

9 October 2023

Kia ora [REDACTED]

Your Official Information Act request, reference: GOV-027824

Thank you for your email of 16 September 2023 to [REDACTED], Recovery Coordinator, asking for copies of numerous documents (policies and processes) under the Official Information Act 1982 (the Act).

Due to the nature of your request, it was transferred to my team for response.

The requested information is attached

We have identified 145 documents within scope of your request. Those documents are listed in the appendix. As staff names were not requested, they have been deemed outside the scope of your request and removed. Please note that the process (*NGCM*) *Maintain Vocational Support* (page 450) is no longer used by ACC. Further, considerable effort has been made to provide every document requested. However, if you identify anything that has been missed, please let us know.

We have withheld some phone numbers

This decision has been made under section 9(2)(a) of the Act. In doing so, we have considered the public interest in making the information available and have determined that it does not outweigh the need to protect our staff members' privacy.

If you are not happy with this response

you can contact the Ombudsman via info@ombudsman.parliament.nz or by phoning 0800 802 602. Information about how to make a complaint is available at www.ombudsman.parliament.nz.

Ngā mihi



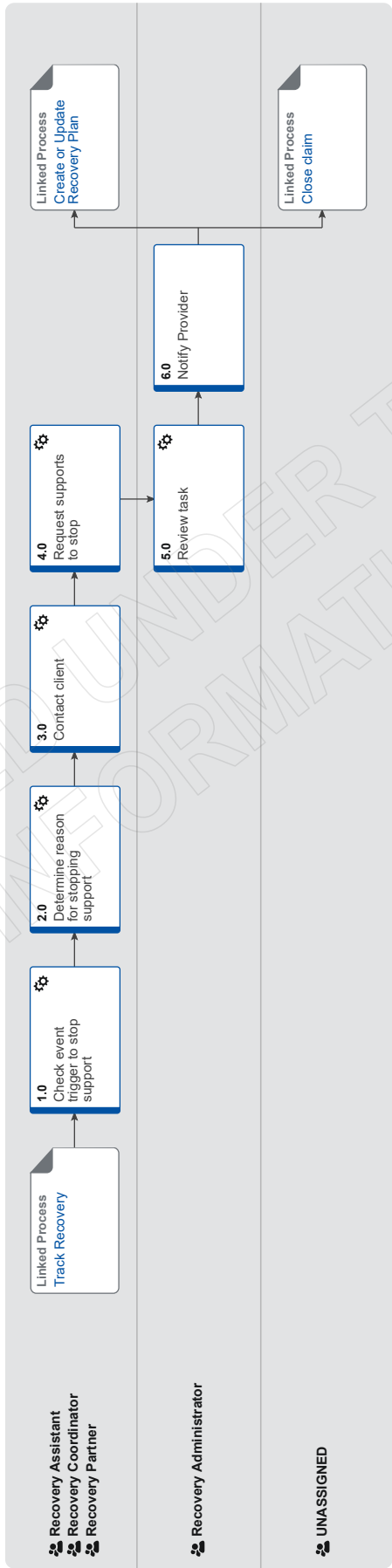
Sara Freitag
Acting Manager Official Information Act Services
Government Engagement

Appendix: documents provided with this letter

- (NGCM) Stop Supports
- Service delivery expectations Policy
- Arrange Section 103 Assessment
- When to Review Cover and Entitlements Policy
- Vocational Independence Assessments (VIOA/VIMA) [Policy]
- Vocational Independence Deterioration and Surgery Policy
- Provide Internal Guidance - Hotline
- Vocational Independence Medical Assessment (VIMA) Service Page
- Vocational Independence Assessments (VIOA/VIMA) [Policy]
- Vocational Independence Occupational Assessment (VIOA) Service Page
- Vocational Independence Assessments (VIOA/VIMA) [Policy]
- Vocational Medical Assistance (VMA) Service Page
- Vocational Medical Services Overview (VMS) Service Page
- Vocational Rehabilitation Equipment Service Page
- Vocational Rehabilitation Needs Assessment (IOA/IMA) Policy
- Vocational Rehabilitation Review (VRR) Service Page
- Vocational Rehabilitation Services Overview (VOC) Service Page
- Requests for client information policy
- Requests for client emails
- Requests for call recordings Policy
- Responding to a witness summons Policy
- Review Annual Practising Certificate (APC) Status
- Respond to Clarification Request from Advisor (Recovery Team Member) – System Steps
- PSD - Audit clinical records
- P & I - Manage missing clinical records
- P&I - Manage quality of clinical records
- P&I - Request clinical advice
- Consequential Injury Claims Policy
- Maintain Weekly Compensation
- Individual Rehabilitation Plans Policy
- Make Functional Limitations Profile Independence Allowance Payments
- Provider case conferences Policy
- Create Request for Written Guidance – System Steps
- Provide Internal Guidance - Hotline
- Mental injury Because of a Physical Injury Policy
- Move documents
- Arrange Education Based Rehabilitation Assessment
- Arrange Functional Capacity Evaluation
- Arrange Medical Case Review (MCR) Assessment
- Arrange Medical Single Discipline Assessment
- Extend Non-Acute Rehabilitation (NAR) Service
- Arrange Vocational Independence Occupational Assessment (VIOA)
- Arrange Vocational Independence Medical Assessment (VIMA)
- Arrange Vocational Medical Assistance
- Arrange Vocational Rehabilitation Review Assessment
- Assess and Fund Counselling Treatment
- Assess Cover for an Additional Injury or Change in Diagnosis
- Complete Client Information Requests
- Conduct Welcome Conversation
- Conduct Recovery Check-in Conversation
- Create or Update Recovery Plan
- Handle Client Enquiry
- Manage Non-Compliance
- Re-open claim
- Refer for an Injury Profile
- Respond to a Government Agency Information Request
- Set Up Back To Work Support
- Set Up Education Support
- Set Up Job Search Support
- Set Up Pain Management Service Support
- About Vocational Rehabilitation (VR) Policy
- Recovery Plan Check
- Education Based Rehabilitation Assessment Service Page
- Percentage Increases Policy
- Recovery Plan Policy
- Calculate Weekly Compensation

- Reimburse Client Rehabilitation Costs Policy
- Recalculate Weekly Compensation
- Recalculate Weekly Compensation - Section 60
- Recalculate Weekly Compensation Claims paid from Pathway
- Reinstate Weekly Compensation
- Request Set Up of Weekly Compensation Payments
- Set Up Backdated Weekly Compensation
- Set Up Weekly Compensation - Loss Of Potential Earnings (LOPE)
- Set Up Weekly Compensation - PAYE
- Add an Eform
- Transfer Weekly Compensation Costs between Claims
- Transition Claim
- Transfer a Claim
- Determine Transfer of Weekly Compensation to a new claim due to Further Injury
- Weekly Compensation and New Zealand Superannuation (post-1 July 2019) Policy
- Weekly Compensation and New Zealand Superannuation (pre-1 July 2019)
- Weekly Compensation Indexation (Accident Compensation Act 2001)
- Weekly Compensation Indexation Rates
- Weekly Earnings Calculations for Permanent Employee
- Approve ERA Weekly Compensation Payment
- Approve Weekly Compensation Entitlement
- Recalculate Weekly Compensation Claims paid from Pathway
- Civil Damages for Mental Injury
- Deduction Types - Hierarchy List and Legislation Policy
- Deductions from Weekly Compensation Payments
- Decline Entitlement when Client is Non-compliant Policy
- Eligibility Criteria for Weekly Compensation Policy
- Eligibility criteria
- Prepare and Lead an Internal Resolution Consultation (IRC)
- Notification of decisions based on legal opinion Policy
- Eligibility for Weekly Compensation while Client is Overseas Policy
- Establish a Payment of Backdated Weekly Compensation for 90 Days or More
- Interest on Backdated Weekly Compensation Policy
- Make a Vocational Independence Deterioration Decision - Non Surgery
- Complex Regional Pain Syndrome (CRPS) - Factors to consider when assessing cover
- Net Loss of Earnings Reimbursement - ACC Approved Appointments
- Neuropsychological Assessment Referrals Service Page
- Official Information Requests Policy
- Overview of the Pain Management Service
- Pain Assessment for Independence Allowance and Lump Sum Policy
- Payment error correction Policy
- Planning Vocational Rehabilitation (VR) post IOA/IMA Policy
- Prepare and Attend Review Hearing (RH)
- Process a Permanent Injury Compensation application
- Issue Recovery Decision
- Reasons to Revoke Cover
- Clients with Tinnitus &/or Hyperacusis Service Page
- Seek Internal Guidance (Claims Assessment)
- Privacy Reporting Took - Reporting an Incident
- Transitional Provisions and Combining Whole Person Impairment to Determine Independence Allowance Policy
- Assess Claim for Cover (Treatment Injury)
- Business Rule: What a written communication to a client is to specify
- What to include in emails to clients, providers and employers Policy
- When to change diagnosis codes Policy
- When to Refer to the Technical Accounting Specialists (TAS) for Advice
- When to withhold personal information Policy

- Who Processes Client Reimbursements Policy
- Seek External Clinical Advice
- Business Rule: Written communication of decision
- Allocate Claim
- Allocate Task
- Setup Overseas Claim
- Stop Supports
- Track Recovery
- Transfer a Claim from a BAU Actioned Cases Department
- AEP Annual Claims Handback
- Transition Claim to Te Ara Tika
- Transition client into Remote Claims Unit (RCU)
- Transition client out of Remote Claims Unit (RCU)
- PSD - Audit clinical records
- (OP&I) Identify and Record a Provider / Supplier Issue
- About Vocational Independence
- About Vocational Rehabilitation (VR) Policy
- Adverse events and their impacts Policy
- Advocate Communications Policy
- Eligibility for serious injury Policy
- Maintain Vocational Support Policy
- Recovery Support to determine need for a medical case review
- Assess and Fund Treatment



Summary

Objective

To stop a support.

Background

A support can be stopped for a variety of reasons, eg if the client recovers more quickly or slowly than expected or because an event has occurred that means the client is no longer eligible.

Owner

[Out of Scope]

Expert

Procedure



PROCESS

Track Recovery

Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Check event trigger to stop support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the notification via MyACC, phone, email or in person, to stop a support.

NOTE What if you have received a AUTO Alert: Weekly Comp Ceases 8 Weeks task?

Generate a "Stop Payment task", copy and paste the details from the original task to this task. This will auto-route to the Centralised Weekly Compensation queue for the payments team to action. The payments team will continue with the process below. Close the AUTO Alert: Weekly Comp Ceases 8 Weeks task. This process ends.

NOTE What if the task is about a sensitive claim?

If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims queue.

NOTE What triggers can generate a notification to stop a support?

The following can act as triggers to stop a support:

- Non-compliance
- Suspending entitlements
- Stopping payments
- Confirming WSI (wilful self-inflicted injury) or suicide
- Disentitling due to crime
- When the client voluntarily withdrawals
- When the client has recovered more quickly than expected and has gone back to work prior to the expiry of their medical certificate.

NOTE What do you do if you are revoking cover?

Refer to the link below for what to do if you are revoking cover.

 **PROCESS** Revoking Cover

NOTE What do you do if your client is going to return to work?

Refer to the process linked below for what to do if your client is going to return to work

 **PROCESS** Close claim

NOTE What entities or parties can provide a notification?

Notifications from the following can trigger or generate a need to stop a support (these can be grouped as Client, Providers, Internal/External sources, Medical Reports):

- specialist
- GP and or other treatment providers
- other allied services such as data integrity information (i.e. when a client is in prison)
- receipt of a medical certificate or medical information such as medical reports
- other events such as non-compliance
- Vocational Independence (VI)/Medical Case Review (MCR)/Medical Single Discipline Assessment (MSDA) outcome
- information about their earner status (eg self-employed, earner or non-earner)

2.0 Determine reason for stopping support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Refer to the notes below to determine the reason for stopping the support.

NOTE What are the main mechanisms by which supports can be stopped?

There are two ways to stop support:

1) Suspension

We can suspend a support if there is evidence that, although the client might continue to need assistance, they are no longer eligible to receive it from ACC. This means that the client's symptoms or limitations relate wholly or substantially to something for which ACC is unable to grant cover, such as

- gradual process injury disease or infection, that does not have cover itself
- the ageing process
- the client no longer meets the relevant eligibility criteria for a support they are receiving.

2) Disentitlement

the client is remanded in custody or is serving a term of imprisonment

- the client was injured while committing a crime
- the client was receiving an entitlement while serving a term of imprisonment.

NOTE In what other circumstances would we suspend a support?

- the client has an overseas medical certificate that we do not recognise.
- supports can be suspended if the claim was accepted under 1972 or 1982 Act, however the criteria is different, refer to the 'Suspend entitlement when client is no longer eligible' policy below.



Suspend Support When Client is No Longer Eligible Policy

NOTE In what other circumstances would we disentitle a client?

Supports may cease because:

- the client was injured whilst committing a crime
- the client is in jail
- cover is no longer required
- supports have been suspended
- payments are being returned by the bank
- the client's mail is being returned
- the client cannot be contacted.

For further information, refer to the 'Disentitling Certain Crimes or Imprisonment' link below.

(Note: This is a BAU process which is currently being updated, contact a practice mentor when using this process).

 [Disentitling Certain Crimes or Imprisonment](#)

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NOTE What if you think an entitlement or support should be stopped?

What if you think weekly compensation should be stopped?

If you are suspending weekly compensation where the client has been paid for 6 months or less:

You will require clinical guidance however not technical guidance. The final decision on suspending weekly compensation will be based on the clinical guidance in consultation with your Team Leader.

The recovery team member will create a NGCM General Task and assign it to a Team Leader for their endorsement. Record the following in the description field:

Decision type [SUSPEND] DECISION

- Provide in detail what information you are basing your decision on (eg "report shows that the injury has resolved, the ongoing incapacity is due to other non injury related issues").
- What documents/information you have based this decision on.
- The final decision. ("I consider we should suspend weekly compensation as the covered injury is no longer causing incapacity")
- Who was consulted (eg "Recovery Support").

If you are suspending weekly compensation where the client has been paid for 6 months or more:

You will need to request written guidance. Refer to the Seek Internal Guidance process below to confirm when technical services comment is required. You will also require technical guidance in the following scenarios:

- When issuing a decision to suspend weekly compensation due to the client no longer being entitled to support where they have been in receipt of this support for longer than 6 months.
- Non compliance.
- When entering into the vocational independence assessment process via the ACC191.
- Completing the final sign off of vocational independence via the ACC198.

For more information regarding seeking Internal Guidance, please refer to the Seek Internal Guidance process below.'

What if you are suspending other supports.

The recovery team member can make the decision following a review of the information.

Should you want to seek input from your Team Leader is required, you will create a NGCM General Task and assign it to a Team Leader for their endorsement. Record the following in the description field:

Decision type [APPROVED/ADVERSE/DECLINED/PARTIALLY APPROVED] DECISION


- Provide in detail what was requested (eg "6 hours home help per week over next 4 weeks").


- The final decision recommendation.

- b Review all information and ensure it is correct prior to stopping any supports/entitlements or payments.

NOTE What if you need more information on stopping supports/entitlements or payments?

Refer to the Stop Recurring Client Payment in Eos process and Suspend Support When Client is No Longer Eligible Policy below.


 **PROCESS** Stop Recurring Client Payments in Eos

 Suspend Support When Client is No Longer Eligible Policy

3.0 Contact client

Recovery Assistant, Recovery Coordinator, Recovery Partner

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

 View a 'safe contact'

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

 Identity Check Policy

NOTE What if you are unable to establish contact?

- If you are unable to reach the client on your first attempt, leave voicemail message and send a call back notification if appropriate. Create a Contact Action on the Recovery Plan to contact the client again in 3 days' time (unless urgent). Note in the task description that this is the first attempt to contact the client.

- 2nd attempt in 3 days: leave voicemail message and send another call back notification if appropriate. Consider contacting other stakeholders for an update and to confirm client contact details. Push out the task for another 5 days.

- 3rd attempt in 5 days: leave voicemail message. If you are unable to make contact with the client, seek internal guidance on whether it is appropriate to send the decision letter.

 **PROCESS** Seek Internal Guidance

 Recovery Plan - Create Contact Actions - System Steps

- c Discuss stopping the supports with the client and ensure you have the client's understanding that supports will stop. Clearly outline what supports will stop. This may include weekly compensation, treatment or social rehabilitation.

NOTE What are the legislative timeframes for stopping supports?


The associated timeframes for this are:
VI= 3months = legislation
MCR= ACC policy

Current policy is:
2 weeks (if claim was under 365 days, and 4 weeks if over).

NOTE What if your client requires ongoing financial assistance or support outside of the scope or remit of ACC supports?

Refer to Partnering with MSD overview and Partnering with MSD Flowchart which outlines the supports provided by MSD that may be helpful for our clients.

 ACC Partnering with MSD

 ACC Partnering with MSD Flowchart

- d In Salesforce, against the client's claim, record the details of the discussion with the client, including the decision to stop the support.

- e Create a new contact. Record the following in the description field:

- Decision Letter sent
- The final decision
- Who was consulted
- Rationale for the final decision

- f Generate the SPD998 decision letter for the client if ACC has made the decision to cease or suspend entitlements.

NOTE What if the client wants to stop receiving a support they are otherwise still entitled to? (Voluntary withdrawal)

A support can be ended for a client who indicates that they don't want to receive it anymore, as long as the following steps are completed:


- 1) Call the client, identify check the client and ask them to confirm:
 - What date they want to end the support (it needs to be on or before the expiry date of their latest medical certificate)
 - That they understand that: "This won't affect your eligibility for other ACC support such as treatment costs. But if you change your mind at a later date, and want to resume payments of weekly compensation, we will need to consider if you are still eligible at that stage."
 - That the request to end the support is their decision, and not a decision ACC is making


- 2) Determine whether you need to send the client a written communication about their support ending. You must send the client the 'VOL100 Voluntary withdrawal from a support - client' letter via post or email if either:
 - you have any doubts that the client fully understands or agrees to the terms of stopping the support due to voluntary withdrawal, or
 - the claim managed by Supported or Partnered Recovery (If the claim is managed by Enabled or Assisted Recovery and you're comfortable the client understands and agrees to the terms, then no written communication is needed)-

- 3) Create a new contact. Record the following in the description field:
 - the phrase 'voluntary withdrawal'
 - a summary of the agreement by the client to the terms of stopping a support due to voluntary withdrawal
 - if applicable, note what written communication was sent to the client

- 4) Update the Recovery Plan with the outcome.

- 5) Go to 4.0 Request supports to stop.

 SPD998 Suspension or cessation of entitlement - client



 Voluntary Withdrawal from receiving a Support Policy

 VOL100 Voluntary withdrawal from a support - client

- g Send the decision letter to the client.


NOTE What if the client's preferred method is via email?

Confirm the email address is verified, then send the letter to the client.

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

NOTE What if the client's preferred method is via mail?

Generate the 'NGCM - Send letter task' and attach the letter if your client's preferred method is via post.

-  Send letters from Client Recovery and Claims Assessment

h Update the Recovery Plan with the outcome.

4.0 Request supports to stop

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Generate the relevant task for the appropriate team to action.

NOTE What if all supports are being suspended due to an injury being resolved?

If clinical services deem incapacity is no longer injury related, all supports ie treatment, social rehabilitation, training for independence, Stay at work and weekly compensation would stop and therefore we would always update the injury resolved indicator.

1) In Eos, go to the ACC45 Claim, 'Indicators' tab and Add an 'Injury Resolved Indicator' to prevent further payments being made to the client.

2) Set the Status as 'Confirmed' and the From Date for when all supports will cease as per the recovery team members instructions.

3) Notify all relevant stakeholders the date when ACC supports will cease. The reason for the decision to stop supports should not be disclosed to the stakeholders.

NOTE What if the decision is to suspend or disentitle supports? Eg Home Help, Training for Independence, Stay at Work?

All purchase order end dates will have to be amended to match the end date of the service as per the Recovery Team member instructions.

In Eos, create a "NGCM - Suspend or Stop Entitlements" task and fill in the task description with:

- Purchase Order Number
- Date you want the purchase order to end

This will auto-route to Recovery Administration for them to action.

Provide the purchase order numbers and the end dates for each if there are ongoing purchase orders.

NOTE What if the decision is to stop weekly compensation payments?

1) Update the approved incapacity to reflect the advised end date for weekly compensation.

2) In Eos, go to the ACC45 Claim, 'Indicators' tab and Add a 'Limited Weekly Compensation Indicator' to prevent further incapacity being approved and further payments being made to the client (set the status as Active).

