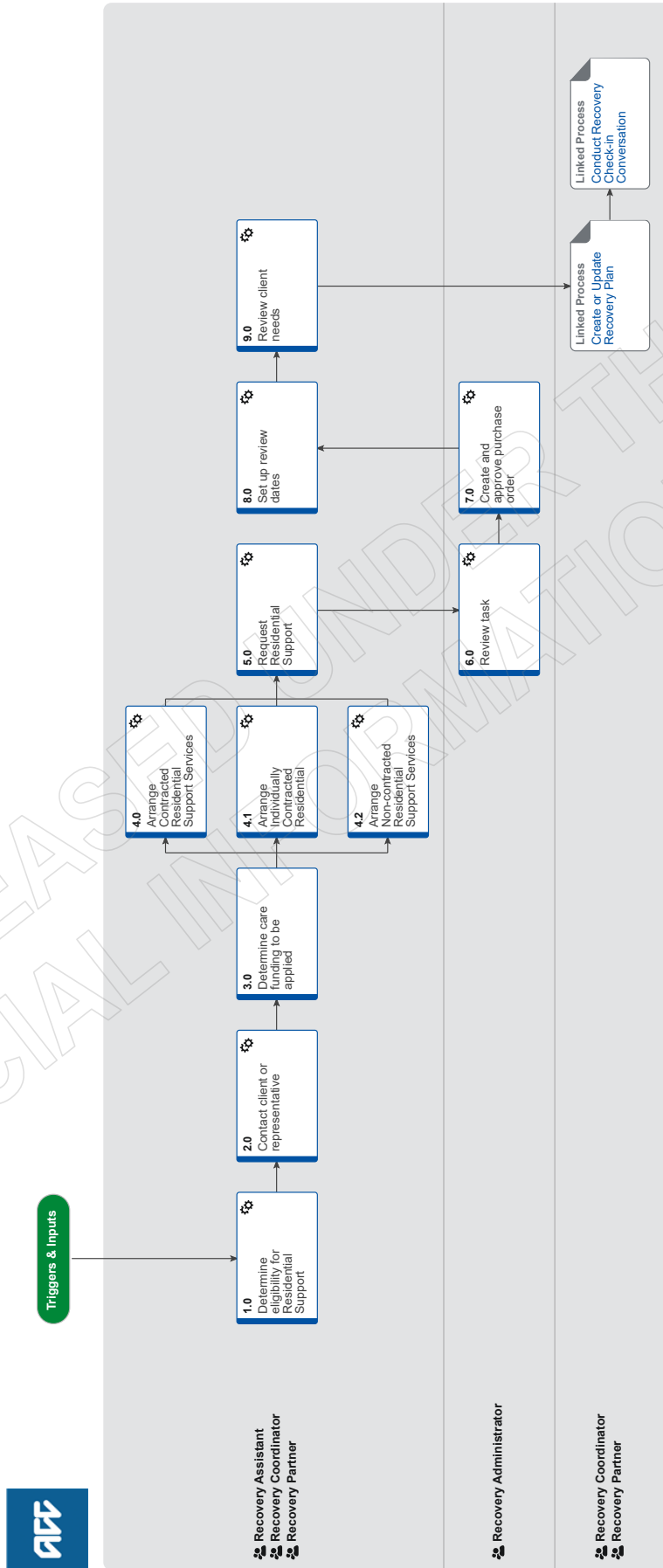
Transition the client to the appropriate Team for ongoing management.

-  **PROCESS** Transition Claim

NOTE What if you are still unsure?

Discuss with your Team Leader and determine the appropriate next step.

h In Salesforce, ensure there is a relevant Recovery Check-in in the Recovery Plan to check on the client's needs/circumstances and set the date to be in line with the end date of the social supports.



Summary

Objective

To assess and arrange longer-term residential support for:

- a client who needs a supportive living environment and/or assistance with self-care tasks and a socially enriching home environment for life
- a client with complex injuries that requires rehabilitation or complex medical management, or
- a client who has emerging vulnerabilities and safety concerns.

Residential Support Services are split into short-term and long-term care.

- Short-term support is expected to last less than six months. Go to Assess and Set Up Short-term Residential Support process.
- Long-term support is expected to be for more than six months.

Background

Residential Support Services are either contracted (RSS), individually contracted (RSS-I) or non-contracted. It is preferred that services are provided by contracted facilities; however, this can be balanced with client choice. The benefit of the contract is that it sets good standards for housing and care, protecting the client.

See AC Act 2001, Section 82: Corporation may provide other social rehabilitation.

Owner [Out of Scope]

Expert

Procedure

1.0 Determine eligibility for Residential Support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- In Salesforce, open Te Kete and review the client's current circumstances.
- Review the request and the supporting information available.

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

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

 Deemed Cover and Entitlements Policy

NOTE What are the different ways you may receive a request?

You may receive any of the following:

- ACC706 Early notification of complex case form
- request from the client or whanau for Residential Support
- Specialized inpatient rehabilitation provider discharge recommendations
- Recommendation in a needs assessment

- Check that the information is complete and comprehensive.


Pre-injury and post-injury functional information should be provided, such as:

- significant mobility changes as a result of the injury.
- significant difficulties with self-cares as a result of the injury.

NOTE What if the information is incomplete?

Request the information required. You may need to request hospital ward notes or an additional assessment, such as a Support Needs Assessment (SNA).

To arrange a Support Needs Assessment for a client, go to Arrange Support Needs Assessment process.

 **PROCESS** Arrange Support Needs Assessment

NOTE What if it's unclear the need for residential support relates to the covered injury or that partial funding may be appropriate?

If information shows significant comorbidities impacting mobility or self-cares, go to Seek Internal Guidance. Use the Recovery Support Decision Tree tool to determine the kind of guidance you need. Once guidance is received, return to this process.

 **PROCESS** Seek Internal Guidance

- Check the information provided to confirm if a residential care facility has been recommended, or confirmed.
- Confirm the client meets the following criteria to be eligible for Residential Support Services:
 - The client must have an accepted claim.
 - The client's needs are directly related to that covered injury.
 - The client is not able to live at home even with community supports.

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


Before you contact the client, whānau or Authority to Act, consider alternative ACC services under the Integrated Home and Community Contracted Services (IHCSS) for the client.

If required, call the client, whānau or ATA to advise they are not eligible for this service and whether there is an alternative being offered. Explain to them their right to review and the options, including:

- seek further assistance eg, Ministry of Health funding via District Health Board or Ministry of Social Development funding
- seek independent advice from citizens advice.

Record the conversation as contact on the claim.

Issue a SPD999 Decline entitlement decision to the client. This process ends.

 **PROCESS** Set Up Integrated Home & Community Support Service - Contracted

 SPD999 Decline entitlement decision - client

 Residential Support Service Page

NOTE What if the client is being partially or dual funded?

Refer to 'Residential Support Service Page'.

 Residential Support Service Page

2.0 Contact client or representative

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Confirm who you need to contact to discuss the Residential Support:

- the client
- alternative contact person, eg whānau, advocate, or legal Authority to Act (ATA).

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

 Identity Check Policy

c Explain the purpose of the Residential Support Service, and confirm they agree to the recommended service.

d Advise on a timeframe for the Residential Support based on the information on file.