3) Generate a 'Stop Payment' task if a task is not automatically generated. Send to the Client Payments team by manually transferring to the Centralised Weekly Compensation queue for the payments team to action. The payments team will continue with the process below.

 **PROCESS** Stop Recurring Client Payments in Eos

NOTE What if the task is about a sensitive claim?

If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims queue.


5.0 Review task

Recovery Administrator

a In Eos, 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?

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to NG PRINCIPLES Working in the Administration Team.

-  Principles of Working in the Administration Team

b Edit and change the end date of each line of the purchase order. This information should be in the task. Purchase orders should not be cancelled.


6.0 Notify Provider

Recovery Administrator

a Email the Provider and inform them which supports and treatment have been stopped.

NOTE What email template do you use?

Use the 'Cancelling Service Email' template.

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Close claim**
UNASSIGNED



Summary

Objective

ACC strives to provide a high standard of customer service at all times, as required by our legislation. We must meet clients' reasonable expectations and deliver the highest practicable standards of service and fairness. The Code of ACC Claimants' Rights was established so clients understand what they can expect from ACC. Our customer service commitment includes providing a timely response to telephone calls and correspondence.

Owner

[Out of Scope]

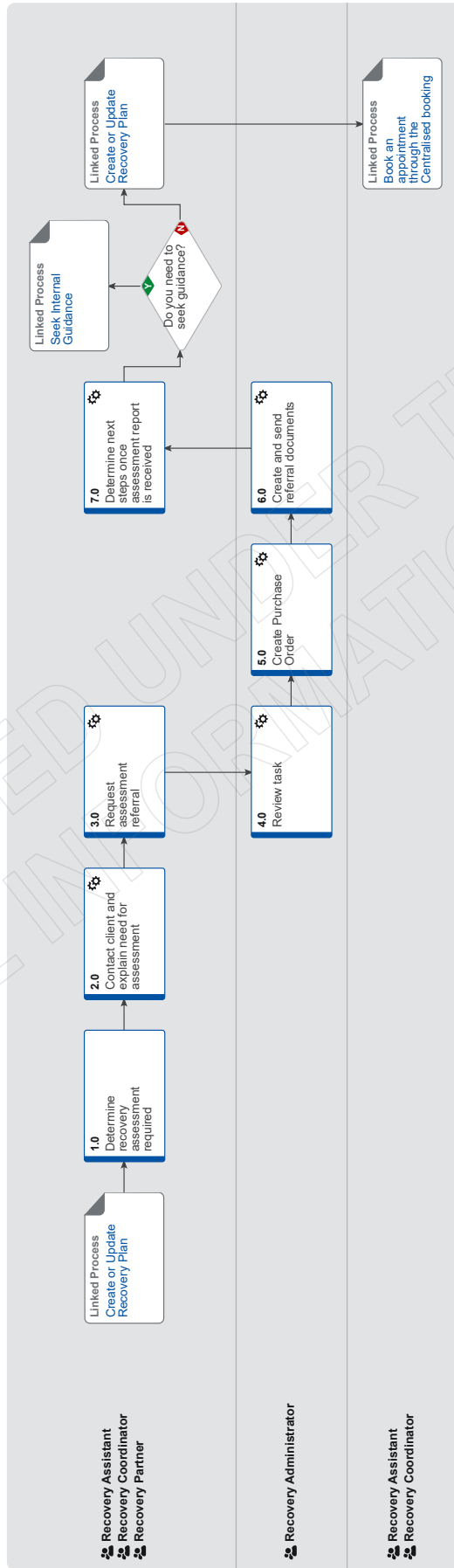
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Policy

1.0 Rules

- a** The following guidelines state the agreed maximum timeframes for case and claims management staff responding to telephone calls and written correspondence:

- You must return all telephone calls within 24 hours or the equivalent of 1 working day
- You must reply to all written correspondence within 7 days
- You must reply to all emails within 48 hours (2 working days) of receiving them. This includes sending an interim acknowledgement if a formal written response is required. An interim response must include the timeframe in which the final response will be sent.



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Summary

Objective

To refer the client for a Section 103 Assessment (s103).

Background

A Section 103 assessment determines if a client is able to engage in their pre-injury role (Section 103 of the Accident Compensation Act (AC Act) 2001), and is also one of the medical assessments within the Vocational Medical Services.

The s103 assessment is used to determine if a client can return to their pre-injury role. The assessment is provided by an Occupational Physician or suitably qualified medical assessor, who will provide you with an independent opinion and a detailed report. The assessor will consider whether the client has sufficiently recovered from their injury to be able to engage in their pre-injury employment.

This service may be requested at any stage during a client's rehabilitation.

Owner

[Out of Scope]

Expert

Procedure



PROCESS

Create or Update Recovery Plan Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine recovery assessment required

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a Confirm client's eligibility for the s103 assessment.

NOTE When would you consider referring for a s103?

A s103 assessment may be requested at any stage during a client's rehabilitation.

- it's likely that the client is now able to engage in their pre-injury role - remember to consider the client's injury, their pre-injury work tasks and expected claims outcome
- there's other relevant information on the client's file eg in previous medical reports or GP notes, that indicates the client may now be able to do their pre-injury role
- an Initial Medical Assessment (IMA) report indicates a client may be cleared for their pre-injury role – for further information refer to Section 103 Assessment (VMS) Service Page
- if at any time, you are considering an IMA and there's a chance a client may be cleared for their pre-injury role, you should refer for the s103 assessment in the first instance.

For additional information and s103 questions, refer to (NGCM) Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance

NOTE s103 referral following an IMA.

Following an IMA, there are occasions where the report indicates the client could carry out their pre-injury role. In this instance, best practice is to be followed and the client referred for a standalone s103 assessment.

- If the assessment has been completed within the past month and the assessor who completed the IMA is in agreement, a s103 referral can be sent directly to the assessor without an appointment. The client will need to be notified of this as the assessor will contact the client for a consultation by phone in order to complete the assessment

- If you require a different assessor to the one that completed the IMA, or the IMA was completed over 1 month ago, then you will need to refer for a new s103 assessment as outlined above.



Section 103 Assessment (VMS) Service Page

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. It is recommended that cover is confirmed prior to referring for an assessment.



Deemed Cover and Entitlements Policy

- b What if the assessment is needed for a sensitive claim?

NOTE Check a function assessment is on file before referring for the section 103 assessment

For Sensitive claims, before the s103 Occupational Medical Assessment is conducted the client needs to have a recent s103 "Function" Assessment by a Psychiatrist that clearly outlined personal injuries caused by sexual acts qualifying under Schedule 3.

Once the s103 "Function" Assessment report is received it is referred to MA who will advise if the s103 Occupational Medical Assessment is required.


2.0 Contact client and explain need for assessment

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Ensure current medical notes are on file so they can be sent to the s103 assessor.

NOTE What if the current medical notes are not on file?

You will need to obtain these before the referral is sent to the provider. Refer to (NGCM) Request Clinical Records. To see what documents need to be sent with the referral, refer to 3a.

 **PROCESS** Request Clinical Records


- b Check that the client has granted ACC the authority to collect medical and other records.



View Client Consent


NOTE What if the client has not granted ACC authority to collect medical and other records?

You will need to obtain the client's authority to collect medical and other records. Refer to (NGCM) Obtain Client Authority to Collect Information.


 **PROCESS** Obtain Client Authority to Collect Information

- c** Open Group VMS SharePoint site and identify potential providers that the client can use for this service.

NOTE Suitable providers will be geographically close to the client and capable of providing the assessment. Take the client's cultural or other needs into consideration.

 Group VMS SharePoint site


- d** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.


 Identity Check Policy

- e** Explain to the client that you are referring them to this service and what the service will do, as well as what their responsibilities are. Check for their preference of provider, date, and time.

NOTE How do you explain the s103 assessment to the client?

Explain to your client that we are needing help in identifying their capacity to perform their pre injury role, therefore it is now necessary to get this assessment from a clinician whom specialises in this area, this will help both ACC and the client understand current impacts of injury and if they are able to engage in their pre injury employment.


 Section 103 Assessment (VMS) Service Page

 Client Legislative Rights and Responsibilities Policy

- f** Advise the client:

- if it is determined that they don't have the functional capacity to perform their pre-injury role, their supports with ACC will continue.
- if it is determined they do have the functional capacity to perform their pre-injury role then ACC weekly compensation payments could cease.

- g** Advise the client of potential providers you have identified in their location or in the area closest to them, in the VMS tool.


 Group VMS SharePoint site

NOTE What else do you need to discuss with the client?

• Discuss potential assessors in the local area. Provide your client with the time, place, and name of the assessor. Make sure that your client can attend, explain to them the benefits of attending the appointment and their responsibilities to participate in their rehabilitation.

• there is no cost, that we can contribute or arrange travel and that they can bring a support person with them.


• the specialist will send us a report which we will send them a copy if they would like us to

 Client choice of providers Policy


NOTE What if there are no providers at the client's location?

Consider the most appropriate provider that the client might travel to and discuss this option with the client. If you are not sure, seek guidance from Hotline Practice Mentor.

If you need to arrange transport for the client, send a request to the Recovery Administration to set up taxi or transport.

 **PROCESS** Arrange Ancillary Taxi Service

- h** Choose the next available appointment in the Group VMS SharePoint site. When you receive confirmation of the appointment from the Provider, record a contact. Go to Group VMS SharePoint site Page to open the VMS bookings.

 Group VMS SharePoint site

NOTE Do ACC receive a confirmation of the booking?

For the Group VMS SharePoint site, ACC do not receive any confirmation from the Provider that the assessment is booked. However, if the client's name and claim number are recorded in the spreadsheet, then it is considered that you have that booking confirmed. When the referral documents are emailed to the Provider you will usually get an email back confirming receipt. If the Provider then cancels, ACC will be informed.

NOTE What if the provider does not appear as a current participant?

Load the "vendor/provider" as a participant. This enables Recovery Administration to validate the email and then email the purchase order directly from Eos if required.

The Recovery Team Member must ensure all known participants are loaded on the file and then removed when no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

- i** Create a reminder action to notify the client of appointment details the day prior to the appointment.


 Create a Notification - System Steps

- j** In Salesforce, add a contact note as a record of the conversation.

- k** Add the agreed intervention to the Recovery Plan.

NOTE How do you update the Recovery Plan?

Go to (NGCM) Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

3.0 Request assessment referral

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a** In Eos, find all the documents that need to be sent along with the referral.

NOTE What documents do you need to include?

- Current medical certificate
- Relevant medical information eg specialist reports (for clients with a mental injury claim this would include Psychiatric and Psychological reports)
- Any information relating to the client's function eg Physiotherapist's notes
- Relevant vocational rehabilitation documents eg Back to Work, Stay at Work, Standalone Workplace Assessment Reports, ACC188 Job Analysis form or Job Description from employer/client
- Recovery Plan (RP) and/or prior to 01/08/19 Individual Rehabilitation Plan (IRP)
- Signed ACC6300 or ACC6300D Authority to collect medical and other records. NOTE: If verbal consent was provided please note this in the task eform for Recovery Admin.

NOTE What do you do if you don't have all the information to complete the referral?

Once you have requested the additional information required, create a reminder action, set the target date for when you expect to receive the information. If you require further information, refer to Gather Additional Information or Advice.

 Gather Additional Information or Advice

b Perform privacy checks on documents.

 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

Check documents:

- are relevant to the referral
- do not contain any third-party information
- do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 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, before adding the document to the document group.

 NGCM - Redact information from PDF documents

c Create a referral-specific document group and enter 'Section 103 Assessment' and today's date in the document group description field.

d Add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?

When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files. E.g. Medical records and reports from claim: 100XXXXXXXX


Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

 Manage document groups

e Generate a Medical Assessment Referral task for Recovery Administration for 'Section 103 Assessment'.

NOTE How do you refer a task to Recovery Administration?

Please see Referring Tasks to Recovery Administration - Principles for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

NOTE How do you generate and send a referral task to Recovery Administration?

Go to NGCM Create a Referral Task.


 Creating Manage Referral Tasks - System Steps

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

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

NOTE What information do you need to include in the referral task?

- VMS booking sheet region used (eg Southern folder>Dunedin>Dr ABC)
- Date and time of the booking
- Vendor preference, if applicable
- SAW, WPA, Functional FCE reports, if applicable
- IMA report
- Any recommendations and questions from Recovery Support
- Confirm provider delivery method (email/courier).
- Provide the correct service code. Refer to the Purchase Order guidelines.

 Service Contracts and Contracted Providers - MFP spreadsheet

NG GUIDELINES Purchase Order Details - Section 103 Assessment

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

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

- Call Recovery Administration
- Give the Recovery Administrator who answers the call the claim number
- The Recovery Administrator will open the claim in Eos and find the task on the claim
- Transfer the task into the Recovery Administrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.

NOTE What if the request is required in the future?

If the support is required in the future, the Recovery team member will set a reminder task for themselves to a future date when the service is required to send a task to Recovery Administration.

NOTE What are the SLAs?

The referral tasks route to the Recovery Administration team with an SLA of 24 hours.

- f** Complete all the mandatory fields and any additional information to be included in the referral form including:
- questions received via written guidance or hotline advice from Recovery Support
 - the standard questions supporting reason for referral or assessment request.

NOTE What if your client has a Care indicator?

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

Disclosure of Care Indicator Information to Third Parties Policy

4.0 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 the target date needs clarification?

Target date clarification may need to be sought in the following situations:

- Target date has passed
- Target date is in 0-6 weeks time
- You are unsure of the target date based on the information provided.

If this is the case, go to NG PRINCIPLES Working in the Administration Team in below Note.

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

If required information is missing from the task, or you need guidance on working within the Administration Team, go to NG PRINCIPLES Working in the Administration Team.

Principles of Working in the Administration Team

5.0 Create Purchase Order

Recovery Administrator

- a** In Eos, generate a Purchase Order for the specified referral.

Creating purchase orders using general + QE

NG GUIDELINES Purchase Order Details - Section 103 Assessment

NOTE What if the s103 Assessment is following an IMA?

The purchase order should be updated to include the VMS01 code and a VMA01 code if an IMA assessment has been completed in the past month. The VMA01 allows the assessor to contact the client to ensure the s103 questions have been covered.

- b** Identify and select the vendor as specified by the Recovery Team Member.

- c** Locate the vendor via the Group VMS booking sheet, once selected add the vendor as a 'Vendor' - participant in Eos.

Group VMS SharePoint site

- d** Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Refer to the 'Request Authorisation for a Purchase Order - System Steps'.

Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.

1) In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.

2) Select 'OK'.

3) Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

6.0 Create and send referral documents

Recovery Administrator

- a** Create the referral for s103 Assessment.

NOTE What if the 103 referral is following an recent IMA

• If the assessment has been completed within the past month and the assessor who completed the IMA is in agreement, a s103 referral can be sent directly to the assessor without an appointment. The client will need to be notified of this as the assessor will contact the client for a consultation by phone in order to complete the assessment

• If you require a different assessor to the one that completed the IMA, or the IMA was completed over 1 month ago, then you will need to refer for a new s103 assessment by following the arrange section 103 assessment from the beginning.

ACC7401 Section 103 referral - vendor

- b** Populate with extra information noted on the referral task. This should include time date and location of assessment
- c** Check the task to ensure all relevant information is captured before you exit the document.

NOTE What does a quality referral look like?

Refer to Admin Template - Medical Assessment Section 103. This also contains the Admin Template for the SMR03 you'll send to the client.

Admin Template - Medical Assessment Section 103

- d** Ensure you have completed the document (to convert the document into a non-editable pdf).
- e** Link the referral to the document group 'Section 103 Assessment'.
- f** Perform privacy checks using NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- g** Update the VMS booking sheet with the date the referral is sent.

NOTE For information and instructions to open a VMS booking sheet, go to Book an appointment through the Centralised booking system (CBS).

PROCESS Book an appointment through the Centralised booking system (CBS)

- h** Generate a Bulk Print of the "Section 103 Assessment" Document Group.

Create Bulk Print

- i** Generate the Bulk Print Index.

NOTE How do you generate the Bulk Print Index?

- Click properties
- Click view contents less
- Right click convert to PDF
- Save to desktop
- Upload to Claim using document type VCF006
- Label as Bulk Print Index
- Delete file from desktop

- j** Create and send an email using 'Requests and referrals' template and attach the documents and bulk print.

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

NOTE What if you identify the documents you're sending exceed 10MB?

Use Adobe Pro to

Reduce file size:

- Select Optimize PDF
- Select Reduce File Size

Or

Split document

- Select organize page
- Select Split
- Select Split by File Size (up to 10MB)

The document will save in the same location and the original document and will be name PART1, PART2 (depending in the size of the file being split).

NOTE What if the document is too large to send in a single email?

Contact the vendor and ask if the referral can be sent by courier. If yes, confirm correct physical address go to Prepare and Send Client Information by Courier then return to this process. Otherwise, send by email.

PROCESS Prepare and Send Client Information by Courier

- k** Save the bulk print to desktop and attach to the email.
- l** Send the SMR03 Specialist medical review appointment - client letter to the client with the appointment details via their preferred contact method.
 - SMR03 Specialist medical review appointment - client
- m** In Salesforce, closed the assigned referral task.

7.0 Determine next steps once assessment report is received

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive notification that the s103 report has been received and is attached to the claim.

NOTE What should you expect from the s103 Assessment?

The medical assessor will conduct a clinical examination of the client and provide their opinion and recommendations, focussing on the client's fitness for work, taking into account an in-depth review of:

- the client's pre injury role and work tasks
- the client's pre-injury work hours
- the physical environment
- the client's current injury and any non-injury restrictions.

The medical assessor will complete a report, answering the standard S103 questions and any additional questions asked in the referral. This will provide a clear opinion regarding whether the client is able, following a personal injury, to engage in employment in which they were employed when they suffered the personal injury. Where there are other non-injury related factors that are considered the primary reason for the client not being able to return to work this should be indicated in the report.

NOTE What if the report is complex?" "

Obtain guidance from Recovery Support to confirm next steps. This will ensure a robust decision is being made prior to issuing any formal decision.

PROCESS Seek Internal Guidance


NG GUIDELINES VMS Report Expectations

NOTE What if the client fails to attend and/or participate in the s103 Assessment?

If the client fails to attend or take part in the s103 Assessment you should find out why. In some cases you may need to consider implementing the non-compliance process, seek guidance from Recovery Support and refer to Decline Entitlement When Client is Non-compliant Policy.

Decline Entitlement When Client is Non-compliant Policy


- b** Perform Privacy and Relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- d Discuss the report and next steps with client. Consider if a face-to-face meeting is required, refer to NG GUIDELINES Client Face to Face Meetings.

 NG GUIDELINES Client Face to Face Meetings

NOTE What is the assessor considers that the client continues to be incapacitated?

The client continues to be eligible for weekly compensation and no decision needs to be issued. The client can be advised of the outcome and provided with a copy of the report. Any recommendations in the report can be followed up on.

NOTE What is the assessor identifies the client has capacity to engage in their pre-injury role?

If the decision is complex, contact Recovery Support for guidance.

Weekly compensation will stop because the assessment confirmed the client has the capacity to engage in their pre-injury role.


For clients in receipt of weekly compensation less than 12 months provide 2 weeks' notice and for clients in receipt of weekly compensation more than 12 months provide 4 weeks' notice. Advise client a copy of the S103 report can be sent to both them and their treating provider along with the SPD998 letter.

 **PROCESS** Stop Supports

NOTE What if the client requests that the report is changed or incorrect?

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Go to Managing a client's request to change personal information (CHIPS).

 Managing a client's request to change personal information

- e Provide a copy of the s103 report to the client and key stakeholders.

 NGCM - FINAL Emailing from Eos - System Steps

- f In Salesforce, add a contact note as a record of the conversation.

- g Update the agreed intervention in the Recovery Plan.

 **PROCESS**

Create or Update Recovery Plan
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS**

Book an appointment through the Centralised booking system (CBS)
Recovery Assistant, Recovery Coordinator

 **Do you need to seek guidance?**

Recovery Assistant, Recovery Coordinator, Recovery Partner

YES...  **PROCESS** Seek Internal Guidance

NO... Continue

Summary

Objective

Recovery team members are responsible for regularly reviewing the scope of ongoing cover and whether support is still linked to the covered injury. Recovery team members are also responsible for the checking the initial fund code on a file when it is allocated to them.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** Each time new support is requested or considered, or further medical information is received for a client, you must confirm the link to the covered injury.

You must also review cover:

- if it was granted incorrectly
- if the diagnosis changes
- if there is doubt around whether the effects of the injury originally covered by ACC are the cause of the client's current inability to carry out activities.

Check that the fund code is correct and include evidence to support this.

2.0 Paying for support when claim is being assessed

- a** If a client has requested support and ACC needs to confirm responsibility for this, it is reasonable not to pay for the support until a decision has been made.

NOTE Example

Susan sustained a lumbar sprain lifting a heavy box and ACC granted cover for this. Nine months later Susan applies for weekly compensation (WC) as she is unable to work because of back pain. Due to the nature of the injury and the length of time between the original accident and the application for WC, it is reasonable for ACC to assess whether the covered lumbar sprain is the cause of her current inability to work, before paying WC.

- b** However, if a client is currently receiving support, ACC must continue to pay for this while assessing the claim.

NOTE Example

Adam fell off his tractor and hurt his knee. Cover was granted for a knee sprain and ACC started to pay WC based on Adam's inability to work as a farmer. Three months later he is still struggling with the injury and hasn't returned to work. Adam is referred for an MRI scan on his knee, which shows a cyst that is likely to have been there for some time. The specialist considers this is now the cause of Adam's pain and inability to work. ACC must keep providing support until we receive all the medical evidence and a formal decision can be made whether to cease the support.

3.0 Change of diagnosis

- a** If the client's diagnosis changes, you must consider the new diagnosis and whether ACC should still be responsible for cover. Eos needs to be kept up to date and cover letters reissued if the new diagnosis is accepted by ACC. Sometimes the provider will lodge the original claim with a working or suspected diagnosis, and this is updated when further information is received. To ensure ACC has accurate records, the diagnosis should be updated with relevant evidence. This is important because ACC cover is linked to ongoing liability for that injury in the future.

NOTE Example

Manju fell while playing netball and hurt her knee. She sees her GP who lodges the claim as a knee sprain. ACC accepts cover for a knee sprain. Later, it is confirmed that Manju sustained a meniscal tear and she will need surgery to repair this. Once ACC has appropriate medical evidence, the injury on Eos is updated as meniscal tear, and a fresh cover letter issued to the client.

PROCESS

Assess Cover for an Additional Injury or Change in Diagnosis

Summary

Objective

This policy explains the vocational independence assessments. Use this policy to understand:

1. Vocational Independence Occupational Assessment (VIOA)
2. Vocational Independence Medical Assessment (VIMA)

Background

After we have determined that assessing a client's Vocational Independence (VI) is appropriate, formal assessments are arranged with external assessors to determine whether a client has achieved VI. These assessments consist of:

- An occupation assessment – the Vocational Independence Vocational Assessment (VIOA)
- A medical assessment – the Vocational Independence Medical Assessment (VIMA)

For more understanding of VI, please refer to the 'About Vocational Independence (VI)' page.

Owner

[Out of Scope]

Expert

Policy

1.0 Vocational Independence Occupational Assessment (VIOA)

- a** A VIOA is undertaken by an occupational assessor who recommends work types that are suitable based on the skills the client has gained through education, training, or experience.

They will consider:


- the progress and outcomes of vocational rehabilitation carried out under the client's Recovery plan (RP) / Individual Rehabilitation Plan (IRP); and
- the types of work identified in the client's RP/IRP are still suitable for the client because they match the skills that the client has gained through education, training, or experience.

2.0 Requirements when making an VIOA referral

- a** When referring the client for a VIOA you should:
- Tell the client:
 - about the assessment
 - that we will provide their pre-incapacity earnings to the occupational assessor
 - that they're entitled to bring a support person or persons to the assessment
 - provide all the VIOA related information to the assessor, including the client's employment history, occupational reports and pre-incapacity earnings (do not include medical information as it is not relevant for the VIOA)
 - tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
 - take all reasonable steps to safeguard the assessor, such as providing a security service if needed

3.0 Information covered in the assessment

- a** We must ensure that the VIOA report meets our criteria and quality standards. The VIOA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the VIOA report from the assessor.

 VIOA Report evaluation checklist

4.0 Work types – what's a reasonable number?

- a** In most situations, 8-12 work type detail sheets are reasonable for an VIOA.

To have an excessive number of similar work types in an VIOA doesn't influence whether a client will be found vocationally independent.

5.0 Next working day rule

- a** Occupational assessors must follow the next working day rule when considering the types of work that are suitable for the client, meaning the client could start a job the next working day if it was available.

The client must not only have the skills but have also completed the necessary training and education in a work type before it can be identified as suitable. This includes any licence required for specific occupations.

6.0 Incomplete rehabilitation

- a** If an assessor believes that the vocational rehabilitation, as agreed in the RP/IRP, is not complete, they must:
- contact the case owner to discuss their concerns
 - state this on an ACC195 Vocational Independence occupational assessment report (406K) and provide options and recommendations for further vocational rehabilitation assistance.

7.0 Vocational Independence Medical Assessment (VIMA)


- a** A VIMA is undertaken by a medical assessor (occupational physician) who will assess how the client's injury affects their ability to work and provides an opinion whether the client is able to work for 30 or more hours a week in any of the work types recommended in the VIOA. They will also consider whether vocational rehabilitation is complete.

8.0 Requirements when making an VIMA referral

- a** When referring the client for a VIMA you should:
- Tell the client:
 - about the assessment
 - that they're entitled to bring a support person or persons to the assessment
 - provide all the related information to the assessor, including the VIOA and medical, rehabilitation and vocational reports
 - tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
 - take all reasonable steps to safeguard the assessor, such as providing a security service if needed

9.0 Information covered in the assessment

- a** We must ensure that the VIMA report meets our criteria and quality standards. The VIMA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the VIMA report from the assessor.








 VIMA Report evaluation checklist

10.0 No sustainable work types

- a** If the medical assessor considers that the client is not capable of undertaking any of the identified work types, they must:

- advise the client that they will recommend further rehabilitation
 - prepare and present a report that contains:
 - options for further recommended rehabilitation/treatment as required
 - the basis and reasoning for the recommendation(s)
-

11.0 Links to Legislation

-  Accident Compensation Act 2001, section 108 - Assessment of claimant's vocational independence
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 24 - Occupational assessor
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 25 - Conduct of occupational assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 26 - Report on occupational assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 27 - Medical assessor
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 28 - Conduct of medical assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 29 - Report on medical assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-

Summary

Objective

This policy explains the vocational independence deterioration (VID). Use this policy to understand:

1. Eligibility for Weekly Compensation following surgery
2. Determining deterioration due to surgery Other circumstances to consider
3. How to deal with applications for weekly compensation after surgery
4. The rate of weekly compensation payable to the client
5. Ceasing weekly compensation after post-VI surgery Links to legislation
6. Legislation References

Background

If a client has surgery for a covered injury after achieving vocational independence (VI), their VI may deteriorate as a result of the surgery and they can ask for weekly compensation.

Typically, for a client to regain entitlement to weekly compensation following vocational independence it is necessary for them to undergo a VI reassessment. However, given the practical difficulties that arise when surgery is proposed, or when surgery has recently been carried out, ACC has developed a specific policy to address this.

The policy allows the client to regain eligibility for weekly compensation immediately following surgery if a Medical Advisor (MA) determines that their VI will deteriorate due to surgery. This policy means that the client does not have to go through the VI reassessment process and receives their entitlement in a timely manner.

Owner

[Out of Scope]

Expert

Policy

1.0 Eligibility for weekly compensation following surgery after a VI decision

- a** A client can regain their eligibility to weekly compensation following surgery if:
- they have previously been declared vocationally independent
 - the surgery is related to the injury or injuries for which the VI decision was originally made
 - the client or their advocate has requested weekly compensation for the surgery recovery period
 - a Medical Advisor (MA) has determined that the client's VI will deteriorate due to the surgery

Our previous policy stated that to be eligible for weekly compensation after post-VI surgery, the client had to be an earner at the date of surgery. This is no longer a requirement.

2.0 Determining 'deterioration' due to surgery

- a** A client's VI has deteriorated when they can't work 30 hours or more in one or more weeks in all of the jobs that they were previously declared vocationally independent for. If the client can work 30 hours or more per week in any one of the relevant jobs, then they're still vocationally independent.

We determine deterioration based on advice from the MA regarding a number of factors, which are specific to each individual, and may include:

- the nature of the surgery
- the estimated recovery time, which is specified by the surgeon in the Assessment report and treatment plan (ARTP)
- the opinions of the client's GP or surgeon
- the nature of the work for which the client was deemed to have VI
- the medical history of the client
- the client's age or health

Once ACC is satisfied that a client's VI will deteriorate, or has deteriorated due to surgery, then the client regains their eligibility to weekly compensation. See Managing weekly compensation for surgery after VI.

VI assessments (VIOA and VIMA) should be used to determine deterioration if there is sufficient reason to believe that the client may have lost their VI prior to surgery.

3.0 Clients who apply for weekly compensation after surgery

- a** Some clients may not apply for weekly compensation until after their surgery has taken place. In this situation, if the request is made during the expected recovery period provided on the ARTP, then ask the Medical Advisor to determine whether the client's VI has deteriorated due to the surgery.

However, if the request is made after the expected recovery period, the client's VI should be reassessed (VIOA and VIMA) to determine whether the client has lost their VI.

4.0 Weekly compensation rates post -VI surgery

- a** The client is entitled to the greater of:
- the rate of weekly compensation they were last entitled to, updated for indexation if applicable. This means the client can still receive their previous entitlement even if they have no job
 - the recalculated rate, based on their actual recent earnings if applicable

5.0 Ceasing weekly compensation post-VI surgery

- a Once ACC has accepted that a client's VI has deteriorated and has reinstated weekly compensation, ACC can only end weekly compensation once the client has again been determined to be vocationally independent through a VI reassessment.


The client must complete the VI assessment even if they have returned to work.

Previous policy was that weekly compensation was stopped at the date specified in the ARTP. However, now a client must be certified as vocationally independent for weekly compensation to end.

6.0 Further Vocational Independence decision

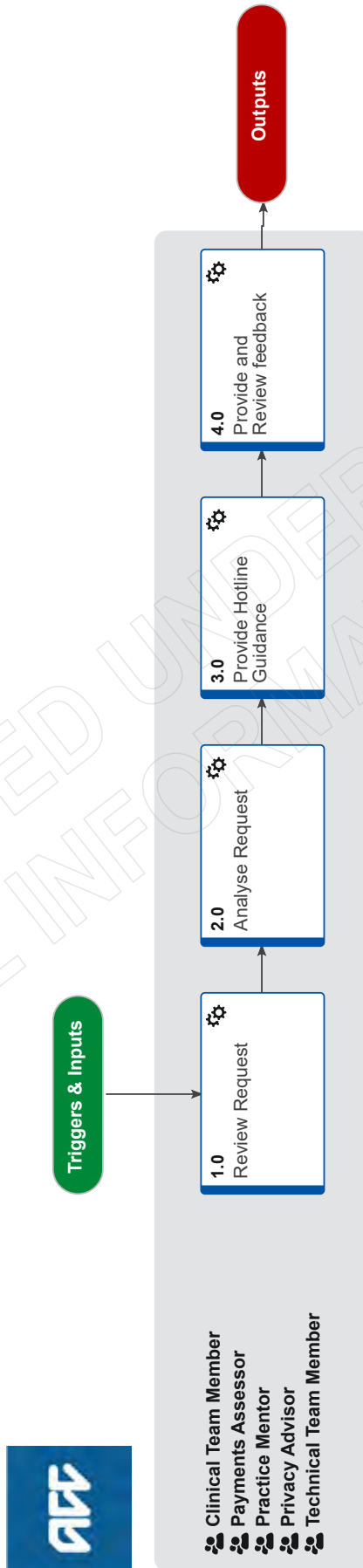
- a If ACC determines that the client once again has vocational independence, ACC issues a further vocational independence decision. The weekly compensation end date is three months from the date ACC issues the decision.

7.0 Links to Legislation

-  Accident Compensation Act 2001, section 113 - Claimant who no longer has vocational independence regains entitlement to weekly compensation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>

PROCESS **Make a Vocational Independence Deterioration decision - Surgery**

RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To provide guidance to frontline staff via the Hotline.

Background

Hotline Guidance is available for any of the following areas:

- Clinical Services
- Technical Services
- Practice Mentors
- Payments
- Privacy
- Technical Overpayments

Owner

[Out of Scope]

Expert

Procedure

1.0 Review Request

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** In Salesforce, open the claim using the claim number provided by the frontline staff member.

NOTE What if you are not a Salesforce user?

Open the claim in Eos using the claim number provided.

- b** Listen to the caller's question and confirm the steps that have been taken by the caller to resolve the issue.

NOTE What if you are aware of some self service content in Promapp, CHIPs, or within the decision tree tool?

Still provide your advice to the caller, but inform them that next time, they can refer to this specific process/piece of knowledge or tool to get the information they need.

NOTE What if you've been contacted directly, outside of the Hotline?

If the call is about clarifying advice you've already provided, this is appropriate.

If not, and this is the first time the staff member has done this, resolve their query and request that they use the Hotline next time. Advise that you won't be able to resolve their query next time if they call you directly.


If a staff member repeatedly calls the same advisor, redirect them to the Hotline and inform their Team Leader.

- c** Determine if you're the correct person to provide guidance.

NOTE What if you're not the correct person?

Decide who would be the correct person/advisor hotline and transfer the call. If you are unable to transfer the call to another person/advisor, suggest to the frontline staff member to call back later.

Refer to the guide below on how to transfer calls.

 [Skype Calling and Call Functionality](#)

2.0 Analyse Request

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** Assess whether the issue can be answered during the call (ie you can provide guidance within 15 minutes).

NOTE What if you're unable to provide guidance within 15 minutes?

If you're unable to provide guidance, recommend that the staff member requests Written Guidance

Ensure you document this in Salesforce by selecting "Create Guidance", "Hotline Guidance", and complete the mandatory fields.

For Payments, Privacy, and Technical Accounting services (TAS), if any guidance was provided, ensure you document this in Eos, in the "Add eForm" section of the Recovery Support subcase.

- b** Review the claim background information, including prior claims, if the frontline staff member has not already provided this.

NOTE What if you need more time to review information prior to providing guidance?

Inform the staff member that this will be the case, providing them with an idea of when they can expect you to get back to them, and how you will do this (Skype, Teams, Phone call etc).


3.0 Provide Hotline Guidance

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** Provide guidance to the staff member

NOTE What if the issue needs additional guidance from a different Advisor, Specialist or Assessor?

Refer to the guide below for information on how to transfer calls to another Advisor, Specialist or Assessor or how to initiate a conference call with them.

 [Skype Calling and Call Functionality](#)

- b** Agree next steps with the staff member. Ensure there is an agreed understanding of the next steps before the call comes to an end.

NOTE What if you need more time to consider information and/or type up your guidance?

Set the expectation with the frontline staff member how long this will take, so they can prioritise other work whilst waiting for this guidance if needed. Give them the option of going on hold or ending the call and getting back to them once this guidance is completed, ensuring there is an agreed understanding of how you will do this.

- c** In Salesforce, record the guidance provided within the 'Recovery Support' tab, create the Hotline guidance form and fill in the fields.

NOTE What if you are a Clinical Advisor and you have received a request regarding Surgical guidance via the clinicaladvisorsurgery@acc.co.nz inbox?

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

NOTE What if you are in Privacy, Payments, or TAS?

In Eos, record the guidance provided within the Recovery Support sub-case by selecting "add eForm" and completing the fields.

NOTE What if you need to edit or delete the Hotline Guidance you created?

In Salesforce open the hotline guidance:

- If you need to edit the hotline guidance to add/remove information, select 'Edit Hotline Guidance'
- If you need to remove hotline guidance entered on the wrong claim, select 'Delete'

If you are not a Salesforce user, you can edit your guidance in Eos via the Recovery Support sub-case for the above reasons.

NOTE What if there is no Recovery Support sub-case? (Privacy, Payments, TAS)

From the ACC45 claim select "Add Sub Case", then select Recovery Support.

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

Complete the steps below in Salesforce:

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

4.0 Provide and Review feedback

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** If applicable, provide feedback on the guidance request.

NOTE How do you provide feedback on the guidance request?

In Salesforce, navigate to the Recovery Support tab and select the 'Provide Feedback' option. On the Provide Feedback form, complete the mandatory question and comments sections, and submit your feedback.

- b** If applicable, review feedback on the guidance provided.

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

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

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

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

Summary

Objective

The Vocational Independence Medical Assessment (VIMA) considers whether a client's vocational rehabilitation is complete and if they have the ability to return to full time work.

Owner

[Out of Scope]

Expert

Procedure

1.0 What should you expect from the VIMA?

- a** The medical assessor will conduct a clinical examination of the client, and should take into account:
 - the supporting documentation provided with the referral, including medical reports, the IMA and whether any outstanding medical treatment has not been addressed. This includes pain issues.
 - any other injuries the client has suffered in the past
 - any existing non-injury factors or condition(s) the client suffers that could prevent or are preventing the client from achieving vocational independence
 - any other information the client provides that the assessor considers is relevant
- b** The medical assessor should share their clinical opinion openly and in a way, that respects the dignity and cultural values of the client. They should actively engage the client in the decision making and ensure the recommendations are fair and reasonable.
- c** The medical assessor is required to provide a copy of the VIMA report back to ACC within the required timeframes and the report to meet agreed quality standards. At a high level, the VIMA report should include the following type of information:
 - a list of the information we provided to the assessor
 - any other information the client provides the assessor which is relevant
 - the clinical findings from the assessor's examination, including any comment on pain and fatigue
 - their medical opinion and rationale regarding the client's fitness for work. This should include a recommendation on whether each of the job types identified in the VIOA are suitable given their injury and vocational independence. To be considered as suitable, the client must be able to work safely for 30 hours or more per week, over a period of employment, e.g. over a period more than 4 weeks.
 - include the basis and reasoning for each recommendation
 - if required, state why the client has not achieved vocational independence and consider if they need any further treatment or rehabilitation
 - all comments that the client makes about whether the identified types of work and the associated work tasks are suitable for their injury and vocational independence.
- d** The VIMA report should be reviewed against the VIMA report evaluation checklist to make sure it meets ACC quality standards and discuss any issues with the assessor first. If you are unable to solve any issues directly with the assessor, escalate your concerns through clinicalquality@acc.co.nz.



VIMA Report evaluation checklist



Report Expectations.pdf

2.0 Standard or complex referrals

- a** Arrange a standard VIMA for the client, unless any of the following complex assessment criteria apply. The case must include one of the following criteria to qualify for complex:
 - the case relates to a serious injury
 - the client has a covered sensitive claim
 - the covered injury is a moderate to severe traumatic brain injury
 - it has been two and a half years or more since the date of covered injury.

There may be occasions where the case is exceptionally complex and an assessor requests consideration for additional hours. The VMSEXC code is available for these cases.

If you wish to use the exceptional code, you must request approval from your team leader and if needed they will escalate it to the clinical team for further review.

3.0 Assessor requests for further information or an additional assessment

- a** Arrange a standard VIMA for the client, unless any of the following complex assessment criteria apply. The case must include one of the following criteria to qualify for complex:
 - the case relates to a serious injury
 - the client has a covered sensitive claim
 - the covered injury is a moderate to severe traumatic brain injury
 - it has been two and a half years or more since the date of covered injury.

There may be occasions where the case is exceptionally complex and an assessor requests consideration for additional hours. The VMSEXC code is available for these cases.

If you wish to use the exceptional code, you must request approval from your team leader and if needed they will escalate it to the clinical team for further review.

4.0 Client is 'risky' or aggressive

- a** If your client has a Care Indicator or you consider them to pose a potential risk to the assessors safety then you need to clearly outline this in the referral letter and have a conversation with the assessor prior to them contacting the client. You should clearly document this in Eos using the standard template.

5.0 When to refer for a VIMA reassessment

- a** A VIMA reassessment can be referred for using the VMV03 service item code. A reassessment can only be referred to the same practitioner that completed the initial assessment. The initial assessment needs to have taken place within the last 3 months. A reassessment may be helpful where a significant development has occurred since the original assessment, such as a new injury.



6.0 When a Client also has Sensitive Claim

- a If the case involves a sensitive claim, contact the Partnered Recovery team and arrange for all medical notes and reports to be sent to the VIMA assessor.
-

7.0 Failure to attend or complete an assessment

- a After accepting a referral the medical assessor must:
 - let us know within two working days if they can't contact the client or complete an assessment, so that we can arrange another assessor
 - provide us with a written record of any non-attendance at an assessment by the client.
-

8.0 Other links

-  Promapp: VIOA/VIMA Policy Page
<https://go.promapp.com/accnz/Process/9a4af2d9-b22>
 -  Promapp: VMS Centralised SharePoint Booking System Service Page
<https://go.promapp.com/accnz/Process/3cf0f18a-53fa>
-

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Summary

Objective

This policy explains the vocational independence assessments. Use this policy to understand:

1. Vocational Independence Occupational Assessment (VIOA)
2. Vocational Independence Medical Assessment (VIMA)

Background

After we have determined that assessing a client's Vocational Independence (VI) is appropriate, formal assessments are arranged with external assessors to determine whether a client has achieved VI. These assessments consist of:

- An occupation assessment – the Vocational Independence Vocational Assessment (VIOA)
- A medical assessment – the Vocational Independence Medical Assessment (VIMA)

For more understanding of VI, please refer to the 'About Vocational Independence (VI)' page.