If you need further information, contact the provider.

NOTE What do you need to consider when deciding on the timeframe?

Consider:

- expected timeframes for independent mobility
- expected timeframes for the client to be able to manage at home with community services.

If you are unsure about the timeframe, go to Seek Internal Guidance. Use the Recovery Support Decision Tree tool to determine the kind of guidance you need. Once guidance is received, return to this process.

 **PROCESS** Seek Internal Guidance

e Discuss a suitable residential care facility with them.

NOTE What if the DHB has already selected the residential care facility?

Confirm with the client, whānau or the ATA that the facility is suitable, and check if they have any concerns.

f In Salesforce, add a Contact to record the discussion with the client or representative.

3.0 Determine care funding to be applied

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine the care funding options available for Residential Support Services.


NOTE What are the three funding options for Residential Support?

Residential Support Services fit into three different options, depending on the level and duration of care required, and whether the supplier holds an RSS contract:

- Contracted Residential Support Services - A facility holds an RSS contract with ACC. Within Contracted RSS there are two options being Care and Rehabilitation.
- Individually Contracted Residential Support Services - A facility holds an individual RSS contract with ACC for a specific client (generally for clients with complex needs).
- Non-contracted Residential Support Services - A facility does not hold a Residential Support Services contract but can provide care for the client. Generally used for clients in Aged Care facilities.

Refer to the RSS Reference Guide to determine which of the above option to use.

 Residential Support Services (RSS) Reference Guide

 Residential Support Service Page

4.0 Arrange Contracted Residential Support Services

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Using the Contracted Suppliers by Geographic Area of Coverage, locate a residential care facility who holds a Residential Support Services (RSS) contract.

NOTE **How do you find a residential care facility who holds an RSS contract?**

In the Contracted Suppliers by Geographic Area of Coverage, filter by 'Contract' and search for 'Residential Support Services'.

 Contracted Suppliers by Geographic Area of Coverage

NOTE **What if the DHB has chosen the residential care facility and provided details?**

Search the 'Contracted Suppliers by Geographic Area of Coverage' to find out if the facility holds the RSS contract. If they hold a contract, add them as a Participant on the claim.

If they do not hold a RSS contract, refer to the RSS Reference Guide to determine which activity to go to:

- Activity 4.1 Arrange Individually Contracted Residential Support Services.
- Activity 4.2 Arrange Non-contracted Residential Support Services.

 Contracted Suppliers by Geographic Area of Coverage

 Residential Support Services (RSS) Reference Guide


- b** Contact the residential care facility to confirm they are able to provide the supports as identified for the client at the time of their discharge.

NOTE **What should you discuss with the residential facility?**

Discuss and agree on the client's:

- Service needs
- Level of care
- The facility's capacity
- Duration of the clients stay
- If you have identified that the client requires 'Rehabilitation', check the facility is able to provide this service. You can also do this by checking the contract details in MFP.

Refer to the RSS Reference Guide for the Levels of Contracted Residential Support Services.

 Residential Support Services (RSS) Reference Guide

NOTE **What if the facility holds an RSS contract but does not provide for the full care and rehabilitation costs?**

If the residential care facility advises that it cannot provide the required care for the contracted rate and that RSS-I is required, go to Activity 4.1 Arrange Individually Contracted Residential Support Services.


4.1 Arrange Individually Contracted Residential Support Services

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Complete the ACC4237 Contract Request Form (RSS-I) while talking to the residential care facility.

Advise the facility that:

- you will email them the RSSI Costing Template, which accompanies the form.
- they should complete and return the costing template to you within 10 working days to provide a breakdown of the cost.

 ACC4237 Individual Residential Support Services - Contract Request form

 RSSI Costing Template

NOTE **What if the facility prefers to complete the ACC4237 Contract Request Form (RSS-I)?**

Email the form and the costing template to the facility.

- b** In salesforce, create a reminder action to ensure the costing template is returned.

- c** Once the form has been completed and the costing template has been returned, upload the costing template to the claim.


- d** Obtain your team leaders sign off.

- e** Approval from a Technical Specialist may also be required in instances where:

- The daily rate is high
- The need for residential care may not be primarily due to the covered injury
- There is a query about whether an Individual RSS contract is appropriate
- There is a query about whether the Supplier is appropriate
- More input and advice is needed

NOTE **How do you obtain approval from a Technical Specialist?**

Go to the Seek Internal Guidance process, Activity 3.1 Request Written Guidance. If pharmaceuticals are listed on the pricing tool, clinical and technical guidance is required.

 **PROCESS** Seek Internal Guidance

- f** Once approval has been received, email the ACC4237 form to the Procurement Team (Health.Procurement@acc.co.nz). Procurement may contact you to discuss the details of the ACC4237.

- g** On receipt of a signed RSSI contract, save it to Eos. Make sure you select the correct document name heading in Eos: "RSSI - Residential Support Service Individual Contract. Go to Activity 5.0 Request service.

NOTE What if there has been a price increase for the Individually Contracted Residential Services?

Complete steps a. through to g. again

4.2 Arrange Non-contracted Residential Support Services**Recovery Assistant, Recovery Coordinator, Recovery Partner**

- a** Consider whether Non-contracted Residential Support Services is appropriate.

NOTE What are the circumstances where a Non-contracted Residential Support Service might be used?

There are no suitable contracted facilities in the area. For example, where the client is being cared for within an aged care facility and where most other residents are funded by the Ministry of Health. Non-contracted should not be used for long term care. If long term care is required then set up an individual contracted RSS service - see step 4.1

- b** Determine the type of care needed for the client.

NOTE What are the common types of care offered by non-contracted RSS in aged care facilities?

Rest home care – the resident is assessed as generally able to be independent (are mobile and can feed themselves), but needing assistance with personal care or supervision of activities of daily living. They are assessed as unable to safely live in their own homes (or other community settings) either due to their disability needs and/or lack of informal supports.

Hospital level care (also known as Continuing care) – the resident is assessed as having significant disability, usually in combination with medical problems, which requires 24- hour supervision with Registered Nurse input for their care (e.g., medication management, wound care), and assistance with mobility.

Dementia care – the resident is assessed as needing 24- hour supervision, in a secure environment due to risk of wandering or becoming lost due to memory loss or confusion. Dementia residents must be provided care in a facility / annex separate to rest home and continuing care

Psychogeriatric care (also known as specialised hospital care) – the resident is assessed as needing 24-hour supervision. This level of care is for people with major behavioural issues (including severe dementia or addictions). They need a high level of specialist nursing care.

- c** Locate a non-contracted facility.

NOTE How do you find a Non-contracted Residential Support Service in the client's region?

To find a Non-contracted Residential Support Service in the client's region, refer to the national websites below. Aspire Canterbury website has a directory of services, which provides links to other services that may be national.

-  IHC In Your Community
<https://ihc.org.nz/idea-services/residential-services>
-  Aspire Community Support
<https://www.aspire.org.nz/what-we-offer/>
-  Hohepa
<https://www.hohepa.com/>
-  HealthCare New Zealand
https://www.healthcarenz.co.nz/nzcare_disability/
-  Eldernet
<https://www.eldernet.co.nz/Home>
-  Aspire Canterbury
<https://www.aspirecanterbury.org.nz/directory/directory-of-services/>

- d** Use the Non-contracted RSS Pricing Tool to work out a daily rate for the Services. Work through it with the facility to obtain a daily bed rate.

-  Non-Contracted RSS Pricing Tool

NOTE What do you need to discuss with the facility?

There will be a few specific questions to ask as per the tool:


- Where is the facility located?
- What is the type of care to be provided?
- What is their daily bed rate?
- In cases of partial funding, what percentage of the daily bed rate is ACC funding?

- e** Upload the RSS pricing Tool from the vendor to Eos, adjusting the tool in excel to include page breaks and save and upload as a PDF document.

- f** Once the information is entered into the tool, a daily rate will be provided. Confirm this rate with the facility and let them know you will need to obtain approval to proceed.

NOTE How do you obtain approval from a Technical Specialist?

Go to the Seek Internal Guidance process, Activity 3.1 Request Written Guidance.

-  **PROCESS** Seek Internal Guidance

NOTE What if the facility requests a higher daily rate than that given by the tool?

In the request for written guidance from a Technical Specialist, include details of:



- the rate given by the tool, and
- the higher rate the facility has requested and reasons why they have requested a higher rate.

5.0 Request Residential Support**Recovery Assistant, Recovery Coordinator, Recovery Partner**

a In Eos, check the following documents are on the claim (if applicable):

- Support Needs Assessment
- Behavioural Support Services reports
- Training for Independence reports


b Perform privacy checks on documents.

-  Privacy Check Before Disclosing Information Policy
-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if you find information that needs to be redacted?

Send an email to Recovery Administration (recoveryadmin@acc.co.nz) and include the document to be redacted plus your redaction instructions.

c In Eos, create a document group titled 'Residential Support' and add the applicable documents to the group.

-  Manage document groups



d In Eos, at Recovery Plan sub-case level, 'Add Activity' and select 'Choose Activity' and search 'NGCM-Admin Request' task. For further information, refer to Referring Tasks to Recovery Administration – Principles.

-  Referring Tasks to Recovery Administration - Principles

e Provide the following information in the e-form:


- Vendor name
- Vendor code
- Start date of purchase order, service item code and bed night rate
- If extending the purchase order, include the purchase order code
- Expected end date
- Frequency: How many nights
- Name of document group or advise no documents are to be sent
- If it is a shared funding arrangement, specify to cc. in the appropriate contact for the Ministry of Health.
- If your client has a care indicator. Refer to 'Disclosure of care indicator information to third parties' policy for information about when this needs to be shared

For non-contracted, you also need to include in the task 'Unit price per day' as per the written guidance on file from Technical Services.

-  Purchase Order Details - Residential Support
-  Disclosure of Care Indicator Information to Third Parties Policy

NOTE What if the client needs residential support while awaiting housing modifications?

Go to Arrange Ancillary Accommodation Services.

-  **PROCESS** Arrange Ancillary Accommodation Services

f Consider the timing of the task. The tasks route to the Recovery Administration team with a Service Level Agreement (SLA) of 24 hours.

NOTE What if the request is urgent and needs to be completed that day?

Call Recovery Administration, provide the claim number and request the task is completed today.

NOTE What if the request is required in the future?

If the support is required in the future, set a reminder task for the future date when the support will be required.

When the reminder task is due, return to Activity 5.0 Request service.

Review the contract timeframes and SLAs as specified in the service page.


g In the Recovery Plan, update the life area.

Consider the following:

- the current approval period
- next review date to reassess the client's needs (if required)
- the rationale for residential support services
- next steps

NOTE What if you are unsure how to update the Recovery Plan?

Go to Create or Update Recovery Plan.

-  **PROCESS** Create or Update Recovery Plan

6.0 Review task

Recovery Administrator

- a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.
- b Review the task to ensure it has all the information you need to proceed.

NOTE What if you don't have all the information you need to proceed?


Go to the 'Task clarification' section in NG PRINCIPLES Working in the Administration Team for instructions.


 NG PRINCIPLES Working in the Administration Team


7.0 Create and approve purchase order

Recovery Administrator

- a In Eos, generate a purchase order using the entitlement type Residential Support.

 Purchase Order - Handy Hints on how to create and edit POs


 Creating purchase orders using general + QE


 Purchase Order Details - Residential Support


NOTE What if the request is to extend an existing Purchase Order?

- 1) Locate the purchase order and 'Open'.
- 2) Select 'Add', 'Intervention', 'OK'.
- 3) Search for the purchase order code and select 'Add to List', 'OK'.
- 4) Add information as provided in the task and 'OK'.

- b Select the vendor (as identified in the task) from the Contracted Suppliers by Geographic Area of Coverage list. Add the vendor as a 'Vendor - Contracted' participant in Eos.


 Service Contracts and Contracted Providers - MFP spreadsheet

 Contracted Suppliers by Geographic Area of Coverage

 Manage Participants (Eos Online Help)

NOTE What if you are supplied with a non-contracted vendor?

Refer to the 'Search for a Party' system steps.
Add the vendor as a 'Vendor - Non-Contracted' participant in Eos.

 Search for a Party

- c Approve the purchase order.

NOTE What if the purchase order requires a higher delegation to approve?

Save the purchase order and refer to the system steps below.

 Request Authorisation for a Purchase Order - System Steps

- d Advise the residential facility of the purchase order details by email, ensuring you include the following information by screen shot of the purchase order:


Vendor name
Vendor code
Claim number
Claimant name
Purchase order number
From and to dates
Number of Units
Rate per Unit
Frequency: Day/Week


If it is a shared funding arrangement, cc. in other agencies so that they are aware of it.

- e Advise the client of the approval. 'Add document' and generate the GT01a letter to the client. Complete the document and convert it to non-editable PDFs.

 GT01a - Generic Letter price per unit - claimant

- f Perform privacy checks on the documents in the group.

 Privacy Check Before Disclosing Information Policy

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- g In Eos, in the Party Record, check the client's preferred communication channel (SMS, email).

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

- h In Salesforce, close the referral task.

8.0 Set up review dates

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, add a Recovery check-in that is in line with the client's likely recovery timeframe.

Review dates vary based on the complexity of client need.

For example:

- For clients with a complex injury sustained within the past 24 months and who are undergoing rehabilitation, arrange a Recovery check-in in 3 months (from the Residential Support commencement date).
- For clients with a complex injury who are either in long term rehabilitation or a home for life, arrange a Recovery check-in in 12 months (from the Residential Support commencement date).

- b** In Salesforce, create a reminder task for six or 12 months to expect to receive an ACC1156 Rehabilitation Care Plan.


9.0 Review client needs

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the Recovery Plan in Salesforce and information in Eos (ACC1155 Individual Rehabilitation Care Plan and any other recent assessments).

NOTE What if you receive an incident report?

Advise your Recovery Leader and notify the Engagement and Performance Manager.
Refer to Record an injury, incident or potential hazard in HR Self Service (The Sauce).

-  Record an injury, incident or potential hazard in HR Self Service

NOTE What if you receive a request for the client to leave the facility for a period of time?