Owner

[Out of Scope]

Expert

Policy

1.0 Vocational Independence Occupational Assessment (VIOA)

- a** A VIOA is undertaken by an occupational assessor who recommends work types that are suitable based on the skills the client has gained through education, training, or experience.

They will consider:


- the progress and outcomes of vocational rehabilitation carried out under the client's Recovery plan (RP) / Individual Rehabilitation Plan (IRP); and
- the types of work identified in the client's RP/IRP are still suitable for the client because they match the skills that the client has gained through education, training, or experience.

2.0 Requirements when making an VIOA referral

- a** When referring the client for a VIOA you should:
- Tell the client:
 - about the assessment
 - that we will provide their pre-incapacity earnings to the occupational assessor
 - that they're entitled to bring a support person or persons to the assessment
 - provide all the VIOA related information to the assessor, including the client's employment history, occupational reports and pre-incapacity earnings (do not include medical information as it is not relevant for the VIOA)
 - tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
 - take all reasonable steps to safeguard the assessor, such as providing a security service if needed

3.0 Information covered in the assessment

- a** We must ensure that the VIOA report meets our criteria and quality standards. The VIOA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the VIOA report form the assessor.

 VIOA Report evaluation checklist

4.0 Work types – what's a reasonable number?

- a** In most situations, 8-12 work type detail sheets are reasonable for an VIOA.

To have an excessive number of similar work types in an VIOA doesn't influence whether a client will be found vocationally independent.

5.0 Next working day rule

- a** Occupational assessors must follow the next working day rule when considering the types of work that are suitable for the client, meaning the client could start a job the next working day if it was available.

The client must not only have the skills but have also completed the necessary training and education in a work type before it can be identified as suitable. This includes any licence required for specific occupations.

6.0 Incomplete rehabilitation

- a** If an assessor believes that the vocational rehabilitation, as agreed in the RP/IRP, is not complete, they must:
- contact the case owner to discuss their concerns
 - state this on an ACC195 Vocational Independence occupational assessment report (406K) and provide options and recommendations for further vocational rehabilitation assistance.

7.0 Vocational Independence Medical Assessment (VIMA)


- a** A VIMA is undertaken by a medical assessor (occupational physician) who will assess how the client's injury affects their ability to work and provides an opinion whether the client is able to work for 30 or more hours a week in any of the work types recommended in the VIOA. They will also consider whether vocational rehabilitation is complete.

8.0 Requirements when making an VIMA referral

- a** When referring the client for a VIMA you should:
- Tell the client:
 - about the assessment
 - that they're entitled to bring a support person or persons to the assessment
 - provide all the related information to the assessor, including the VIOA and medical, rehabilitation and vocational reports
 - tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
 - take all reasonable steps to safeguard the assessor, such as providing a security service if needed

9.0 Information covered in the assessment

- a** We must ensure that the VIMA report meets our criteria and quality standards. The VIMA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the VIMA report from the assessor.








 VIMA Report evaluation checklist

10.0 No sustainable work types

- a** If the medical assessor considers that the client is not capable of undertaking any of the identified work types, they must:

- advise the client that they will recommend further rehabilitation
 - prepare and present a report that contains:
 - options for further recommended rehabilitation/treatment as required
 - the basis and reasoning for the recommendation(s)
-

11.0 Links to Legislation

-  Accident Compensation Act 2001, section 108 - Assessment of claimant's vocational independence
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 24 - Occupational assessor
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 25 - Conduct of occupational assessment
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 -  Accident Compensation Act 2001, Schedule 1, cl 29 - Report on medical assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-

Summary

Objective

The Vocational Independence Occupational Assessment (VIOA) considers whether each of the work types identified are suitable for the client because they match the skills the client has gained through education, training, and experience. The VIOA is part of the Vocational Independence Test.

Owner


[Out of Scope]

Expert

Procedure

1.0 Occupational Assessor's Role

- a** It is not the VIOA provider's role to consider whether the work types they identify are medically sustainable for the client. Following the VIOA, ACC will ask an Occupational Physician to comment on whether the work types identified are medically sustainable for the client. To arrange this please refer to the Vocational Independence Medical Assessment [VIMA] process.

 Vocational Independence Medical Assessment (VIMA) Service Page

2.0 Referring for an VIOA

- a** A VIOA referral is generated by creating a purchase order with the entitlement type: VIOS1 (standard) or VIOC1 (complex). Refer to Arrange Vocational Independence Occupational Assessment (VIOA) process.

 Arrange Vocational Independence Occupational Assessment (VIOA)

- b** Standard or complex referrals: You must arrange a standard VIOA for the client, unless one or more of the following complex assessment criteria apply. The client has:

- dual diagnosis/co-morbidity
- active mental health issues and/or significant co-morbidity that will make the assessment take longer
- a serious injury profile of 1,2,3,5,6,8,10 or 13, including traumatic brain injury and spinal cord injury with an ASIA Scale of A,B,C or D
- a sensitive claim
- alcohol and other drug abuse
- communication issues

If the VIOA assessor identifies any complex assessment criteria when completing the standard assessment, they may ask you to make the assessment a complex referral. You will need to change the purchase order.

- c** My client has a Care Indicator: If your client has a Care Indicator or you consider them to pose a potential risk to the assessor's safety, then you need to clearly outline this in the referral letter and have a conversation with the assessor prior to them contacting the client. You should clearly document this in Eos using the standard template.

3.0 VIOA timeframes

- a** The occupational assessor needs to adhere to the attached timeframes.

Must...	Within...
Accept or decline the referral	two Business days of receiving it. Note: If the referral contains inadequate information, the Supplier may request further details from the claims manager.
Notify the Client Services Staff if they are unable to contact the client	three Business days of accepting the referral.
Commence the assessment	five Business days of accepting the referral.
Notify the Client Services Staff if the client fails to attend a scheduled assessment	the same day the client fails to attend.
Complete the Vocational Independence Assessment report	10 Business days of receiving referral.
Forward three copies of the completed Vocational Independence Assessment report to the Client Services Staff	10 Business days of receiving referral.

 VIOA Timeframes.png

- b** The assessor should contact you if they are unable to contact the client within 2 days of accepting the referral or if they are unable to complete the referral in the specified timeframes. You are then able to chose and alternative supplier or negotiate a set timeframe.

4.0 VIOA report

- a** The assessor should complete the ACC195 Vocational Independence Assessment Report. The report must identify:

- The client's current work experience, training (including any work-related training and incomplete formal qualifications), skills and the dates they gained them.
- How the identified roles compare with pre-incapacity earnings
- The vocational rehabilitation carried out and whether it has been completed.
- A list of the suitable work types identified and the reasons why.
- A work type detail sheet for each of the suitable work types identified.
- Any potential vocational barriers to them getting a job in the work types identified.
- Any environmental modifications to enable the claimant to function safely in that type of work.
- The work types identified in the IOA that were excluded or removed.
- Any concerns or issues the client has with the recommendations made.

The assessor is also required to complete Part 1 of the ACC197 Vocational Independence Assessment. This requires them to list the work types considered suitable.

When you receive the report, you should use the VIOA checklist to review the report and make sure it meets our quality standards (see VIOA evaluation checklist) you should discuss with the assessor any questions you have and if required, agree on a timeframe for completing an amended report. ACC should then send a copy of the report to the client to comment on before sending it to the VIMA assessor. Use the VID09 letter as your 'cover letter' when you send it to your client or if you have booked the VIMA appointment you can use the VI05 letter (using Option 2).

 VIOA Checklist.docx

5.0 Does the Occupational Assessor only consider the roles listed in the IOA?

- a** When identifying suitable work types with the client, the occupational assessor should start by going over work types identified in the IRP and IOA, as well as any other options that have become suitable for the client because of their vocational rehabilitation.

The occupational assessor can also consider any additional types of work that belong to the same major industry group as the types of work identified in the IOA or are closely aligned to the types of work in the IOA.

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Summary

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Owner

[Out of Scope]

Expert

Policy

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 VIMA Report evaluation checklist

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 -  Accident Compensation Act 2001, Schedule 1, cl 27 - Medical assessor
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 28 - Conduct of medical assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Accident Compensation Act 2001, Schedule 1, cl 29 - Report on medical assessment
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-



Summary

Objective

Vocational Medical Assistance (VMA) is an advisory service that case owners, general practitioners (GPs) and Vocational Rehabilitation Service (VRS) providers can access when they need immediate expert medical advice or a quick consultation with about the client's vocational rehabilitation progress.

Owner

[Out of Scope]

Expert

Procedure

1.0 Who is VMA for?

- a** Vocational Medical Assistance (VMA) is an advice-giving service that ACC, GPs and VRS providers can access when they need quick, expert medical advice. It is primarily for clients receiving vocational rehabilitation (such as the Stay at Work (SAW), Back to Work (BTW) or Pathways to Employment (PTE) service). There are two components of VMA:
- Liaison Services (advice from an expert by phone or email)
 - Case Conferencing (phone and/or face-to-face meeting with support team)

2.0 When to refer for a VMA:

- a** VMA Liaison Service: ACC, GP or VOC provider should consider using this service when they require immediate expert occupational medicine advice by phone or email to answer general clinical questions about a client's vocational rehabilitation. The Liaison Service may be appropriate when:
- General advice about the client's injury and how it relates to their rehabilitation & work is needed.
 - Advice about the need for, or appropriateness of, a specific rehabilitation intervention.
 - To discuss or clarify aspects of a Vocational Rehabilitation Review (VRR) report, or an Initial Medical Assessment (IMA) report which greater than 2 weeks old.

NOTE Example: VMA Liaison Services

Your client is referred for an IMA. The Occupational Physician arranges an MRI following the assessment. The MRI is completed and you request the Occupational Physician interrupt and respond to the MRI report. The IMA provider can use the VMA Liaison service to charge for their time taken.

- b** VMA Case Conference: ACC, GP or VOC provider should consider using this service when they need a phone or face-to-face meeting with members of the client's vocational rehabilitation team to discuss and reach a consensus on how to solve a vocational rehabilitation problem. The Case Conferencing Service may be appropriate when:

- There are concerns about the client's rehabilitation progress eg barriers or symptoms preventing participation.
- The client's progress has stalled and there needs to be a discussion around client's current level of fitness.
- Following the IMA or VIMA, there is disagreement or clarification with the client and treating GP is needed
- A medical assessor who completed a VRR or IMA recommended a vocational rehabilitation programme and a review is needed with the treating medical providers and client.

NOTE Example: VMA Case Conferencing

Your client was struggling to increase their hours at work. The SAW provider had arranged a VRR. After the VRR the SAW provider arrange for a case conference with the client, medical assessor and GP to discuss the recommendations and approval for the next stage of the return to work.

3.0 How can someone be referred for a VMA?

- a** A VMA service can be referred for by ACC, a GP or VOC provider. Each client has five pre-approved VMA services (any combination of Liaison and/or Case conference) and no purchase order is required.

To refer for a VMA Liaison ACC, the GP or VOC provider phones or emails the VMA provider, asking the VMA provider to respond to a question. Make sure you provide the client's name and claim number.

To refer for a VMA Case Conference, ACC, the GP or VOC provider contacts the VMS provider to let them know you'd like to arrange a VMA Case conference. You will need to discuss when they're available and whether a teleconference or a face-to-face meeting is best.

The VOC provider must tell ACC when referring for a VMA. If the client has had five VMA services already, approval from ACC and a purchase order (VMA01 Liaison or VMA02 Case Conference) is required.

NOTE How to book and hold a Case Conference

If possible, arrange to have the case conference within 10 working days of talking to the VMS provider. Contact the required attendees by phone or email and invite them to attend. If it's a:

- face-to-face conference, confirm the location, date and time
- phone conference, confirm the date and time and who will be phoning them

Before attending, review the client's claim file to check VR plans are on the file and the client's VR progress to date. If for some reason, you're unable to attend, consider sending a representative.

Recovery Team Member or VOC provider: Facilitate the conference and record the minutes.
Note: If both the RTM and the VOC provider are attending, decide in advance who will facilitate the meeting and record the minutes. If the VOC provider records the minutes, they must provide them to the case owner for distribution afterwards



PROCESS

Arrange Vocational Medical Assistance

4.0 What should you expect from the VMA?

- a** VMA Liaison: the VMS provider should provide their advice to the requestor by phone or email either immediately or within two working days. If the case owner was not the requestor, the VMS provider will send the case owner a record of their advice. The service should be prompt, flexible and tailored to client needs. It should be provided:
 - within 48 hours of request
 - by phone or email
 - by a medical assessor who may or may not have examined the client
 - in isolation or together with any Vocational Rehabilitation Service (VOC) or other Vocational Medical Service (VMS)
- b** VMS Case Conference: the VMS provider should be available to participate in a VMA case conference within 10 days of the request. The case conference should be arranged by the client's case owner or VOC provider. It may involve any combination of the client, their case owner, employer, GP, VOC provider, Pain Management Services provider and any other appropriate rehabilitation provider. The service should be provided:
 - by a VMS provider who has assessed the client, either for a VRR or IMA, prior to attending the case conference
 - provided in conjunction with a VRR or IMA, or following a VIMA
 - by face-to-face meeting or teleconference
 - within 10 days of the request

5.0 Useful Information and tips

NOTE Alternative services

If the question you are trying to answer is complex, then consider referring to a Vocational Rehabilitation Review (VRR).



Vocational Rehabilitation Review
<https://go.promapp.com/accnz/Process/60a00b10-48>

NOTE Timeframes

If the service is initiated during vocational rehabilitation, then VMA must end before the client enters the Vocational Independence process. No further assistance can be offered past this point, as this may be perceived as providing on-going rehabilitation.



Summary

Objective

Vocational Medical Services (VMS) is a collection of contracted services that enable a client's GP, employer and Vocational Rehabilitation Service (VRS) provider to get support and expert advice and clinical leadership at any point throughout a client's vocational rehabilitation (VR) process. The services encourage teamwork between health professionals and relevant stakeholders.

Owner

[Out of Scope]

Expert

Procedure

1.0 Overview of the Vocational Medical Services (VMS)

a VMS consist of the following services:

- Vocational Medical Assistance (VMA) for quick advice to support a client's rehabilitation and/or return to work.
- Vocational Rehabilitation Review (VRR), a brief clinical assessment to review a client's rehabilitation or work.
- Section 103 assessment (S103) to determine if a client is able to engage in their pre-injury role.
- Section 105 assessment (S105) to determine if a client is able to engage in work they're suited to by reason of their experience, education or training (Extension of Earner / LOPE).
- Initial Medical Assessment (IMA) to identify whether the types of work identified in the Initial Occupational Assessment (IOA) are, or are likely to be, medically sustainable for the client.
- Vocational Independence Medical Assessment (VIMA): determines whether a client can work in other roles for 30 hours or more a week. The VIMA is the final assessment of the vocational independence assessment process.

2.0 Key principles of VMS

- a Vocational Medical Services are designed to support ACC's vocational rehabilitation. Key principles include:
- Support and advice through the rehabilitation process: using clinical experts to offer support and advice at the right time through the rehabilitation process to ensure a safe and timely return to work.
 - Provide flexibility: by providing tailored support and advice to clients.
 - Be responsive: providing services in a timely manner throughout the client's rehabilitation journey.
 - Encourage team work: by actively fostering good working relationships between health professionals – making sure the client experiences a single clear direction in their rehabilitation.
 - Promote openness and transparency: by ensuring the purpose, processes, and possible outcomes of the VMS are communicated and delivered in an open and transparent way to clients.

3.0 Who is VMS for?

- a Many clients can return to work without requiring the advice of a medical expert. However, we can consider providing VMS to any client who has a covered personal injury and is either:
- entitled to weekly compensation or Loss of Potential Earnings (LOPE)
 - likely to be entitled to weekly compensation if we don't provide vocational assistance
 - no longer entitled to weekly compensation because they've reached the NZ Superannuation Qualifying Age (NZSQA)
 - on parental leave
 - is determined by ACC as requiring a vocational rehabilitation service in order to achieve a specific agreed outcome.

We must consider vocational rehabilitation (including VMS) as soon as we decide that a client is likely to be eligible. If a client needs the support, we can provide vocational rehabilitation until the client achieves their vocational outcome e.g. returns to their pre-injury role.

If the client is not eligible for weekly compensation, and does not meet the above criteria, the client is not eligible for vocational rehabilitation (including VMS). You can consider referring the client under other services – see alternative services.

4.0 Who can provide VMS?

- a VMSs are provided by registered medical practitioners who hold post graduate qualifications in Industrial Health (DIH), Occupational Medicine (PG Dip Occ Med) or an equivalent. They must have a minimum of two years' current experience working in an occupational setting. VMS providers in each area can be found in the centralised booking system.

 VMS Centralised Booking Sharepoint Lists
<https://accnz.sharepoint.com/sites/Group-VMSBookir>

PROCESS VMS Centralised SharePoint Booking System Service Page





5.0 VMS Provider Performance Management

- a If your concerns relate to the completeness of the report, errors or omissions, manage these directly with the assessor.








If the results of this assessment find there are clinical quality concerns, at the discretion of the engagement and performance manager, clinical input can be requested upon the matter and the engagement and performance manager will address the concerns directly with the assessor. If any amendment to the report is required, the assessor has two working days from the day the issue was raised to return the amended report to the case owner. You will be kept informed of progress.

6.0 Alternative and related services

- a** The case owner may refer for a follow-up assessment or review subsequent to a VRR, IMA or VIMA if appropriate, eg when:
- there has been a significant development since the original assessment, such as a new injury
 - the client's rehabilitation progress has been faster than expected
 - the client has had a VRR and recently started a return to work programme but is having some difficulty with it, and the VRS provider thinks a significant investigation is needed that requires more than VMS Liaison or Case conference.
- b** Alternative services to consider include:
- To establish causation or treatment: medical case reviews (MCR) or single discipline assessments (SDA)
 - Identifying suitable work types based on experience, education or training: Initial Occupational Assessment (IOA)
 - Treatment services: GP with Special Interest (GPSI) service, Vocational Rehabilitation service (VRS) and medical services included in the Clinical Services contract, including in-rooms procedures.

-  Initial Medical Assessment (IMA)
<https://go.promapp.com/accnz/Process/6ad47664-56>
-  Vocational Medical Services Section 103 assessment
<https://go.promapp.com/accnz/Process/d7908d0b-71>
-  Vocational Medical Services Section 105 assessment
<https://go.promapp.com/accnz/Process/3ef695e8-be4>
-  Vocational Independence Medical Assessment (VIMA)
<https://go.promapp.com/accnz/Process/cd91fcb3-515>




7.0 Referral forms

- a** Vocational Rehabilitation Review:
Case owner referrals/ Recovery Team Members referrals:
- ACC98 ACC referral for Vocational Services
- Provider to provider referrals:
- ACC6245 Provider referral for Vocational Rehabilitation Review
-  ACC98 ACC referral for Vocational Services
 -  ACC6245 Provider referral for Vocational Rehabilitation Review
- b** S103: ACC7401 Section 103 referral - vendor
-  ACC7401 Section 103 referral - vendor
- c** S105: ACC7402 Section 105 referral - vendor
-  ACC7402 Section 105 referral - Vendor
- d** IMA: ACC699 Initial medical assessment referral – PO – vendor: Pack
-  ACC699 Initial medical assessment referral - PO - vendor-pack
- e** VIMA:
- VI04 Approval - Medical assessment with appointment
 - ACC192 Vocational Independence medical assessment referral documents list
-  ACC192 Vocational Independence medical assessment referral documents list
 -  VI04 Approval - Medical assessment with appointment

8.0 Service Item / Purchase Order Codes

-  Service Item Codes - VMS.docx

9.0 Service details

-  Vocational Medical Services Operational Guidelines
-  Vocational Medical Assistance (VMA)
<https://go.promapp.com/accnz/Process/ed59f54d-28f>
-  Vocational Rehabilitation Review (VRR)
<https://go.promapp.com/accnz/Process/60a00b10-48>



Summary

Objective

Equipment may fall under vocational rehabilitation if the outcome of the rehabilitation is to:

- maintain employment
- obtain employment
- regain or acquire vocational independence.