An absence request (ie service interruption) can occur for the following reasons:

- short stay away from facility (ie need for acute care or to attend family occasions) - for the first 2 days continue paying at the bed day rate, for additional days pay at the bed retention rate (RR950).
- in facility but unable to participate in rehabilitation (eg ill health, disruptive behaviour) - continue paying at the bed day rate.

Create an admin request task to amend the purchase order.

Stop the Purchase Order from Day 3 of client leave from the facility, and add RR950 (bed retention) for the dates of client's leave. Re-start RR code from the date of the client returning from leave. Confirm the dates with Recovery Partner if required.


Note: Before discharging care due to an ongoing service interruption, go to Seek Internal Guidance on the implications of continuing/stopping funding Residential Support.

-  **PROCESS** Seek Internal Guidance

- b** Determine if a formal assessment is required to check if the client's accident-related needs have changed eg, SNA, SRNA, NASC assessment, and Medical Case Review Assessment.

NOTE What if you need to arrange a Support Needs Assessment?

Go to Arrange Support Needs Assessment.


-  **PROCESS** Arrange Support Needs Assessment

NOTE What if you need to arrange a Needs Assessment Services Coordination (NASC) assessment?

Contact the residential care facility and the client's GP.

NOTE What if you need to arrange a Medical Case Review?

Go to Arrange Medical Case Review Assessment.

-  **PROCESS** Arrange Medical Case Review (MCR) Assessment

NOTE What if the client is stable?

Create a reminder task to refer for an Social Rehabilitation Needs Assessment (SRNA) at one to two year intervals.

-  **PROCESS** Arrange Social Rehabilitation Needs Assessment

- c** Determine next steps based on the results of the formal assessment:

- Does the client still need ACC funded residential support?
- Consider if they are ready to transition home with community supports.
- Consider if they require non-ACC supports.
- Consider if they need increased residential supports?
- Consider if they need a further equipment assessment?
- Consider if they need to transition to partial funding.

NOTE What if you need to arrange partial funding?

As part of the review of client's needs, you may work out that the client requires partial funding. For example, move to RSS fund sharing with the Ministry of Health.

As this is an extension of the service with a change, request guidance from a Technical Specialist.

Go to the Seek Internal Guidance process, Activity 3.1 Request Written Guidance.

-  **PROCESS** Seek Internal Guidance

NOTE What if the decision is to cease funding?

- Contact the client and authorised representative to advise the decision.
- Contact the Residential Support facility to advise the decision. Need to be mindful of the Plan and agreed funding dates, where funding may need to continue to agreed Plan date.
- Issue the decision.

d Update the Recovery Plan when there are any funding changes. Update review dates including the ceasing of funding.

 **PROCESS**

Create or Update Recovery Plan

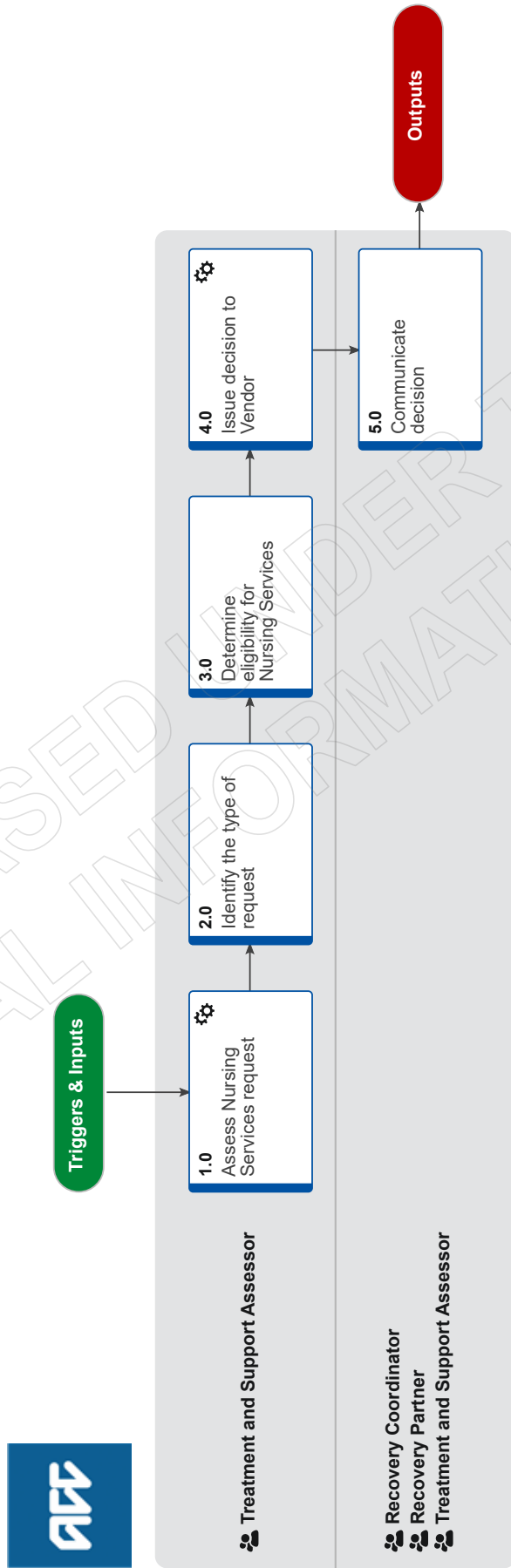
Recovery Coordinator, Recovery Partner

 **PROCESS**

Conduct Recovery Check-in Conversation

Recovery Coordinator, Recovery Partner

RELEASED UNDER THE
OFFICIAL INFORMATION ACT



Summary

Objective

Use this process to set up Long Term and Extended Nursing Services to supports the client's needs.

Background

Long term and Extended Nursing Services is accessed via a ACC179 Nursing services notification referral received from a Nursing Services Supplier. The ACC179 must be accompanied by an initial assessment and treatment plan completed by a Registered Nurse.

Owner

[Out of Scope]

Expert

Procedure

1.0 Assess Nursing Services request

Treatment and Support Assessor

- a** In Eos, open the 'Alert: You have mail' task.

NOTE **What if you are in a Recovery Team and have received an ACC179 to your inbox?**

If you have received it via email forward the email to claimsdocs@acc.co.nz. Delete the email from your inbox. If you have received it via task move the task to Elective SC - TMT Triage. This process ends.

NOTE **What if you need to refer the client for Nursing Services?**

Create a 'Alert: You Have Mail' task, include the Vendor details, reason for nursing services, & commencement date and send the task to Elective SC - TMT Triage.
(If there has been a CNA completed advising nursing is required, please attach to task and mention in task)

IMPORTANT: Please note that a referral and CNA are two different requests.

- b** Open the ACC179 Nursing services notification form in the documents tab on the claim.
c Compare the below information provided on ACC179 to the details on the claim:

- Date of accident
- Date of lodgement
- Mechanism of injury
- Severity of injury
- Injury diagnosis
- Covered injury

NOTE **What if there are discrepancies between the information provided on the ACC179 and the claim?**

Contact the Health Provider and confirm we are treating the correct client and the correct covered injury. Record this as a 'contact' on the claim.