See Vocational Rehabilitation.

Owner

[Out of Scope]

Expert

Procedure

1.0 Provision of vocational equipment

- a** We provide vocational rehabilitation equipment if there is an assessed injury-related need and the equipment items are required to address that need. For criteria for funding work items and exceptions, see Standard work items to start employment.

We purchase vocational equipment through our MRES supplier using the process outlined at Assessment and equipment ordering.

- Standard Work Items to Start Employment Policy
- Assessment and Equipment Ordering Service Page
- Enable New Zealand
<https://enable.co.nz/>

2.0 When should the employer purchase the equipment?

- a** Employers are asked to purchase equipment items when:
- the employer needs to provide it under the Health and Safety in Employment Act 1992. We won't contribute to work items, clothing or equipment required under this Act, and this should be checked by the client services staff when the request is made
 - the item is standard work-related equipment that the employer would provide for any employee, such as a computer. We can provide any modifications or software required to meet the client's injury-related needs.

3.0 Should ACC contribute to the cost of the equipment?

- a** We may contribute to the purchase of an equipment item if the item is required as a result of a covered claim but is likely to benefit both the employee (client) and the employer. In this instance it is appropriate to ask the employer whether they will provide the item or contribute towards the purchase of the item.

The employer is responsible for finding and purchasing the equipment through their normal channels, with assistance from the assessor if necessary.

The Recovery Team member:

- negotiates the amount of ACC's contribution to the purchase price with the employer
- sets up the employer as a non-contracted supplier in MFP
- enters a purchase approval for the negotiated amount using service item code EV01.

We reimburse the employer for the agreed portion of the cost when an invoice is received. The employer owns the equipment and the client is not able to take the item to another work site without the employer's agreement.

4.0 Providing ACC funded vocational equipment

- a** If the equipment item is required as a result of a covered claim and will provide no additional benefit to the employer, we can fund the full cost of the item.

See Assessment and equipment ordering to source the equipment item.

The vocational rehabilitation assessor is then responsible for setting up the equipment for the client. This activity is included in the package price for the service.

Please note that vocational rehabilitation equipment cannot be trialed.

- b** Height Adjustable Desks - Sit to Stand Desks: The Clinical and Technical teams have provided a joint guidance document, linked below.

- Assessment and Equipment Ordering Service Page
- Height adjustable desk / Sit-stand desks requests guide

Vocational Rehabilitation Needs Assessment (IOA/IMA) Policy v12.0



Summary

Objective

This policy defines the assessments required when assessing the vocational rehabilitation needs of a client. Use this policy to understand:

1. Eligibility criteria
2. Initial Occupational Assessment (IOA)
3. Initial Medical Assessment (IMA)
4. When to refer for IOA/IMA
5. Legislation References

Background

ACC is required to determine the vocational rehabilitation (VR) needs of a client before providing the client with the appropriate vocational rehabilitation. There are two assessments used to assess a client's needs, the initial occupational assessment and the initial medical assessment. These assessments are completed together and help establish suitable and sustainable work options that vocational rehabilitation can be targeted towards.

Owner

[Out of Scope]

Expert

Policy

1.0 Eligibility Criteria

- a** To be eligible for referral for an IOA and IMA the client must be:
- entitled to receive VR assistance
 - unlikely to maintain their current employment; or
 - unlikely to regain fitness for their pre-injury employment
 - have completed an IOA (prior to the IMA)

2.0 Initial Occupational Assessment (IOA)

- a** An IOA is undertaken by an occupational assessor (vocational or career's consultant) who will identify the types of work that may be appropriate for the client based on their skills, education, and experience. This is not a medical assessment and effects of the client's injury are not taken into account during this assessment.

The assessment will also identify:

- the client's vocational needs and any vocational barriers to them returning to work or achieving work readiness
- vocational rehabilitation likely to assist the client to return to work or achieve work readiness for the identified work types
- any additional steps the client could take to return to work or achieve work readiness for the identified work types

3.0 Requirements when making an IOA referral

- a** When referring the client for an IOA you should:
- Tell the client:
 - about the assessment
 - that we will provide their pre-incapacity earnings to the occupational assessor
 - that they're entitled to bring a support person or persons to the assessment
 - provide all the IOA related information to the assessor, including the client's employment history, occupational reports and pre-incapacity earnings (do not include medical information as it is not relevant for the IOA)
 - tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
 - take all reasonable steps to safeguard the assessor, such as providing a security service if needed
 - record the agreement to undertake an IOA, and its purpose, on the client's Recovery Plan (RP) / Individual Rehabilitation Plan (IRP)

4.0 Information covered in the assessment

- a** We must ensure that the IOA report meets our criteria and quality standards. The IOA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the IOA report from the assessor.

 IOA Report Evaluation Checklist

5.0 Work types – what's a reasonable number?

- a** In most situations, 8-12 work type detail sheets are reasonable for an IOA.

To have an excessive number of similar work types in an IOA doesn't influence the VR provided or whether a client will eventually be found vocationally independent.

6.0 Initial Medical Assessment (IMA)

- a** An IMA is undertaken by a medical assessor (occupational physician) to determine whether the types of work identified in the IOA are, or are likely to be, medically sustainable for a client taking into account the effects of their injuries.

An IMA should also identify:

- any recommended rehabilitation or treatment the client needs to help them return to work or achieve work readiness
- if it is indicated that regaining fitness for the pre-injury role is achievable

7.0 Requirements for IMA Referrals

a When referring the client for an IMA you should:

- Tell the client:
 - about the assessment
 - that they're entitled to bring a support person or persons to the assessment
- provide all the related information to the assessor, including the IOA and medical, rehabilitation and vocational reports
- tell the assessor about any behaviour that could indicate risk, including any potential for the client to become aggressive or violent
- take all reasonable steps to safeguard the assessor, such as providing a security service if needed
- record the agreement to undertake an IMA, and its purpose, on the client's Recovery Plan (RP) / Individual Rehabilitation Plan (IRP).

- 📄 Accident Compensation Act 2001, Section 93 - Medical assessor
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 94 - Assessments when medical assessor unavailable
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 95 - Conduct of initial medical assessment
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 96 - Report on initial medical assessment
<http://legislation.govt.nz/act/public/2001/0049/latest/D>

8.0 Information covered in the assessment

a We must ensure that the IMA report meets our criteria and quality standards. The IMA evaluation checklist provides a checklist of these standards and should be used to confirm these have been met before accepting the IMA report from the assessor.

📄 IMA Report Evaluation Checklist

9.0 When to refer for an IOA and IMA

a When there is information to indicate that the client may not regain fitness, or sustain, the employment they held at the time of their injury, consideration should be given to assessment of their vocational rehabilitation needs via an IOA and IMA.

📄 Guidelines for when to refer for the IOA and IMA

b If the decision is made to refer the client for these assessments, the client's circumstances should be taken into consideration when scheduling the assessments.

NOTE Examples

A client has recently begun treatment for significant PTSD symptoms. Check with the treating provider when it would be appropriate for the client to engage with an IOA assessor to discuss future vocational options.

A client has surgery scheduled in the near future. The IMA assessment should be scheduled following adequate recovery from surgery.

10.0 Links to Legislation

- 📄 Accident Compensation Act 2001, Section 89 - Assessment of claimant's vocational rehabilitation needs
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 90 - Occupational assessor
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 91 - Conduct of initial occupational assessment
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
- 📄 Accident Compensation Act 2001, Section 92 - Report on initial occupational assessment
<http://legislation.govt.nz/act/public/2001/0049/latest/D>



Summary

Objective

A Vocational Rehabilitation Review (VRR) is a brief clinical assessment to assist people returning to work following an injury.

Owner

[Out of Scope]

Expert



Procedure

1.0 Who is the VRR for?

- a** The VRR service is designed for anyone who is currently receiving a Stay at Work (SAW), Back to Work (BTW) or Pathways to Employment (PTE) service and medical aspects of 'fitness for work' are unclear, or rehabilitation has stalled. It is designed to be readily available and easy to access for case owners, vocational rehabilitation providers and GPs.

2.0 When to refer for a VRR?

- a** Use this service when you need an expert clinical opinion and recommendations from a medical specialist on the client's fitness for work, medical certification and/or their ability to participate in a Vocational Rehabilitation Service (VOC) programme.
The VRR can be done at any point in the client's vocational rehabilitation (up until they begin Vocational Independence Assessments).

Consider referring for a VRR when:

- momentum and confidence in the rehabilitation process has been lost
- there is a difference of opinion between the VOC provider and GP that is impacting a proposed return to work plan
- a clearly defined medical opinion on fitness for work is required
- a client doesn't have a GP and needs medical clearance to undertake a return to work programme with a VRS provider
- the client fears re-injury or pain when undertaking extended duties
- the client is experiencing an increase in pain during a work trial and it is unsure if it is safe
- the employer is reluctant to extend the client's duties in case they aggravate their injury
- medical leadership is required to restore a team approach.

3.0 How can someone be referred for a VRR?

- a** If the case owner identifies a need for a VRR, then
 - the case owner sends a referral to the VRR provider
 - the case owner should inform the VOC provider and GP of the referral

If the GP identifies a need for a VRR, then the GP requests a VRR by either:

- phoning the case owner
- ticking the relevant option on the eACC18 Medical certificate. The case owner then makes the referral on their behalf
- Contacts the VRR provider directly and requests an appointment

If the VOC provider identifies a need for a VRR, then if the client has previously had:

- fewer than 3 VRRs, the VOC provider can make a direct referral to the VRR provider using the ACC6245 provider referral form (no purchase order required). They must let the client's case owner and GP know.
- 3 or more VRRs, the VOC provider must contact the case owner to request approval before sending the referral.

ACC6245 Provider referral for Vocational Rehabilitation Review

- b** When ACC is making a referral for a VRR, the case owner should first contract the client to explain the review and discuss the benefits. Use the VMS centralised booking system to allocate an appointment time.

VMS Centralised SharePoint Booking System Service Page

- c** Create a purchase order in Eos (using VMR01 or VMR05) and generate and complete an ACC98 Referral form and send to the VRR provider with the appropriate referral documents

ACC98 ACC referral for Vocational Services

- d** Prepare a VR11 Vocational rehabilitation review appointment - client letter and send it to the client, with a VOCIS131 Vocational rehabilitation review - client information sheet if needed.

Email or phone the client's VOC provider, GP and employer (if consent given) and let them know of the assessment. Alternatively you can send the following letters:

- VR12 Vocational rehabilitation review notification – employer
- VR13 Vocational rehabilitation review notification – GP, with a VOCIS132 GP information sheet if needed

NOTE Standard or Complex Referral:

Always refer for standard referral unless your client meets one of the following criteria:

- a client who is unable to return to their pre-injury role
- a client whose case relates to a Serious Injury
- a client who has a covered Sensitive Injury claim
- where the covered injury is for a moderate to severe traumatic brain injury
- where the claim is older than 6 months at the time of the referral

NOTE Your client has had more than 3 VRR?

If a VRS provider has requested prior approval for a VRR referral, then within 48 hours:

- check Eos to confirm the number of previous VRR services the client has had
- consult with the clinical advisors as necessary
- discuss the request with the referrer and the client
- make a decision to approve or decline the request.

If you decide to approve the request, create a purchase order in Eos (using VMR01 or VMR05) and select 'Authorise PO'. If the VOC provider is the referrer, email the PO number to the requestor and let them know you've approved the request.

- If you decide to decline the purchase order:
- create a purchase order in Eos and select 'Decline PO'
 - generate and send the following decline letters:
 - VR14 Additional vocational rehabilitation review - decline – client
 - VR15 Additional Vocational rehabilitation review - decline - GP

NOTE Alternative services to consider

For clients with complex diagnostic issues, consider Medical Case Review or Single Discipline Assessment.

NOTE Can VRR assessments be completed via telehealth?

Yes, VRR assessments are telehealth enabled-where clinically appropriate. Telehealth may not be the best option for some clients and there will be some instances where VRR assessments need to be completed in person.



PROCESS

Arrange Vocational Rehabilitation Review Assessment

4.0 What should you expect from the VRR?

- a** The medical assessor will conduct a brief clinical examination of the client and provide their opinion and recommendations, focussing on the client's fitness for work. You should expect:
 - brief face-to-face assessment with very rapid turn-around time
 - determine restrictions and fitness for work relating to the covered injury and/or other conditions
 - explain to the client their current condition, injury recovery process and fitness for work
 - provide the next rehabilitation steps (the service should complement the VRS being provided)
 - identifying any other factors affecting recovery
 - the assessor will clarify the diagnosis. However, the service is not designed for clients with complex diagnostic issues.
- b** Following the VRR, the provider will complete a short report. The provider will also:
 - communicate with GP - discussing the diagnosis, injury management, barriers to rehabilitation, and fitness for work recommendations
 - communicate with other treatment providers and VOC provider to discuss and seek support for recommendations
 - communicate with the Client's employer (where applicable) to discuss current restrictions, timelines for recovery, and to facilitate safe and durable vocational rehabilitation
 - communicate with the Client's Case Owner.
- c** The case owner will need to add to the purchase order the VMR02 service code to cover the time taken for the VRR provider to communicate their recommendations with each party.

5.0 Useful Information and tips

NOTE Timeframes

If the service has been initiated during VR, then the VRR component must end before the client enters the Vocational Independence process. No further assistance can be offered past this point as this may be perceived as providing on-going rehabilitation.

Summary

Objective

Vocational Rehabilitation Services (VOC) is a range of services that are designed to assist a client to return to work or where this is not possible, prepare the client for employment.

Owner

[Out of Scope]

Expert

Procedure

1.0 Overview of the different Vocational Rehabilitation Services (VOC)

- a** Vocational Rehabilitation consist of the following services:
 - Standalone Workplace Assessment – assesses the demands of a client's pre-injury job
 - Stay at Work (SAW) Service – supports clients to return to their pre-injury job
 - Back to Work (BTW) Service – supports clients who are no longer employed to become work ready
 - Pathways to Employment (PTE) – support clients who have complex needs (Usually only partnered recovery).
 - Job Search service – offered to clients to support them to find employment when they are assessed as vocationally independent.

2.0 Key principles of VRS

- a** • Rehabilitation and recovery are best achieved at work.
 - Early intervention leads to faster recovery. Services are provided with urgency and intensity to achieve optimal rehabilitation outcomes.
 - Services delivered are flexible and can be tailored to meet the individual needs of each client. Identification and removal of barriers to return to work is essential. In more complex cases, providers use a team to delivery services.
 - Recovery team members use a collaborative approach that involves the vocational rehabilitation provider, the employer, medical practitioner and any other treating health provider. Good communication between ACC, providers, employer, GP and the client are a cornerstone to working collaboratively towards agreed outcomes.
 - Services are "outcomes based". It is vital that all treatment and rehabilitation efforts are targeted towards functional outcomes which return to the client to employment or independence.

3.0 Who is the service for?

- a** Most clients can return to work without being referred to Vocational Rehabilitation. In these cases, the recovery team members takes responsibility for liaising with the client, employer and other providers to assist the client to return to work.

However, we can consider providing vocational rehabilitation to any client who has a covered personal injury and is either:

- entitled to weekly compensation or Loss of Potential Earnings (LOPE)
- likely to be entitled to weekly compensation if we don't provide vocational assistance
- no longer entitled to weekly compensation because they've reached the NZ Superannuation Qualifying Age (NZSQA)
- on parental leave.

This is determined by ACC as requiring a vocational rehabilitation service in order to achieve a specific agreed outcome.

We must consider vocational rehabilitation as soon as we decide that a client is likely to be eligible. If a client needs the support, we can provide vocational rehabilitation until the client achieves their vocational outcome eg returns to their pre-injury role.

If the client is not eligible for weekly compensation, and does not meet the above criteria, the client is not eligible for vocational rehabilitation. You can consider referring the client under other services, such as the Training for Independence contract to address their rehabilitation needs, as appropriate.




 [About Vocational Rehabilitation \(VR\) Policy](#)

4.0 Who is involved in providing Vocational Rehabilitation?

- a** Vocational rehabilitation suppliers can use a range of different health or non-health professionals to deliver Vocational Rehabilitation. The wider team includes the certifying medical practitioner, the treating health provider, employer, ACC and any other rehabilitation providers. The supplier's team may consist of the following professionals:
 - occupational therapist
 - physiotherapist
 - registered nurse
 - medical practitioner
 - psychologist
 - social worker
 - career practitioner
 - vocational counsellor
 - recruitment consultant.

- b** Roles and responsibilities of the vocational rehabilitation team:
- Client: is responsible for their own rehabilitation, required to participate.
 - Employer: provides flexibility in terms of modified duties and work hours.
 - Treating provider (GP, physio etc): provides treatment and participating in and supporting the return to work plan.
 - ACC recovery team member: coordinates the overall management of the client's rehabilitation and managing entitlements.
 - Vocational rehabilitation provider: develops a return to work plan in coordination with other members of the team, providing advice on how to achieve the return to work, the benefits of work and facilitating any equipment, modifications and other treatment if required. Vocational rehabilitation providers are expected to build capacity in the client to enable them to manage their own ongoing recovery in the workplace.


5.0 What VRS should you refer for and when?

- a** Every client is different and we need to take into consideration their individual circumstances and injury related needs when deciding on when to refer for Vocational Rehabilitation Services. Consider the following:
- the client's injury, their current symptoms and the demands of their role
 - upcoming treatment such as surgery
 - the client employment eg size of employer, environment, client's job security etc
 - psychosocial factors eg motivation to return to work, fear avoidance etc
 - the client's cultural needs such as Rongoā, the Client may need to address these before commencing vocational rehabilitation
 - not all clients require vocational rehabilitation and we should initially give our clients a chance to recover on their own.
- b**
- If your client is returning to the same type of employment with their same employer use the SAW service.
 - If your client is returning to a temporarily modified job with their current employer use the SAW service.
 - If your client is returning to a different type of employment with their same/previous employer use the SAW service.
 - If your client is returning to the same type of employment with a different employer use the BTW service.
 - If your client is using as many of their pre-injury skills as possible to get employment use the BTW service
 - If your client has complex needs and will require specialised input to achieve one or more of the above outcomes, use the PTE service.
- If your client is using as many of their pre-injury skills as possible to get employment use the BTW service.
-  Stay At Work (SAW) Service Page
 -  Back To Work (BTW) Services Service Page
 -  Pathways to Employment [PTE] Service Page

6.0 Alternative and related services

- a** Clients can and often must participate in other services while receiving vocational rehabilitation. Providers will liaise with the other service providers and ACC to ensure that the client receives consistent messages about their rehabilitation.
- Listen to the client and their treatment providers to understand if the client needs additional rehabilitation or treatment. If they do, arrange this at the same time as the vocational rehabilitation.
 - If the client is having difficulty managing pain and scores more than 50 on the Orebro, then consider pain management services, but only if the vocational rehab provider agrees this is required.
 - If the client needs help at home due to their injury, then consider social rehabilitation assessments, home help, equipment or training for independence programmes.
 - If the client needs other treatment related to their injury continue to fund other treatment that is required because of the injury, eg surgery, physiotherapy etc.
 - If the client has complex issues that are affecting their return to work, consider the other vocational medical services eg Vocational Rehabilitation Review (VRR) in consultation with the vocation rehab provider.
 - If the client may not return to their pre-injury role, consider referring for an IOA and IMA.

 Vocational Independence Journey

 Vocational Medical Services Overview (VMS) Service Page

- b** Where a client has suffered a mild to moderate traumatic brain injury, the Concussion Service is the lead provider until the client's cognitive symptoms have improved and it is determined that the client is medically able to participate in vocational rehabilitation. You should delay referral to Vocational Rehabilitation Services [VOC] until the Concussion Service Supplier identifies that the client is ready.

7.0 Travel Costs

- a** There are travel codes available in the VOC contract for certain services (VRTD5 and VRTT2), but Recovery Team Members do not need to add these to Purchase Orders. 'Contribution to Exceptional Travel Time and Distance' is done automatically if the round trip of a worksite visit exceeds 150km.

We trust our suppliers to use the closest available provider to the client and to proportion their travel costs when seeing multiple clients. If you have concerns, talk to your supplier to discuss the circumstances.

8.0 VRS related content

 ACC98 ACC referral for Vocational Services

- a** The service schedule and operational guidelines for the Vocational Rehabilitation Services [VOC] contract are available on <https://www.acc.co.nz/resources/#/>
-  Standalone Workplace Assessment Service Page
 -  Job Search Service Page
 -  VOC - Vocational Rehabilitation Service Schedule
 -  VOC - Vocational Rehabilitation Operational Guidelines

Summary

Objective

FOR THE PROCESS REGARDING INFORMATION REQUESTS PLEASE SEE THE PROCESS PAGE HERE:
<https://au.promapp.com/accnz/process?processuniqueid=3ceabd17-816e-4b7f-b759-c0722927a50f>

A request for personal information may result from one of the following processes:

- Complete client information requests
- Respond to a private insurer request for client information
- Receive, Log and Allocate Review Application
- Filing an appeal.

Client Information Requests (CIR) main objective is to collate information and prevent privacy breaches

CIR will prepare the Information request, if the request meets the CIR criteria below. In rare cases, a request for a full client copy file may require an email sweep, call recordings or footprint report.

Owner

Expert

[Out of Scope]

Policy

1.0 Rules

- a** The CIR (Client Information Requests team) is responsible for collating, privacy checking and dispatching the information request. See the 'Complete Client Information Requests' process.
- b** The request for information must be responded to within 20 working days after receiving the request.

PROCESS

Complete Client Information Requests

2.0 Privacy checks

- a** CIR are responsible for privacy checking all files to be released. If needed, secondary privacy checks may be requested at any time
- b** Existing full copies of a claim, that have already been privacy checked by CIR, can be reused for new requests. CIR only need to privacy check the new documents added to the file since the last release.

3.0 Notifications

a In the instance that:


- A Privacy Act or Appeal request is received
- It is also a full copy of a claim
- It also has a case owner


CIR will send a notification task to that case owner. This is to obtain any details about documents which the case owner feels should be secured or not released. On rare occasions, this may include documents that should not be disclosed to protect client safety. Any details about documents which the case owner/review owner feels should be secured or not released should be detailed in an email to the claims officer in CIR who is processing the request.

4.0 Securing documents

a CIR will review and secure any documents which are legally privileged before releasing the file.

See Information requests and legal professional privilege and Requests for personal information.

 Secure a document

 Information requests and legal professional privilege

5.0 Information Request Criteria

a Scoping

A request may meet CIR criteria if it's for a full or partial copy of a claim file (may include multiple claims) needed for either:

- a personal information request from the client or their authorised representative or advocate
- a formal review lodged by the Review Unit
- a statutory appeal lodged by ACC Legal Services
- a Third-Party Administrator (TPA) or Insurance request under the Official Information Act (OIA)

The following is not an exhaustive list of tasks which are in/out of scope, but it details the most common ones.

b In Scope:

- Requests under the Privacy Act for client files from the client or an authorised advocate
- Reviews/Appeals
- Insurance requests made under the OIA
- International lawyers not working for the client
- Most partial files
- TPA reviews and appeals if the file has been handed back to ACC OR if the decision being reviewed was made by ACC
- TPA requests for additional claim files
- Call recordings
- Email Sweeps
- Footprint Reports
- Disclosure of sensitive documents

C Out of Scope

- Requests for a single document to be emailed (excluding sensitive documents)
- Requests which are just for a Schedule of Injuries
- TPA reviews and appeals where the file is still held by the TPA or where the decision itself was made by the TPA
- Provider requests
- Requests for information from government third parties such as MSD and IRD.
- Question-based requests with no accompanying file request
- Employer requests for information
- Employer reviews

There may be circumstances where a request that is usually 'out of scope' will be dealt with by CIR. This will be determined by a Team Leader.

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

Contact the CIR team on DSCCIT@acc.co.nz or by calling [s 9\(2\)\(a\)](#)

6.0 Preparing personal information requests

- a** A request for personal information must be from an authorised person but does not need to be in writing.
- b** CIR has 20 working days from the date of the original request to prepare the information. For this reason, information request should be transferred to CIR as soon as possible.

If an extension is needed CIR must send an extension letter to the requestor to let them know the number of days extended and are required to do this before the expiry of the 20 working days.

-  Personal Information Requests Policy
-  Privacy Check Before Disclosing Information Policy

7.0 Providing the information request

- a** Password protected PDF
 - The information may be provided as a password-protected PDF or WinZip via Email to a verified email address
 - The information may be provided as a USB or CD which may then be couriered or posted.
- b** Printed Copy
 - If the requestor requires a printed copy of their file, CIR prefer them or their advocate to collect it from their local ACC branch/ hub.
 - If the requestor wants us to courier the information to them, they must confirm they accept the courier risks detailed in the ACC6181 Receiving personal information by courier information sheet.
- c** Any questions following release of information should be forwarded to the review owner, case manager, or assisted recovery in the first instance.

NOTE If the request is sent to the branch, how long is this kept before being destroyed?

- The client should be notified when the information arrives at the branch.
- If contacting by email or post the decision a copy of the decision letter should be attached.
- This should be followed up 3 times over a 2 month period.
- The final follow up should be written (verified email or post) if appropriate. This communication should mention that the information will be disposed of if contact is not made, and the timeframe for disposal to be at the end of the third month ensuring this leave adequate time for the client to reply.
- If the client makes contact after the information has been disposed of, contact the CIR team. The information can be reprinted and resent to the branch by the CIR team.

8.0 Preparing copy files for reviews

a Review owner responsibilities

The review owner is responsible for:

- Checking documents for relevance
- Creating the VCF Bulk Print for the relevant documents
- Providing the Review Number, File Name, File Type (Basic PCF, Relevant Documents, or Full File), Review Provider, Recipients, and the Recipients preferred dispatch method in the Task sent to CIR

b Client Information Requests responsibilities

CIR is responsible for:

- Collating the relevant documents (and full copy if requested)
- If the request is for a full copy of a claim, CIR will review and secure any documents that are legally privileged before releasing the file referring to the instructions found in securing documents in Eos
- Privacy checking and transferring the copy to the reviewer (Fairway, ICRA, or TMR) within 20 working days of receiving the review application
- If an extension is required, CIR must make the review specialist aware of the number of days required for extension

NOTE Communicating with review applicants

The relationship with the review applicant is between the review owner and the applicant. Therefore any communication needed should go through the review owner.

9.0 Preparing copy files for appeals

a Appellant Copy

- CIR are not required to provide an Appeal file to the appellant unless they request one.

b Timeframes

- CIR must provide the file within 15 working days of receiving the request.
- If an extension is required, CIR must notify Legal Services as soon as possible with the number of days required for extension

- c** Judge and ACC Counsel files
 - CIR must provide two copies of the file for the appeal, one for the Judge (Court) and one for ACC's Legal Counsel.
 - The two files must be identical, except for legally privileged documents.
 - The Judge's file must not include any legally privileged documents
 - ACC's Legal Counsel file must include all documents, including legally privileged.
- d** Legal Services Responsibilities
 - Legal Services are responsible for couriering the Judge's files to the Court.
 - CIR must not send files directly to the Court.
- b** Contact
 - CIR staff (including those using RCU pseudonyms) are not allowed to contact the RCU clients.
 - Any contact must be completed by the RCU case owner
- c** Privacy Checking
 - CIR staff can look at the claim on Eos and open documents, but must not change anything
- d** Delivery
 - Privacy Act Requests must be sent to the Justice Centre
 - Reviews and Appeals must be sent to Legal Services

10.0 Official information Act Requests

- a** Client Information Requests responsibilities
 - CIR will take all possible measures to contact the client to ensure they consent the exact request.
 - If unable to contact the client, CIR are still able to release the information to the Insurer or Third Party due to the consent form.

11.0 International requests

- a** In Scope:
 - Request by client living internationally
 - Request by client's international advocate or lawyer
 - Request by an international party not acting on behalf of the client (e.g. a lawyer acting on behalf of an international insurer)
- b** Requestor Policies

CIR can action requests made by:

 - a lawyer from a country with comparable Privacy legislation (e.g. Australia)
 - a non-professional advocate, with ATA form, on behalf of a client

If the request is not from a party that directly acts for a client, CIR require:

- a signed authority/consent form for these requests
- consent directly from the client or their counsel to disclose information to the requestor in addition to the authority form provided by the requestor

12.0 Prison Requests

- a** CIR must contact the client to confirm the request, inform them that it needs to be sent as paper, and there are no guarantees that the file will not be opened by the prison.

13.0 Remote Claim Unit (RCU) Requests

- a** Pseudonyms
 - CIR have been given pseudonyms that can be used on RCU claims.
 - CIR will do all the admin on the claims



Summary

Objective

As all client emails should already be on the client's claim file, when a client asks for a copy of all the emails we hold about them we'll provide them with a full client copy file. In rare cases we may need to check other systems to verify that all emails about the client have been uploaded correctly to their file. This check is called an email sweep or an IT sweep.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules


- a** A request for client emails is a request for personal information under the Privacy Act 2020 and the same rules and timeframes apply when you respond to these requests.

A request for client emails must be initiated by the client, their representative or advocate. It does not need to be in writing. You must consider each request on a case-by-case basis.

Email sweeps search for information held by ACC in our Outlook email accounts, including emails that are archived.

The Client Information Request (CIR) teams are responsible for running email sweeps. A 'Complete Request for copy of clients information' task must be sent for claim related email sweeps based on criteria below.


The CIR will not run sweeps for emails that aren't claim related, eg emails relating to ACC staff, client complaints, investigations, levies. These requests must be sent to HR help.

 Complete Client Information request

2.0 Criteria for email sweeps

- a** The client must have a specific reason for requesting the emails, eg they must specify that we haven't provided all the emails they think we should hold about them or ask us for specific emails that we haven't provided.

The request must also meet other CIR criteria.

 Requests for full client copy files
<https://go.promapp.com/accnz/Process/3b1cb87c-a4>

3.0 What we'll provide

- a** In response to a request for a copy of a client's emails we will:

- provide a copy of either:
 - a full client copy file, which includes the relevant emails
 - a full client copy file and the email sweep results
 - email sweep results only, if a full client copy file has recently been provided.
- only provide email sweep results that meet the agreed search parameters
- provide the information either on a password protected computer disk or as a printed file.

only consider restoring archived emails from backup tapes if specifically requested.

 Privacy check before disclosing information

4.0 Attachments

- a** We won't release attachments found in email sweep search results as all claim related information and documents should be on the claim or party record.

However, if an attachment is obviously missing from the record the CIR team leader must follow up with the case owner or relevant business unit.

5.0 Privacy checks

- a** You must privacy check the relevant emails before providing a copy to the client. The CIR team is responsible for:
 - ensuring that all the emails we provide relate to the correct client and claim
 - identifying and removing emails that aren't relevant to the request
 - removing details about other clients or information that is subject to legal privilege or can't be disclosed for other reasons.

Always use an ACC6173 Information disclosure checklist when doing the privacy check.

If needed, a team leader or manager may request a second privacy check.

If you identify any potential issues in the emails, we must still provide the information to the requestor but we may need an extension of time.

6.0 Email sweep results

- a** You must load email sweep results onto the client file as a single pdf document. Do not upload emails individually.



Summary

Objective

ACC's Digital & Channel Operations record some phone conversations between ACC staff members and external parties. We do this for training purposes. All recordings are held for a short time in a system called NICE. We refer to these as call recordings.

Owner

[Out of Scope]

Expert

Policy

1.0 Requests for call recordings

- a** The information in call recordings can be requested under the Privacy Act 2020 or the Official Information Act 1982.

If the person requesting the call was a participant in the call OR the call was about them then this will be a Privacy Act request. Continue to step b.

If the person is requesting access to a call recording about another person, these requests are considered under the Official Information Act, not the Privacy Act. Ordinarily these requests are declined under section 9(2)(a), that withholding the call is necessary to protect the privacy of the parties to the call, however contact the OIA team at governmentservices@acc.co.nz for support when dealing with these requests.

- b** We can offer the requestor:
 - a copy of the recording
 - an opportunity to come to the office and listen to the recording.
 - an excerpt or a summary of the contents.

S56 of the Privacy Act sets out the ways in which personal information may be made available. For support, contact the Privacy Team on 04 816 6464 or privacy.officer@acc.co.nz.

- c** We cannot provide transcripts of call recordings as we don't have the technology to do this for client and customer calls. Please contact the Privacy Team for advice if you receive a request for a call recording transcript.
- d** Before releasing a call recording you must ensure you've identified the correct requested call(s) and completed a privacy check and an ACC6176 Checklist for releasing telephone recordings.

- Personal Information Requests Policy
- Complete Client Information request
- ACC6176 Checklist for releasing call recording(s)

2.0 How to provide a call recording

- a** Call recordings should be requested from the Customer Contact Technology Team (telephony.support@acc.co.nz) as soon as the request is received. If the request for call recording related to a client information request / Privacy Act request you should include the Client Information Request team (DSCCIT@acc.co.nz) in the email who action these types of request.

NOTE Why should you request the recording of the call as soon as possible?

Call recordings are only held for a set amount of time. It is important to let the team know ASAP so that they can prevent destruction of the call recording.

It is an offence under the Privacy Act to destroy information knowing that a request has been made for that information.

- Customer Contact Technology Team
- b** Follow instructions on the complete client information request page
 - Complete Client Information requests
- c** If we provide the call recording we'll usually provide the full recording as a password protected sound file on a computer disk. If needed we may provide an unprotected sound file on an audio CD, or by email if requested. The Client Information Request (CIR) team manage the release of this information.

Where we can't provide the full call recording, eg because it includes information about other people or information that we can't disclose, we'll supply written summary. In some cases, it may be possible to extract a copy of the relevant segment of a call recording.

3.0 Unprotected call recordings

- a** An unprotected call recording is similar to a printed copy of someone's personal information. If you're asked to supply an unprotected file you must let the requestor know the risks of sending unprotected information by courier or email. See the ACC6181 Receiving information by courier information sheet and Risks associated with email communication.

- ACC6181 Receiving personal information by courier
- Risks associated with email communication policy

4.0 What if the call wasn't recorded or has been deleted?

- a** Not all calls are recorded, and those that are recorded are deleted after they are no longer needed for training purposes. The current timeframe for retaining contact centre calls is 90 days and the current timeframe for retaining recovery team and other service delivery calls is 14 days.
- b** If a particular call was requested but never recorded, or if it has been deleted, we will need to decline the request under 53(a) of the Privacy Act. Use option 6 of the INP07 template.
- c** Although we cannot provide them with a call recordings, we should have a contact note on Eos. You must offer to provide them with this contact note instead.

- INP07
- Personal information request policy

Summary

Objective

Any person who is party to a court case may ask the court registrar to issue a witness summons for a person to:

- attend the hearing and give oral evidence
- produce any document that person has or has authority over, relating to the case.

As an ACC staff member, you can be summonsed to attend court as a witness in matters relating to ACC clients. This will most usually happen in a criminal prosecution against an alleged sex offender when the prosecution or defence want access to ACC sensitive claim file records.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** If you receive a witness summons:
- contact your team manager or branch manager for advice
 - you must attend the court case you've received the summons for. Failure to attend is illegal and you can be fined for not showing up.

If it's difficult for you to attend the court case, you must advise the court registrar in writing, even if you've already told them over the phone. Contact details for the relevant registrar's office are printed on the summons document.

2.0 Witness leave

- a** You must notify your manager as soon as possible when you receive a witness summons.

Cost centre managers must always approve witness leave.

When on witness leave, you must attend work during the times you're not required at the hearing, unless you've gained prior approval to not attend work from your manager.

3.0 Payment for witness leave

- a** If you attend a court or tribunal hearing as a witness you're entitled to leave on full pay, without prejudicing your other paid leave entitlements, eg annual leave.

If you're acting as a witness ...	then you're also entitled to...
on behalf of ACC	actual and reasonable expenses from ACC incurred as a result of being a witness
for other reasons	retain any additional expense reimbursement offered to you for that service

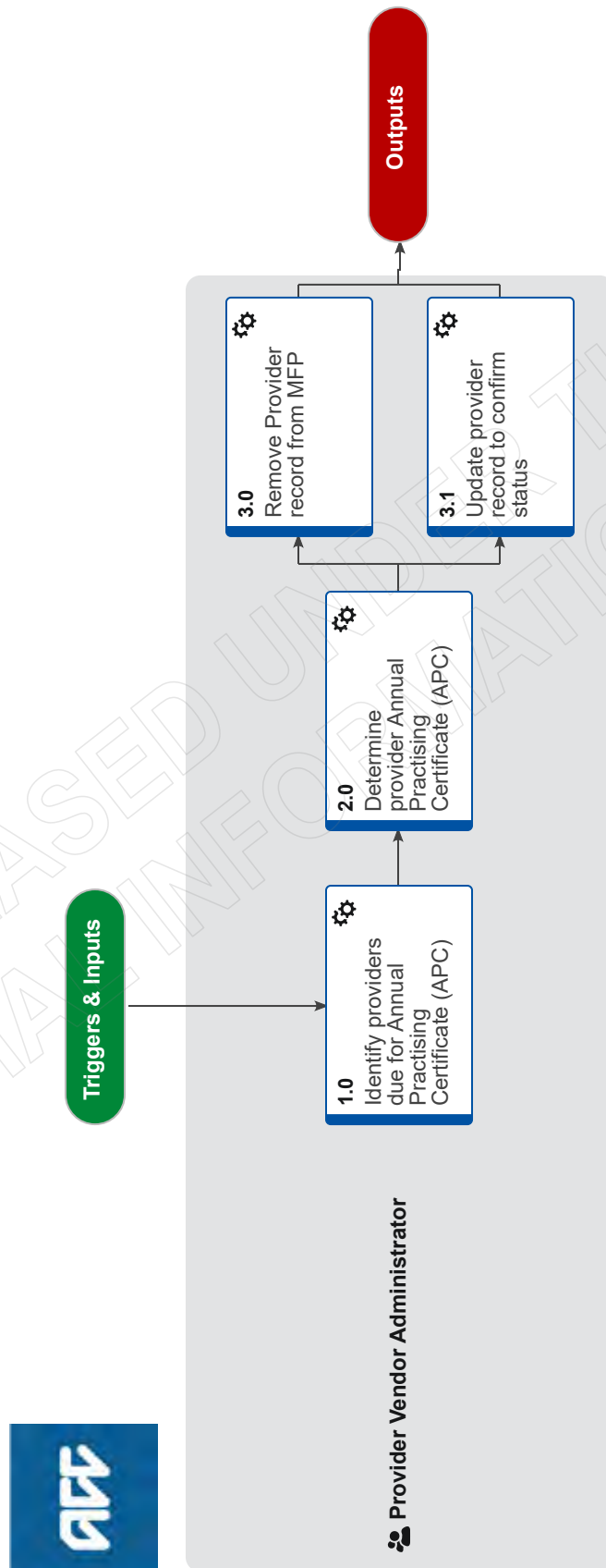


Payment for witness leave.PNG

4.0 More information

- a** You can get a copy of the Dealing with a Witness Summons leaflet from your team manager (TM) or branch manager (BM).

TMs and BMs can contact the Manager Litigation in the General Counsel team for further information.



Summary

Objective

The objective of this process is to:

- identify providers whose annual practising certificate (APC) needs renewing
- confirm a provider's current status with the relevant registration authority
- update a provider's status in Medical Fees Processing (MFP)
- identify Rongoā Providers whose annual declaration needs renewing

Before you begin:

APCs are not current when a provider:

- isn't practising anymore
- hasn't renewed their certificate
- is overseas
- is deceased
- is on maternity leave

Rongoā Providers annual declarations:

- all expire on 30 September each year
- communicated by email confirmation from Portfolio Manager on status of Rongoā Providers

Background

ACC registered Providers must hold a Annual Practising Certificate (APC) with their relevant Professional Registration Authority. As APCs must be renewed annually, ACC need to review and update providers APC status each year. Different vocational classes APC's expire at different time years, eg Physio's, Chiropractors all expire 31 March each year. Rongoā Providers annual declaration expires on 30 September each year.

Exceptions:

Providers registered under the Voc Class of Assessor under Initial Occupational and Vocational Independence Occupational service contract do not require an APC

Owner

[Out of Scope]

Expert

Procedure

1.0 Identify providers due for Annual Practising Certificate (APC) expiry

Provider Vendor Administrator

- a Open the Medical Fees Processing (MFP) '6a Full provider list' report.
- b Filter the list by the provider's APC expiration date.

NOTE How do I filter the list?

- go to Data > Filter > AutoFilter. Filter the 'Provider Status' column by 'Active' only
- under 'Provider Valid To', click 'Custom'
- set parameters to cover APCs expired in the last two months.

- c Create a new spreadsheet for the relevant month and save to W:\PSD\01 Team\08 Provider Servicing\03 Performance\03 Reports\02 PVR\Databases\APC Checks

NOTE What if Provider is Rongoā and due for Rongoā Declaration Expiry

- Step 1.0b will use separate report filters for identification of Rongoā using "Provider Type"

NOTE What if Rongoā Practitioner is also registered as another Provider e.g Physio?