NOTE **What if there is a delay between the date of accident and the date the request is received?**

If it isn't clear on the claim why there is a delay, obtain the rationale from the Health Provider. An example of this would be when a client has initially been treated by a GP, the wound has become more complex and is referred for Nursing Services.

- d** Check the initial assessment and treatment plan completed by the Registered Nurse contains the following information:

- Reason for the referral into the service
- Estimated service level, including planned number and frequency of consultations
- Details of the accident and diagnosis
- Treatments to date
- Comprehensive wound assessment(s), including wound size, description and injury site
- Medications and past history that may be relevant to the covered injury
- Determinants of health that may impact recovery eg socioeconomic situation, environmental impacts, nutritional status, co-morbidities, activities of daily living, cognition and perception

NOTE **What if the plan doesn't contain some of the required information?**

Contact the Health Provider to obtain missing information.

- e** For further information on Nursing Services refer to the linked Service Page.

 [Nursing Services Service Page](#)

2.0 Identify the type of request

Treatment and Support Assessor

- a** Check the type of service being requested.

NOTE What if the request is for Long Term or Extended Nursing Services?

These services require prior approval. If the supplier has already exceeded the maximum number of Medium Term services and continued treating the client, you are not obliged to accept a Long Term request for services. You are still able to decline if the referral does not meet the eligibility criteria. Continue with this process.

NOTE What if the request is for a Transfer of Service?

When a client moves permanently or temporarily (eg holiday) or chooses to change supplier the first supplier will notify ACC and will provide the second supplier with the necessary records.

If the client is being transferred temporarily and only requires Short or Medium nursing services prior approval is not needed, but a new purchase order is required for the second supplier. Record this as a 'contact on the claim' then go to Activity 4.0 Issue decision to vendor

If the client is being transferred permanently and the second provider determines Long Term or Extended services are required you will receive a ACC179 and assessment and treatment plan.

NOTE What if the request is for a Treatment Injury claim?

Due to the nature of these claims, these can be approved retrospectively. Continue with this process.

NOTE What if the request is for a subsequent injury?

If a client has another accident and a new covered injury that also requires Nursing Services this doesn't require approval from ACC. The supplier can use Treatment for Subsequent Injury (NS06) to invoice for treatment of the new injury.

Subsequent injury nursing services should commence once the treatment on the primary injury has been completed. It is the responsibility of the supplier to provide a new ACC179 as notification of a subsequent injury. Ensure this notification is recorded on the claim.

 **PROCESS** Set Up On-going Nursing Support

3.0 Determine eligibility for Nursing Services**Treatment and Support Assessor**

a Determine if the client meets one or more of the following eligibility criteria for nursing services:


- has reduced mobility
- has little or no natural support making it unsafe or impractical for them to attend their General Practice Team
- needs care outside of normal practice hours
- has complex injuries eg ulcers, wound with heavy exudates, large bacterial burden, pressure wounds or skin grafts
- has specialised treatment needs eg stoma care, compression therapy, Negative Pressure Wound Treatment
- has a history of leg ulcers, slow healing wounds, heart disease, diabetes or is immunocompromised, which may adversely impact on their injury related rehabilitation

NOTE What if the referral doesn't meet the eligibility criteria?

Contact the Health Provider to advise the request has been declined. If the client was informed of the referral, request the Health Provider contacts the client to advise the decision. Record this as a 'contact' on the claim. Go to Activity 4.0 Issue decision to vendor.

NOTE What if you are unsure if the referral meets the eligibility criteria?

Refer to the Recovery Support Decision Tree to determine guidance needed. Once guidance has been received return to this process.

 Recovery Support Decision Tree

b Based on the information provided, determine if an Oversight Consultation or Comprehensive Nursing Assessment is required to support your decision to approve or decline the request for services.

Examples of when this may be required are:

- A wound has surpassed the normal recovery timeframes
- A wound is not responding to the current treatment plan put in place by the treating supplier
- It is not clear why the wound is not healing
- Client medications and/or co-morbidities may be delaying healing

If you consider the request to be complex, arrange a Comprehensive Nursing Assessment.


NOTE What if you have determined if an Oversight Consultation is appropriate?

Arrange a face to face consultation to be carried out by the treating supplier's Designated Provider with the treating nurse. The first Oversight Consultation per claim doesn't require approval from ACC.

Subsequent Oversight Consultations on the same claim require prior approval and a Purchase Order number. Suppliers can request this informally by phone or email.


For further information on Oversight Consultations and Designated Providers, refer to the linked Service Pages.

 Nursing Services - Oversight Consultation Service Page
<https://go.promapp.com/accnz/Process/Minimode/Permalink/DCyxFHHmtP3M18Dwso9ZvP>

 Nursing Services – Designated Providers Service Page
<https://go.promapp.com/accnz/Process/Minimode/Permalink/CR9k7ssLyKs16Y9c4ILz7e>

NOTE What if you have determined a Comprehensive Nursing Assessment is required?

Go to the Comprehensive Nursing Assessment (CNA) process. Create a General Task and send it to the appropriate Recovery team to advise of our recommendation, giving a rationale for why.

 **PROCESS** Arrange Comprehensive Nursing Assessment (CNA)

- c** When deciding to approve or decline a request, refer to the 'NG Principles Decision Making' document.

 NG Principles Decision Making

4.0 Issue decision to Vendor

Treatment and Support Assessor

- a** In Eos, create a Purchase Order for the specified nursing services. Select the Treatment pathway and one of the following service codes:

NS01 - Short Term Nursing Package
 NS02 - Medium Term Nursing Package
 NS03 - Long Term Nursing Package
 NS04 - Extended Nursing
 NS05 - Ongoing Nursing
 NS07 - Oversight of Consultation (one-off)

To add the approval letter to the document tab in the claim, select 'Add Doc Type' for the NUR02 Approval for nursing services - Vendor.

 Purchase Order - Handy Hints on how to create and edit POs


NOTE What if the request is declined?

Generate the NUR04 Nursing Services Decline - Vendor letter. Email to the address provided in the ACC179.

NOTE What if the client has to travel to receive their nursing services?


Travel costs are included in the price of the package for Short Term, Medium Term, Long Term and Extended services (NS01, NS02, NS03 and NS04).

For further information refer to the information page below.


 Service Schedule for Nursing Services

NOTE What if the treating provider needs to purchase consumables?

Refer to the Set up Medical Consumables process for guidance on how these can be purchased. A task will need to be sent to the appropriate Recovery team to complete this.

 **PROCESS** Set Up Medical Consumables

- b** Perform the relevant Privacy Checks. Refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks to understand which checks you must perform prior to disclosing information to a 3rd Party.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c** Email the NUR02 Approval for Nursing Services - Vendor letter to the address provided in the ACC179.

5.0 Communicate decision

Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

- a** Check the NG GUIDELINES Client Contact Guidelines to determine who should communicate the decision to the client.

 NG GUIDELINES Client Contact Guidelines

NOTE What if the client is being managed in Assisted Recovery?

Create a 'NGCM - General' task. In the description field advise nursing services have been approved and request the Recovery Plan is updated.

Send a Permanent Injury Compensation application pack v11.0



Triggers & Inputs

- 👤 Cover Assessor
- 👤 Customer Experience Representative
- 👤 Recovery Assistant
- 👤 Recovery Coordinator
- 👤 Recovery Partner

1.0
Generate a request for an application pack

- 👤 Recovery Administrator

2.0
Generate and send application pack

- 👤 Treatment and Support Assessor

Linked Process
[Process a Permanent Injury Compensation application](#)

Send a Permanent Injury Compensation application pack v11.0



Summary

Objective

To send a Permanent Injury Compensation application pack to a client.

Background

When a client wants to apply for a Lump Sum or Independence Allowance entitlement, ACC sends the client a Permanent Injury Compensation application pack. The application pack prompts the client to provide the required information to allow ACC to process their application for a Lump Sum or Independence Allowance.

Owner

[Out of Scope]

Expert

Procedure

1.0 Generate a request for an application pack

Cover Assessor, Customer Experience Representative, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Determine whether or not the request requires escalation. If escalation is not required go to step b.

Identify Claims for Rapidly Deteriorating Clients

NOTE **When does a request require escalation?**

Requests should be escalated when it has been stated or indicated that the client has a terminal or rapidly declining condition.

NOTE **What if the request requires escalation?**

Follow the instructions outlined in the 'Escalate LSIA application for a rapidly deteriorating client' procedure. This procedure ends.

PROCESS Escalate Permanent Injury Compensation application for a rapidly deteriorating client

Rapidly deteriorating terminal conditions

b In Eos generate a 'Send LSIA Application Pack' task at Party level.

NOTE **The task will automatically allocate to the correct work queue.**

Channel Operations Knowledge Base: Permanent Injury Compensation

2.0 Generate and send application pack

Recovery Administrator

a In Eos, generate a 'PIC01 Application for Permanent Injury Compensation' pack.

PIC01 Application for Permanent Injury Compensation

b Send the application pack to the client.

NOTE **What if the client has previously been assessed for the injury(s)?**

A copy of the previous impairment assessment report should be sent with the PIC01 application pack. Procedures for the release of "substantial enclosures" should be followed.

NOTE **What if the client is overseas?**

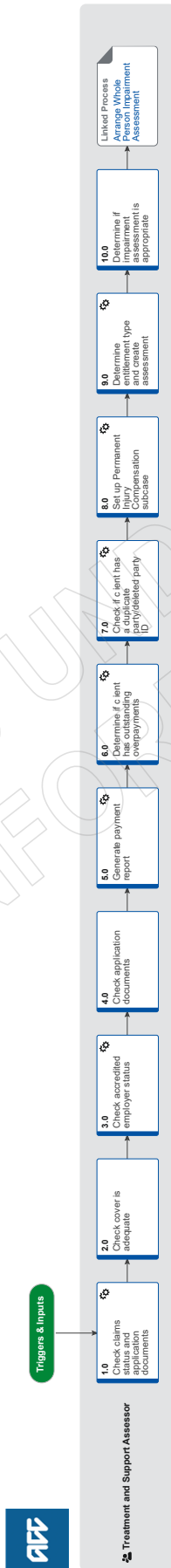
Clients living overseas can apply using the PIC01. However, please note the following:

- ACC is not required to meet any costs incurred overseas, including doctor consultations, or travelling to New Zealand for an assessment (if required)
- The forms must be in English
- They must supply details from the overseas doctor of their registration as a medical practitioner, medical qualifications and contact details
- The assessment will be carried out by an assessor in New Zealand using the medical information provided (however, the assessor may also require the assistance of an overseas doctor)
- In some cases we will require the client to return to New Zealand for an assessment
- PIC is paid in New Zealand dollars



PROCESS

Process a Permanent Injury Compensation application
Treatment and Support Assessor



Summary

Objective

To process a Permanent Injury Compensation application and to determine if a client is eligible for a Whole Person Impairment assessment.

Background

On receipt of a Permanent Injury Compensation application from a client, we must first confirm that the application has been completed correctly, and then determine if the client is eligible for a Whole Person Impairment assessment.

Owner [Out of Scope]

Expert

Procedure

1.0 Check claims status and application documents

Treatment and Support Assessor

- a** Check the ACC554 Medical Certificate and confirm the client's doctor has completed all relevant sections for a first assessment or reassessment.

NOTE **What if the ACC554 Medical Certificate is not completed by a medical practitioner?**

The Accident Compensation Act 2001 defines a medical practitioner as a health practitioner who—

- (a) is, or is deemed to be, registered with the Medical Council of New Zealand as a practitioner of the profession of medicine; and
- (b) holds a current practising certificate

If the person who signed the certificate does not meet these criteria, proceed to 10.0: Determine if impairment assessment is appropriate.

NOTE **What are the relevant sections for a first assessment for an injury?**

All of Section 2

NOTE **What are the relevant sections for a reassessment for an injury?**

Injury and claim details of Section 2

All of Section 3

NOTE **What are the relevant sections if the previous assessment was deferred?**

All of Section 2


As it is not technically a reassessment, Section 3 is not relevant

NOTE **What if the provider or the provider invoicing team require a purchase order for payment for the ACC554?**

Create and authorise a purchase order for the vendor in question from the 'General + QE' tab using the codes ACC554 and COPY.

 ACC554 LSIA Medical certificate

 Create Purchase orders using general + QE

 Add a new entitlement to a claim and add to an existing PO

NOTE **What if the vendor requires more than one hour of ACC554 or 30 pages of COPY?**

Contact the provider for an explanation to confirm the need

If the request seems excessive or unreasonable, consult with a team leader

- b** Check the Remote Claims status of the claim.

NOTE **What if the claim is a Remote Claim?**


Ensure that you are logged into Eos under a Remote Claims user profile before opening or performing any action on the claim.

- c** Check whether the client is in prison by checking the address or imprisonment indicator.

NOTE **What if the client is in prison?**

For lump sums, both the assessment and payment are discretionary with separate consideration for each. Use the decision making principles located under Clients in Prison policy to determine whether or not to proceed.

Assessments for independence allowance assessment are not discretionary, however there are practical considerations around arranging an assessment. There is a possibility of a lower impairment rating if the assessment takes place in prison, particularly for mental injury claims. ACC can suggest to the client that the assessment be deferred until they are released. If a client does decide to proceed with an assessment, Independence Allowance cannot be paid until the client's release from prison.

 **PROCESS** Arrange Whole Person Impairment Assessment

 Clients in Prison Policy

2.0 Check cover is adequate

Treatment and Support Assessor

- a** Check that the injuries which have been applied for on the ACC554 are covered adequately under the claim.


NOTE What if the ACC554 is for an application escalated via the rapidly deteriorating process with held cover?

The application should not be declined. Instead, request a placeholder referral from an impairment assessor in the PIC Assessor List with 'Referral Type' of 'Rapidly Deteriorating'. This can be done via email and ensures that the client remains eligible for an assessment even if they pass away prior to the cover decision.

Until the decision is issued, you will need to manage the application at claim level. This is because a PIC subcase can not be added to a held or declined claim.

If the injury is accepted - proceed to step 3.0.

If the injury is declined - see "What if the ACC554 is for an injury which has been considered for cover, but formally declined by ACC?".