- Rongoā Practitioner will have two Provider IDs with separate APC expiry dates in MFP

2.0 Determine provider Annual Practising Certificate (APC) status

Provider Vendor Administrator

- a Review the responsible authority's online register to check that the provider's APC is current.

NOTE What if the responsible authority doesn't have an online register?

Email the relevant registration authority to check. If they don't respond within a week, escalate to your team manager.

NOTE What if the registration authority confirms the provider's certificate is current?

Go to Activity "Update provider record to confirm status".

NOTE What if the providers certificate is not current but the provider is continuing to practise?

- Generate an APC expired letter in MFP.
- Confirm with Team Manager what return date to put on the "APC Expired" Letter (normally 2 weeks)
- Send the APC expired letter to the provider.
- Update the 'APC expired' spreadsheet in the Provider Vendor Registration team database APC's folder.
- Record that you have sent the letter on the APC spreadsheet.
- If the provider doesn't supply an APC by the return date go to Activity "Remove provider record".
- If the provider does supply their APC by the return date, go to "Update provider record to confirm status"

NOTE What if the provider has let you know that they have an application pending?

If the provider has let you know they have an application for renewal pending or the relevant registration authority website states "working under section 30 of the Health Practitioners Competence Assurance Act", then we consider that the provider holds a current APC. Written or online confirmation from the registration board that an application is in progress is required

- Notebook in MFP
- Update the APC expiry to end of following month to recheck status of APC

 Health Practitioners Competence Assurance ACT.pdf

NOTE What if the registration authority confirms the APC isn't current?


go to "Remove provider record"

NOTE What if the provider will not be continuing to practice?

go to "Remove provider record"

NOTE What if you are unable to confirm the providers APC status?

Re-check the relevant authority's online register within two days to determine if the provider's APC is current.

 Registration Authority.docx

3.0 Remove Provider record from MFP

Provider Vendor Administrator

- a Ensure you have made every possible attempt to get confirmation from the appropriate registration authority before removing the APC status in MFP.
- b Open the providers record in Medical Fees Processing (MFP).
- c Set the provider's status to 'Removed' and select the appropriate reason

NOTE How do I determine the appropriate reason?

If the registration authority confirms the provider:

-does not hold a current Annual Practising Certificate (APC) select 'No current annual practice cert'

-is overseas select either:
-Going overseas for 3-6 months'
-Going overseas permanently'

-is not currently practising and does not have an APC select 'Not practising'

-has been struck off select 'Struck off register'

-is retired select 'Retired'

-is deceased select 'Deceased'

- d Update the MFP 'Risk management' tab and:
 - note 'zero' treatments from the date of the expiry of the current APC- leave the 'End date' blank
 - remove the electronic transaction indicator.
- e Remove the 'Annual Practice Cert' indicator tick in the 'Provider management' screen
- f Save and close the provider record.

NOTE What if there is a prompt to update the linked vendor record?

Click 'Yes' and remove the vendor record with reason "No longer dealing with this vendor"

NOTE What if the provider is a 'Named Provider' on a current contract?

Email the provider's name and contract number to Health Procurement and let them know the record has been removed because the provider has no APC.

- g Update the 'APC expired to' spreadsheet to record that you've sent the 'Annual Practising Certificate removed' letter to the provider.
This process ends.

NOTE How do I determine the action required?

To determine the action required, review the APC indicator in MFP. If the APC indicator in MFP is:

- ticked and the 'Provider valid to' date reflects the future APC extension date, this process ends.

- ticked and the 'Provider valid to' date is the past expiry date, go to step b.

-not ticked and the 'Provider valid to' date reflects the future APC extension date, tick the APC indicator and save the change. This process ends.

d) not ticked and the 'Provider valid to' date is the past expiry date, tick the APC indicator then go to step b.

- b In MFP check for multiple records to ensure you are updating the correct one.
- c Update the 'Provider valid to' date in the 'General' tab of the 'Provider management' screen.
- d Add an MFP 'Notebook' entry showing the provider has a current APC confirmed online or in writing from the relevant registration authority.
- e Save and close the provider record. If prompted to view the linked vendor record, click No if there's been no change to details. This process ends.

3.1 Update provider record to confirm status

Provider Vendor Administrator

- a Open the provider record in Medical Fees Processing (MFP) and determine the action required.



Respond to Clarification Request from Advisor (Recovery Team Member) – System Steps

Document Purpose

This document explains the steps involved in responding to clarification requests from an Advisor.

IMPORTANT:

These steps are only to be used when Written Guidance is required and:

- The claim you need guidance for has not been migrated to Salesforce or
- You don't have access to Salesforce to use the Salesforce Written Guidance functionality

Respond to Clarification Request from Advisor – System Steps

<i>Respond to Clarification Request from Advisor – System Steps</i>	
1	<ol style="list-style-type: none">1. Open the NGCM – Clarify Written Guidance Request task2. Select the Add. Info Tab3. Review the Consolidated Analysis section to view the reason for clarification request
2	Select the Change Button
3	Tick the box to add Clarification Questions & Answers field
4	Enter your Clarifications in the Clarification Questions & Answers field Select OK to save changes
5	From the NGCM – Clarify Written Guidance Request task, select the Close Task Button (located above the Activity Details Tab)
6	<ol style="list-style-type: none">1. In the 'Choose Next Step' screen presented, select the type of Advisor who requested clarification from options:<ul style="list-style-type: none">• Clinical Clarification Provided• Technical Clarification Provided, OR• Close (if the Written Guidance is no longer required)

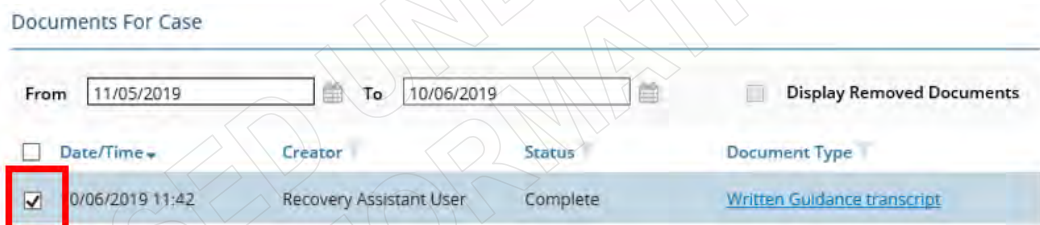
2. Select OK

NOTES:

- If the **Clinical Clarification Provided** step was selected a **NGCM – Triage Request for Clinical Guidance** task is created and automatically routed to the correct department queue. **Don't manually transfer this task.**
- If the **Technical Clarification Provided** step was selected a **NGCM – Provide Guidance** task is created and automatically routed to the correct department queue. **Don't manually transfer this task.**
- If the **Close** step was selected a **Written Guidance Transcript** is created.

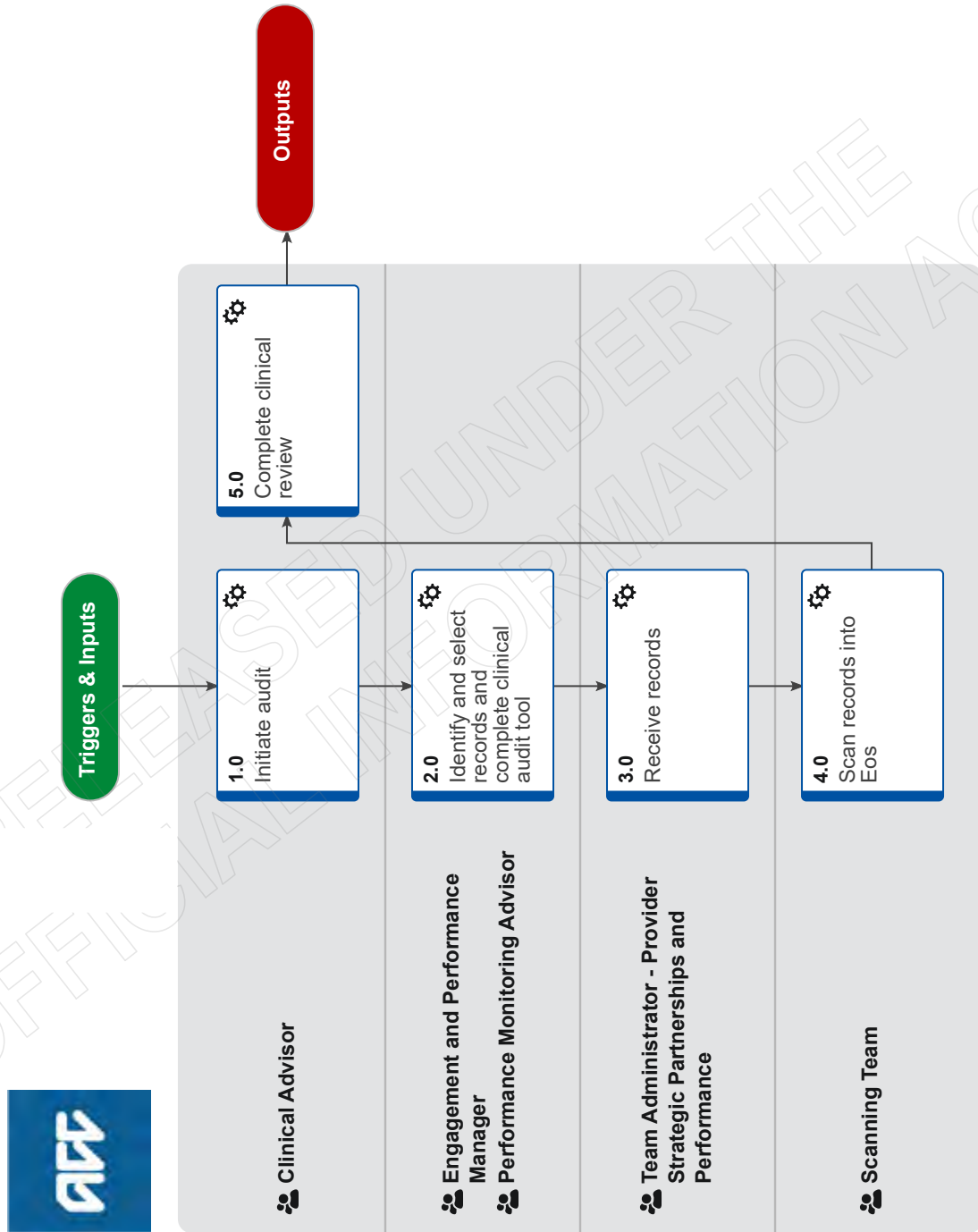
NOTE: You will need to add a description for the **Written Guidance Transcript** so it can be easily identified:

1. In the **Recovery Support** Sub-case, select the **Documents** Tab > **Documents for Claim** Sub-tab
2. Select the checkbox to the left of the **Written Guidance Transcript** document then select **Open**:



NOTE: The transcript will open in a new window

3. Select the **Properties** Button
4. In the **Document Properties** screen, **Description** field enter **Written Guidance is not required**
5. Select **OK**



Summary

Objective

This process defines the steps to take when clinical records require auditing by a clinical advisor

Owner [Out of Scope]

Expert

Procedure

1.0 Initiate audit

Clinical Advisor

- a** Contact EPM to discuss issue and sample size

2.0 Identify and select records and complete clinical audit tool

Engagement and Performance Manager, Performance Monitoring Advisor

- a** Identify claims from InFact, provider reports or integrity services
- b** Update audit tool with your name, vendor name, provider name, issue description and claim numbers and date sections (the yellow sections) for each of the sample records being requested

 4_Clinical Record Audit Toolv1.2 FINAL.xlsx


- c** Create a folder for the provider in the shared drive. Folder name should be set up as first name, space, surname (e.g. John Smith). Save the semi-completed audit template and clinical advice work request form in the folder. Use the following naming techniques to assist the admin team with their tasks
 - Audit template <date> (e.g. Audit template 06_06_19)
 - Work request <date> (e.g. Work request 04_06_19)

NOTE Where's the shared drive?

W:\Public\Clinical Records Review Data

- d** Request clinical records from provider with attached password protected spreadsheet, If e-mailing the provider, Bcc the clinical advisor and PSD Admin team (ClinicalRecordsReview@acc.co.nz) so they are aware of the request.

 PSD05 Uplift clinical records

 Table of services with missing clinical records TEMPLATE.xlsx

- e** If not already done in 2.0 (d), notify Provider Service Delivery Administration team (via ClinicalRecordsReview@acc.co.nz) and clinical advisor that the notes have been requested and the date they are due.

3.0 Receive records

Team Administrator - Provider Strategic Partnerships and Performance

- a** Receive records via ClinicalRecordsReview@acc.co.nz email
- b** open clinical note and type each service date into the audit tool under the relevant claim number,
- c** record if its a clinical note or a client declaration

- d** move to email subfolder DMT processing within the clinical records review
- e** email clinical advisor and EPM to notify notes sent for scanning


4.0 Scan records into Eos

Scanning Team

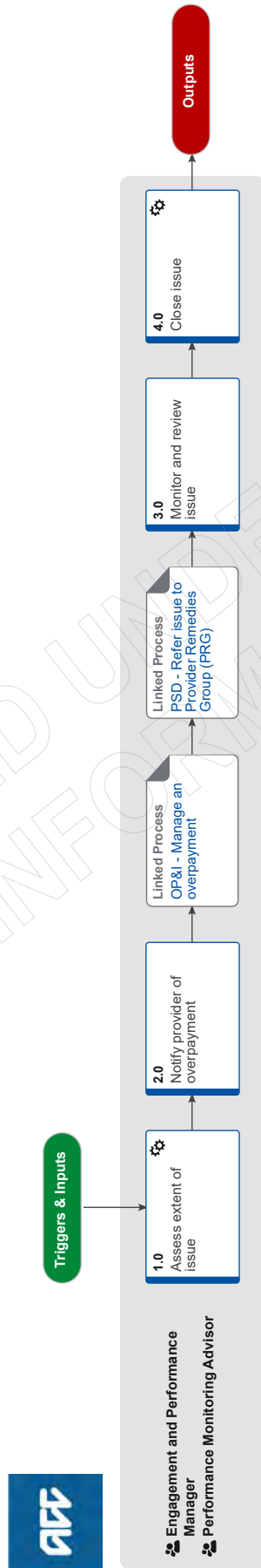
- a** Receive request via DMT email subfolder to scan records into Eos
- b** Scan documents into Eos

5.0 Complete clinical review

Clinical Advisor

- a** Check Eos that notes have been scanned and are available
- b** Complete clinical review using the audit tool saved in the shared drive
- c** Complete draft audit report using the report template
 -  RP01 - clinical notes audit report.doc
- d** Send report to relevant team manager for review and approval
- e** Once approved, create 2 versions one with appendix and one without for provider and save in shared folder
- f** Notify EPM that reports available and discuss next steps
- g** Return to the "request clinical advice" process

RELEASED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

This process is used to manage missing clinical records.

Background

If this process is not suitable for the situation you are managing please discuss how to manage the issue with your manager.

Owner

[Out of Scope]

Expert

Procedure

1.0 Assess extent of issue

Engagement and Performance Manager, Performance Monitoring Advisor

- a Consider the complexity and size of the issue by asking for another selection of records from different days or asking the provider to run a GenSolve report . Consider maximum of 5 years

NOTE If other issues are identified

If other issues are identified consider discussing this with your manager, referring to integrity services, clinical services or manage through the relevant process.

- b Check the selection of records against MFP invoicing data to identify which clinical records are missing.

NOTE How to copy the MFP data to Excel

MFP data can be copied and pasted into Excel by clicking into cell row 1 of MFP and using "Ctrl +Shift" and "A+C" at the same time, then "paste" into Excel.

- c Refer all instances of missing clinical records to Provider Risk of Harm group (PRoH)
- d If not already completed, create a provider Issue or case in Salesforce.

2.0 Notify provider of overpayment

Engagement and Performance Manager, Performance Monitoring Advisor

- a Discuss results of the PRoH review with the provider

PSD07 Missing clinical records

PROCESS

OP&I - Manage an overpayment

Engagement and Performance Manager, Performance Monitoring Advisor

PROCESS

PSD - Refer issue to Provider Remedies Group (PRG)

Engagement and Performance Manager, Performance Monitoring Advisor

3.0 Monitor and review issue

Engagement and Performance Manager, Performance Monitoring Advisor

- a After 3 months, review a further sample of clinical records.

NOTE Has the issue been resolved?

If the issue is resolved, end process.

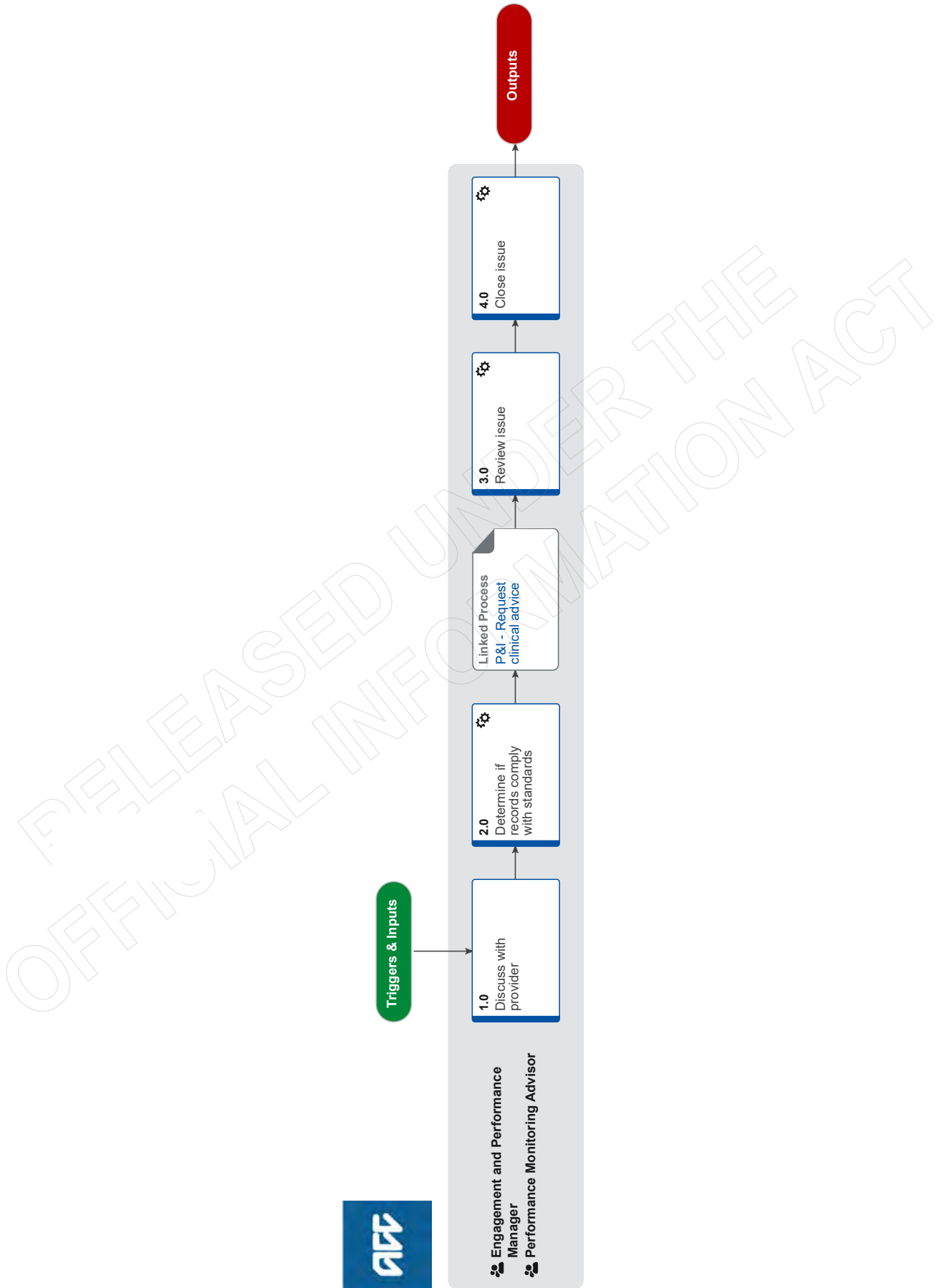
If the issue is unresolved, consider the Restrict invoice process

PROCESS PSD - Restrict Invoice

4.0 Close issue

Engagement and Performance Manager, Performance Monitoring Advisor

- a Update Salesforce to close the issue, record the actions taken, and upload any documentation or communication with the provider.