 PIC Assessor List

NOTE What if the ACC554 is for an injury which has not yet been considered for cover by ACC?

An ACC554 medical certificate is not a claim for cover. However, it may be reasonable or necessary to clarify or update cover before an impairment assessment can proceed. If this is the case:

- If the claim is currently managed by a specific Recovery Partner or Recovery Coordinator, create a 'NGCM - Cover Decision Required' task on high priority with today's date, and edit the description to contain details of the additional diagnosis to be investigated and the date and method via which the request was received. Then transfer the task directly to the managing staff member.
- If the claim is currently managed by a Recovery Team, create a 'NGCM - Cover Decision Required' task on high priority with today's date, and edit the description to contain details of the additional diagnosis to be investigated and the date and method via which the request was received. Then transfer the task to the queue for the recovery team managing the claim (i.e. Assisted, Supported, or Partnered Recovery).
- If the claim is currently in an 'Actioned Cases' department, create a 'Follow up Cover' task on high priority with today's date, and edit the description to contain details of the additional diagnosis to be investigated and the date and method via which the request was received. Then transfer the task to the 'Registration Centre - Low Complex Dunedin' queue to be investigated by the Cover Assessment team.

It may also be appropriate depending on the circumstances to ask the client to withdraw their application, or decline the impairment assessment application in the interim until the cover investigation is being completed - use discretion to choose the appropriate pathway:

- If the client agrees to withdraw their application while the cover investigation takes place, you may close the application and send a 'PIC11 Unable to proceed with application - Client' letter
- If the cover assessment is going to take an indefinite amount of time, or it's unlikely the injury in question will attract cover, you may wish to close the application and send the client a 'PIC08 Decline assessment - Client' letter, noting that the client can contact the Permanent Injury Compensation team again if they attract cover in future.

 **PROCESS** Assess Cover for an Additional Injury or Change in Diagnosis

 PIC11 Unable to proceed with application - Client


 PIC08 Decline assessment - Client

NOTE What if the ACC554 is for an injury which has been considered for cover, but formally declined by ACC?

- Decline the application and send the client a 'PIC08 Decline assessment - Client' letter, including a copy of the declined cover decision for the injury in question.


NOTE What if the ACC554 is for an injury for which cover is currently 'deemed' but not formally accepted?

- Injuries with 'deemed' cover cannot be assessed for Permanent Injury Compensation until a formal cover investigation has been completed, and the 'deemed' cover is formally accepted.
- Decline the application and send the client a 'PIC08 Decline assessment - Client' letter, including a copy of the 'deemed' cover decision for the injury in question.

 Deemed Cover and Entitlements Policy

NOTE What if I am processing an application where a client applies for Mental Consequences as an injury?

Refer to the 'Mental Injury Policy'

 **PROCESS** Mental Injury Policy

3.0 Check accredited employer status

Treatment and Support Assessor

- a** In Eos, check the accredited employer status of the claim.

NOTE What if the claim is not an accredited employer claim?

Proceed to step 4.0.

- b** In Eos, confirm the end of the contracted management period.

NOTE What if the contracted management period has not ended?

Proceed to step 3.0d

NOTE What if the contracted management period has ended, and claim management has been transferred to ACC?

Proceed to step 4.0

NOTE What if the contracted period has ended, and claim management has not been transferred to ACC?

Contact InsurerLiaison@acc.co.nz to request that the claim file be returned to ACC.

- c** In Eos, determine if the accredited employer has Full Self Cover (FSC) or a Partnership Discount Plan (PDP) at the date of injury.

NOTE What if the accredited employer has Full Self Cover (FSC)?

The employer is liable for lump sum compensation. As such, the application should be treated as an accredited employer claim.

NOTE What if the accredited employer has a Partnership Discount Plan (PDP)

The employer is not liable for lump sum compensation. As such, the application should not be treated as an accredited employer claim.

- d** Generate and send the accredited employer a 'PIC04 Info request - Third Party' letter along with an 'ACC557 Accredited Employer's accident details for lump sum application' to complete.


 PIC04 Info request - Third Party

 ACC557 Accredited Employers Accident Details for Lump Sum Application

NOTE What if the provider or the provider invoicing team require a purchase order for payment for the ACC554?

Create and authorise a purchase order for the vendor in question from the 'General + QE' tab using the codes ACC554 and COPY.

 Create Purchase orders using general + QE

 Add a new entitlement to a claim and add to an existing PO

4.0 Check application documents**Treatment and Support Assessor**

- a** Check that all of the required application documents have been returned fully completed.

NOTE What documents are required from the client?

- A completed 'ACC554 LSIA Medical certificate'. A medical practitioner must have signed and dated this document and stamped it to identify their practice.

- A completed 'ACC6300 Authority to collect medical and other records'. This must be signed and dated by the client.

 Definition of "Medical Practitioner"

<https://anzlaw.thomsonreuters.com/Document/I48e0f83283c111e8aca5bab3c9b3f468/View/FullText.html?originationConte>

NOTE If applicable, what documents are also required from an accredited employer?

- A completed ACC557 Accredited Employers accident details for lump sum application'.
- Any corresponding medical information from the employer claim file.

NOTE What if the client has a rapidly deteriorating condition?

The assessment process can commence without the need for a 'ACC554 LSIA Medical certificate'. Refer to Clients with rapidly deteriorating conditions Policy for more information.

 Clients with rapidly deteriorating conditions Policy


NOTE What if the required application documents are missing or incomplete?

If the client has a rapidly deteriorating condition the ACC554 is not required (see What if the client has a rapidly deteriorating condition?).

Depending on what information is missing, determine whether to contact the client, the GP, or if applicable, the accredited employer, and send them the appropriate letter (either a 'PIC03 Info request - Client', or a PIC04 Info request - Third Party') to obtain the necessary information.

In the first instance, the information request should be send to the client, the GP, or if applicable, the accredited employer's verified email address. Should there not be a verified email address, the request should be sent via NZ Post.


 PIC03 Info request - Client

 PIC04 Info request - Third Party

5.0 Generate payment report


Treatment and Support Assessor












- a** In Eos, locate the client's Party ID.
- b** In InFact, generate a '4.09 Lump Sums and Independence Allowance Payment Report' which will show the clients compensation history for Lump Sum / Independence Allowance entitlements. Save the document to a secure location as you will need to upload this to Eos later.

 InFact
http://in-fact/

NOTE What if the 4.09 Lump Sums and Independence Allowance Payment Report shows that the client has received Independence Allowance - Functional Limitations Profile payments in the past which were stopped, and they are not receiving any Independence Allowance payments currently?

Refer to the Make Functional Limitations Profile Independence Allowance Payments procedure.

 **PROCESS** Make Functional Limitations Profile Independence Allowance Payments

-  Lump sum eligibility requirements
-  Determining the whole person impairment rating by taking into account a previous rating
-  Minimum WPI rating threshold
-  Lump sum election requirements
-  Independence allowance election requirements
-  Definition of combined impairment rating
-  Deceased client eligibility for independence allowance
-  Deceased client eligibility for lump sum
-  Single independence allowance eligibility requirement
-  Combined independence allowance requirement if the client was not paid a s78 lump sum entitlement in the past
-  Combined independence allowance requirement if the client was paid a s78 lump sum entitlement in the past


6.0 Determine if client has outstanding overpayments

Treatment and Support Assessor

- a** Check the clients overpayment summary for outstanding overpayments.

NOTE What if the client has outstanding overpayments?

Contact Payments (for Eos debt) or Collections and Recoveries (for Oracle debt) and confirm whether the overpayment should be recovered if the client is eligible for PIC.

 View overpayment information

7.0 Check if client has a duplicate party/deleted party ID

Treatment and Support Assessor

- a** In Eos, complete Party Searches as follows:
- Initials of the clients first and last name with date of birth
 - Initials of alternate names indicated in forms and medical records with date of birth
 - NHI number
 - IRD number
 - Consider reasonable alternative names e.g. nicknames and English/non-English versions

NOTE What if there is a duplicate ID?

Create an Action Client Duplicate task and complete the requested fields, this will route to the correct queue automatically

NOTE What if there is a deleted party ID which still has claims/documents?

Create an Action Client Duplicate task and complete the relevant fields, this will route to the correct queue automatically.

8.0 Set up Permanent Injury Compensation subcase

Treatment and Support Assessor

- a** In Eos, determine the appropriate ACC45 that the claim should be managed from. This claim will be used to administer all Lump Sum / Independence Allowance activities, including the subcase.

NOTE What if there is a sensitive claims component to the assessment?

Manage the request on the sensitive claim, or where multiple sensitive claims exist, the 'master' claim, i.e. the oldest claim or claim where assessment previously applied.

NOTE What if client has been assessed for this entitlement previously?

- If new request is lump sum then work on the same claim as previous. If the previous lump sum payment was paid through Pathway you will need to capture the assessment details on the PIC subcase prior to the reassessment. See the 'Migrate Lump Sum details paid through Pathway' system steps linked below.
- If new request is for combined Independence Allowance then work from the same claim as previous.
- If new request is for a single Independence Allowance then work from the claim the ACC554 is for, i.e. the previously assessed claim if this is to be assessed this time.

Previously-assessed injuries must be included in a reassessment of the entitlement.

 Migrate Lump Sum details paid through Pathway


NOTE What if the client has not been assessed for this entitlement previously?

If the request is for one physical claim always manage on the applicable claim.

If the request is for multiple claims choose a claim that:

- relates to the highest impairment, or
- is currently managed, or
- has had surgery, or
- is the oldest claim listed.

b Set up the Permanent Injury Compensation subcase on the appropriate claim.

 Add or edit a rehabilitation action

NOTE What if multiple claims need to be included in the assessment?

- Link the additional claims to the subcase


 Linking a Claim to PIC Subcase

NOTE What if the automatic injury description from the injury code is not accurate?

- Edit the Injury Details with the correct description

 Update Injury Details on a PIC Subcase

c In the Permanent Injury Compensation subcase, start the 'Pre-Assessment' task.**d** Upload the '4.09 Lump Sums and Independence Allowance Payment Report' you previously generated to the Permanent Injury Compensation subcase using the 'Lump Sums and Independence Allowance Payment 4.09 Report' document type and add 'LS/IA Payment Report' in the text box.

 Upload an Electronic Document in Eos

9.0 Determine entitlement type and create assessment instance**Treatment and Support Assessor****a** In Eos, complete the 'Determine Entitlement Type' E-form. When saved, Eos will generate an Impairment Assessment instance in Eos for the relevant entitlement type.

 Update Permanent Injury Compensation Entitlement Details

NOTE What if an assessment has already been completed and a reassessment is required?

You can create a reassessment instance in Eos by using the 'copy' function on the previous assessment instance. Refer to the 'Use copy function to create reassessment' system step.

 Use copy function to create reassessment

10.0 Determine if impairment assessment is appropriate**Treatment and Support Assessor****a** Review the application and determine if it meets the criteria for a Whole Person Impairment assessment or reassessment based on what kind of payment is being claimed.

 Identify Claims for Rapidly Deteriorating Clients

NOTE What is the criteria for a Lump Sum?


Assessment:

- the injury has cover
- the impairment is certified as permanent
- the injury is certified as stable or 24 months have passed since the date of injury

Reassessment:

- the medical practitioner has certified that there is an increase in impairment since the previous assessment
- if the client has had a reassessment previously, at least 12 months has passed since the last reassessment

 Lump sum eligibility criteria Policy

 AC Act 2001, Schedule 1, Part 3, Clause 61

<https://anzlaw.thomsonreuters.com/Document/lee0acc6a6e0f11e8b22785ae5ff38a3b/View/FullText.html?originationContext>


NOTE What is the criteria for Independence Allowance?


Assessment:

- the injury has cover
- the medical practitioner has certified that there is impairment
- the injury is certified as stable or 12 months have passed since the date of injury

Reassessment:

- the medical practitioner has certified that there is either an increase or decrease in impairment since the previous assessment
- If the client has had a reassessment previously, at least 12 months has passed since the last reassessment

 Independence allowance eligibility criteria Policy

 AI Act 1998, Schedule 1, Part 4, Clause 61


<https://anzlaw.thomsonreuters.com/Document/I8b624b78022911e99495db3043f758b0/View/FullText.html?originationCont>


NOTE What if additional medical / psychology notes or assessment are required before a decision can be made?


Determine what information you require, and from who, then follow the relevant process.

Use the PIC04 Info request - Third Party' letter instead of the MD01 and MD02 letters.


Generate and send a 'PIC03 info request - Client' letter to notify the client of the delay.

 **PROCESS** Request Clinical Records

 Create a purchase order


 PIC03 Info request - Client

 PIC04 Info request - Third Party

 ACC2386 DHB request for copy of notes - Vendor

NOTE What if the client is not eligible for a Whole Person Impairment assessment?


- Contact the client and explain the decision.
- Send the client a 'PIC08 Decline assessment - Client' letter.
- If applicable, send the accredited employer a 'PIC09 Decline assessment - Accredited Employer' letter.
- you must update the 'Description' on the 'Overview' tab to "Not eligible - (and the reason)"
- update the impairment assessment status to 'Declined' . Refer to the system step 'Decline Whole Person Impairment Assessment'.
- determine claim ownership.
- close the task
- this process ends


 PIC08 Decline assessment - Client

 PIC09 Decline assessment - Accredited Employer

 Decline Whole Person Impairment Assessment


 Minimum information required for a first impairment assessment for independence allowance

 Minimum information required for an impairment reassessment for lump sum


 Minimum information required for an impairment reassessment for independence allowance


NOTE What if the client is eligible for an impairment assessment?


Proceed to 'Arrange Whole Person Impairment Assessment'

 First assessment for a lump sum entitlement


 Client reassessment request for a lump sum entitlement

 Client reassessment request for an independence allowance entitlement

 ACC reassessment request for an independence allowance entitlement

 Information needed to confirm medical certification of a permanent impairment for a lump sum entitlement

 Required method for supplying medical information for an impairment assessment

 Extended discretion request

b In the Permanent Injury Compensation subcase close the 'Pre-Assessment' task.

 **PROCESS** **Arrange Whole Person Impairment Assessment**
Treatment and Support Assessor