Summary

Objective

The purpose of this process is for ACC to identify and manage issues related to quality of clinical records.

Background

If this process is not suitable for the situation you are managing please discuss how to manage the issue with your manager.

The process is needed to guide and improve providers' professional conduct, competency, contractual issues and potentially resolve other complaints.

Owner

[Out of Scope]

Expert

Procedure

1.0 Discuss with provider

Engagement and Performance Manager, Performance Monitoring Advisor

- a Notify the provider that you will ask to see a sample of clinical records when completing an onsite visit. If not undertaking a visit (e.g. PMA working remotely), advise the provider that you want to see a sample of clinical records during your phone call and follow up the request in writing.
- b When onsite, request to see 10 clinical records relating to the issue being explored.

2.0 Determine if records comply with standards

Engagement and Performance Manager, Performance Monitoring Advisor

- a Complete the 'EPM clinical record check' spreadsheet

Copy of 20170925 EPM clinical records check V2 (002).xlsx

NOTE What if the notes do not meet requirements (clinical issue)?

PROCESS P&I - Request clinical advice

NOTE What if the notes do not meet requirements (education issue)?

Provide education relevant to issue.
Continue to Activity 5.0.

- b If not completed already, create a Provider issue or case in Salesforce.

PROCESS

P&I - Request clinical advice

Engagement and Performance Manager, Performance Monitoring Advisor

3.0 Review issue

Engagement and Performance Manager, Performance Monitoring Advisor

- a Arrange follow up review with provider

PSD06 Uplift clinical records - review

NOTE Has the issue been resolved?

If the issue is resolved then complete step 4 - Close issue or case in Salesforce.

If the issue is unresolved, refer the issue to the Provider Risk of Harm group (PProfH) or Provider Issues Management Group (PIMG).

PROCESS PSD - Refer issue to Provider Remedies Group (PRG)

NOTE Does the Restrict invoice process need to be used?

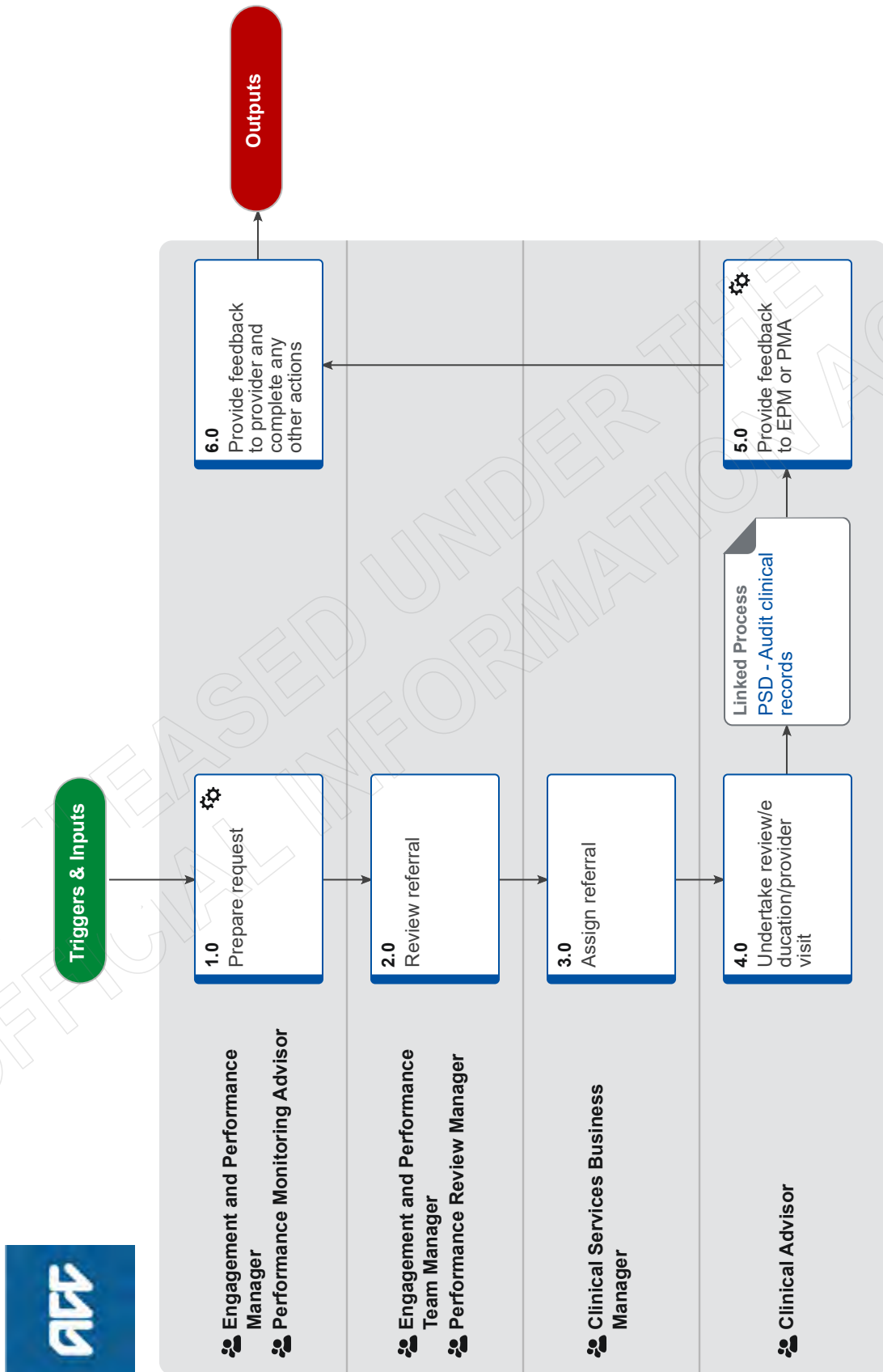
If the issue is unresolved, consider Restrict Invoice Process

PROCESS PSD - Restrict Invoice

4.0 Close issue

Engagement and Performance Manager, Performance Monitoring Advisor

- a Upload all communication and documentation to Salesforce and then update the Salesforce issue or case to closed.



Summary

Objective

This process is used to request clinical advice to support investigation and management of provider issues

Owner




[Out of Scope]

Expert

Procedure

1.0 Prepare request

Engagement and Performance Manager, Performance Monitoring Advisor

- a Complete the clinical advice request form and the Clinical Record Audit Tool.
- b Create a folder to save the Audit Tool in the W: drive - W:\Public\Clinical Records Review Data. PMA's save the Clinical Advice Request Form in the P&I document folder for either low risk, or medium/high risk.
- c Check the clinical notes have been uploaded to EOS before proceeding.
- d Email your manager to notify them of the clinical advice request.
 -  Clinical Advice Request Form
 -  Clinical Record Audit Tool Master
 -  Clinical Audit Request System Step Instructions

2.0 Review referral

Engagement and Performance Team Manager, Performance Review Manager

- a Review the referral for appropriateness and quality.
- b Send referral to health partnerships clinical partners inbox: ClinicalPartnerships@acc.co.nz, copying to referrer.

3.0 Assign referral

Clinical Services Business Manager

- a Log referral in central database.
 - b Assign to appropriate clinical advisor team.
- NOTE** Is there appropriate expertise within the team to manage the request?
If not, consider engaging external auditor via the Clinical Quality Manager.

4.0 Undertake review/education/provider visit

Clinical Advisor

- a Review request and contact referrer to discuss as required.
- b Complete the request. If undertaking a review complete the required report.
- c Notify the Clinical Services Business Manager once the request is complete.

5.0 Provide feedback to EPM or PMA

Clinical Advisor

- a Complete Feedback on clinical advice v2 template and meet / discuss with EPM or PMA.

6.0 Provide feedback to provider and complete any other actions

Engagement and Performance Manager, Performance Monitoring Advisor

- a Give feedback to the provider using 'Feedback on clinical advice v2' template with attached review report. (Do not include the appendix.)

NOTE Is there a risk of harm?

- PROCESS** PSD - Refer issue to Provider Remedies Group (PRG)

NOTE Has there been an overpayment?

If yes, raise an overpayment for the services that do not meet ACC's requirements as per the manage an overpayment process

- PROCESS** OP&I - Manage an overpayment

- b Return to the process that triggered this action.

 **PROCESS** PSD - Audit clinical records
Clinical Advisor



Summary

Objective

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

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

Background

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

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

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

Owner [Out of Scope]

Expert

Policy

1.0 Is there a new injury?

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

2.0 Is the injury a consequential injury?

- a** Does one of the provisions under section 20(2) apply?
 - 20(2)(d) caused by treatment for a covered injury
 - 20(2)(g) caused by a gradual process, disease, or infection arising from a covered injury
 - 20(2)(h) caused by a gradual process, disease, or infection resulting from treatment of a covered injury.
- b** For example - A new claim is lodged for a client with an accepted Serious Injury claim for tetraplegia. The client has developed a pressure sore due to being immobile as a result of their covered tetraplegia. The claim for the pressure sore is considered to be consequential to the Serious Injury claim and can be accepted accordingly.

3.0 The difference between a consequential injury and treatment injury

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

4.0 Treatment Injury delegation

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

5.0 Delegations

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

6.0 Identifying a consequential injury caused by treatment

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

7.0 Determining the date of injury for the consequential injury


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

8.0 Consequential claims under previous Acts


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

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







9.0 Forwarding consequential injury claims

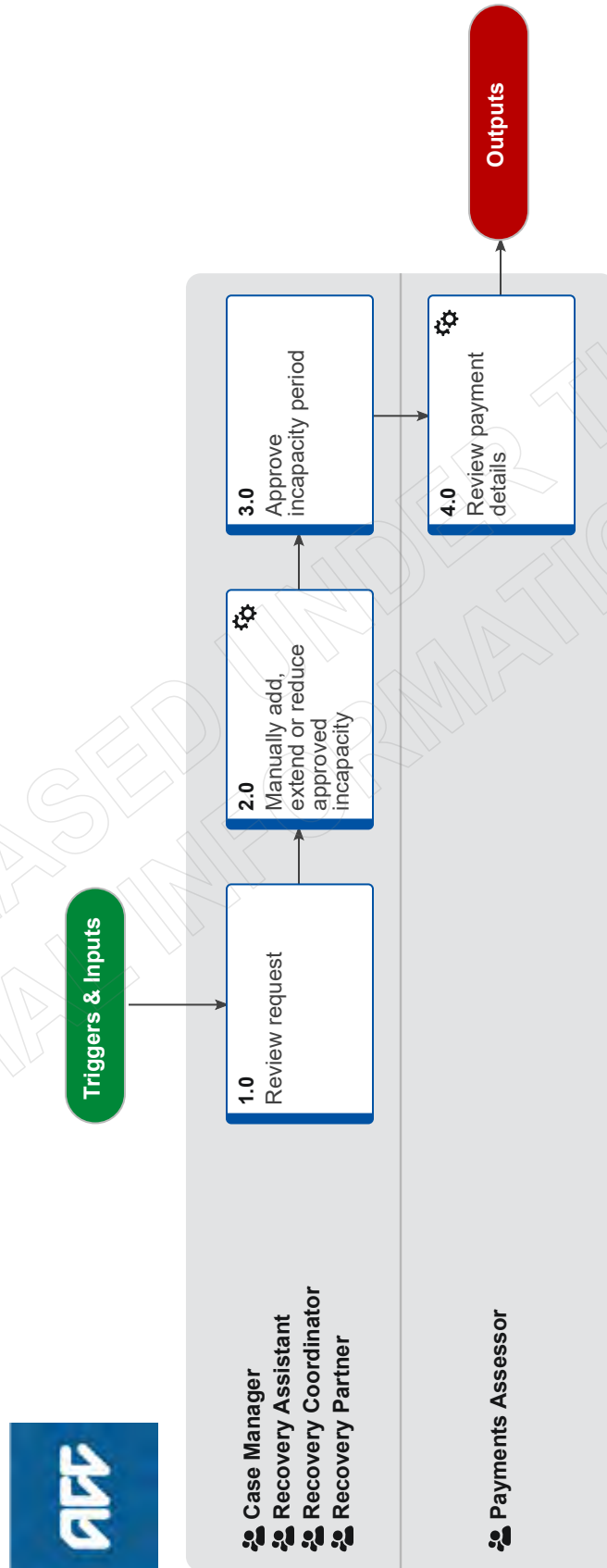
- a** If you determine that a new consequential injury claim with a separate date of injury needs to be set up, then instead of requiring a new ACC45 to be lodged, you can email the below form through to the Registration team.
-  Referral for New Claim Lodgement
- b** All consequential injuries caused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

10.0 Fund code

- a** You must make sure the correct fund code is allocated to the claim.
-  Fund Code Policies (Group)

11.0 Links to legislation and appeal decision

-  Accident Compensation Corporation v Kingi [2012] NZACC 351 (26 October 2012)
<http://www.nzlii.org/nz/cases/NZACC/2012/351.html>
-  Accident Compensation Act 2001, section 20 Cover for personal injury suffered in New Zealand (except mental injury caused by certain criminal acts [or work-related mental injury])
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  Accident Compensation Act 2001, section 28 Work-related personal injury
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  Accident Compensation Act 2001, section 36 Date on which person is to be regarded as suffering mental injury
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  Accident Compensation Act 2001, section 37 Date on which person is to be regarded as suffering personal injury caused by work-related gradual process, disease, or infection
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  Accident Compensation Act 2001, section 38 Date on which person is to be regarded as suffering treatment injury
<http://www.legislation.govt.nz/act/public/2001/0049/lat>



Summary

Objective

To manage incapacity for a client who is unable to work as a result of their injury, and is receiving weekly compensation. Modifying approved incapacity periods covers both extending and reducing periods.

Background

Straight-Through Processing (STP): Eos automatically extends Eos weekly compensation payments for electronic ACC18s if extended incapacity periods have been approved and system rules have been met.

Rules where Eos is unable to automatically to extend weekly compensation are:

- The 'from' date is more than 28 days prior to today's date
- Post incapacity earnings do not exist where abatement applies
- The approved incapacity date is later than the ACC18 'to-date'
- There are outstanding approval requests relating to the client or the claim
- A payment has not been made against the latest collection point.

If any of these rules are triggered, the [Automatic Entitlement Period Authorisation Prevented] task will automatically be sent to the Payments Team.

Manual Changes to Approved Incapacity Periods: You can modify the dates manually for an electronic filed ACC18, or you can edit or add new incapacity periods for an existing entitlement. When this occurs and you have approved the change, Eos creates the [Modified Incapacity] task for the Payments Team to manage the approval of the entitlement.

NOTE: Any action on incapacity where you have selected 'Edit' and then 'OK', will send a [Modified Incapacity] task to the payments team. To View incapacity only, please use 'View'. If you select 'Edit' but make no changes, please click 'Cancel' to exit.

Owner [Out of Scope]
Expert [Redacted]

Procedure


1.0 Review request

Case Manager, Recovery Assistant, Recovery Coordinator, Recovery Partner

- Open the Auto Alert: New Electronic ACC18 task and review the new updated Medical Certificate against the existing approved incapacity.

NOTE Do the dates need to be adjusted?

- If yes, go to 2.0 Manually add, extend or reduce approved incapacity.
- If no, go to Activity 3.0 Approve incapacity.

 View approved incapacity details

NOTE What if you receive a manual medical certificate via the 'NGCM – Action Medical Certificate' task or specialist report via the 'NGCM – Action Attached Documentation' task?

Go to Activity 2.0 Manually add or extend or reduce approved incapacity.

NOTE What if you need to extend or reduce the incapacity dates?

Go to Activity 2.0 Manually add or extend or reduce approved incapacity.

NOTE What if the client has died while receiving weekly compensation?

- 1) Ensure that client party record is updated with the date of death (DOD).
- 2) Advise the payments team by sending the 'Stop Payment' task adding the relevant details.


2.0 Manually add, extend or reduce approved incapacity

Case Manager, Recovery Assistant, Recovery Coordinator, Recovery Partner

- Update the existing approved incapacity details, according to one of the scenario notes below.

NOTE What if you have received an additional medical incapacity which has supporting documentation eg specialist report?

- 1) Add the details into the [Medical Incapacity] section.
- 2) Check for any overlap prior to approving.

 Add medical incapacity manually

NOTE What if you need to extend or reduce an approved incapacity without supporting documentation?


Make the adjustments to the existing record in the [Approved Incapacity] section.

 Add approved incapacity without documentation

NOTE What if the client will be receiving earnings during the period of extended incapacity?

Abatement applies.

- 1) Select 'yes' for abatement for the related incapacity set prior to approval.
- 2) Determine if abatement is simple or complex – go to the relevant steps in the Manage Abatement in Eos.


 **PROCESS** Manage Abatement in Eos

NOTE What if the client has been working during an approved period of incapacity, but has had no abatement applied?

If the client has not resumed their normal work pattern, you will need to:

- 1) Add to the incapacity set for the Fully Unfit For Work (FUFW) period when they were unable to work, and
- 2) Add a new period of incapacity set for Fit For Selected Work (FFSW) for the period they have worked and select 'Yes' for the abatement indicator.
- 3) Ensure that the entire approved incapacity matches the date range for the period previously approved.

 Add approved incapacity


 Extend or reduce approved incapacity without documentation

NOTE What if you need to remove an approved incapacity period?

You cannot remove an approved incapacity period, if payments have been made in the period to be removed. In this case, you will need to reduce the approved period to the last payment made and provide reasons.

If no payments have been made, you can remove the period of inability to work.

Both of these actions will generate a [Modified Incapacity] task for the payments team.

 Remove incapacity details

NOTE What if you have made more than one adjustment to incapacity?

A [Modified incapacity] task will be sent to the payments team each time you make a change. Please close any duplicate or irrelevant tasks, ensuring the payments team only receive / action relevant changes to incapacity that require approval.

3.0 Approve incapacity period

Case Manager, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Approve the incapacity period. Ensure there are no unnecessary gaps in the client's approved incapacity periods to prevent medical certificate expiry notifications being sent inappropriately.

NOTE What if this is an electronic ACC18, where no changes have been made?


Provided system validation rules have been met straight-through processing will occur, otherwise an Automatic Entitlement Period Authorisation Prevented task will be sent to the Payments Team.

NOTE What if your client has a permanent incapacity?

Refer to Medical Certification for serious injury clients on providing 6-12 month Medical Certificates when the client's incapacity is unlikely to change.

 Medical Certification for serious injury clients
<https://accnz.sharepoint.com/sites/TeWhariki/SitePag>

 Straight-through processing business rules

 Approve medical incapacity from AUTO Alert: New Electronic ACC18 Task


NOTE What if the incapacity required approval without documentation?

Once you have approved the incapacity, a [Modified incapacity] task will be sent to the payments team.

 Approve medical incapacity added manually

NOTE What if you receive a message to change the payment department?

You will adjust the update the payment department in the Pathway sub case.

 Change payment department to approve incapacity in Pathway

NOTE What if you receive the message 'This claim has an Injury Resolved Indicator set as Confirmed – This Incapacity cannot be approved'?

If the end of the incapacity period is after the from date that the Injury was considered resolved, you will be unable to approve the incapacity.

Check you should be approving this incapacity and if so, on the ACC45 Claim 'Indicators' tab, Edit the Injury Resolved Indicator From Date to be correct, or the Status to Inactive.

NOTE What if you receive the message 'This claim is in Actioned Cases – This Incapacity cannot be approved'?

If the claim is in an Actioned Cases department, you will be unable to approve the incapacity.

Continue on with the Re-open claim process below

 **PROCESS** Re-open claim

NOTE What if you receive the message 'This claim has a Limited Weekly Compensation Indicator set – This Incapacity cannot be approved'?

If the claim has a Limited Weekly Compensation Indicator set as Active, you will be unable to approve the incapacity.

Check you should be approving this incapacity and if so, on the ACC45 Claim 'Indicators' tab, Edit the Limited Weekly Compensation Indicator Status to Inactive.

- b Close the task you received that triggered the changes to the approved incapacity period.

NOTE What if you have made more than one adjustment to incapacity?

A [Modified incapacity] task will be sent to the payments team each time you make a change. Please close any duplicate or irrelevant tasks, ensuring the payments team only receive / action relevant changes to incapacity that require approval.


4.0 Review payment details

Payments Assessor

a In Eos, open the:

- Automatic Entitlement Period Authorisation Prevented task, and review the details provided in the description, or
- the Modified Incapacity task, and view the details in the Add Info tab.

- b Check that the current payable and non-payable periods align with the new approved incapacity period, and adjust or add as required.


 View payment periods summary

- c Update the payable and non-payable periods to Approved for these to take effect.

 Add a payment period

 Edit a payment period

- d Review the calculation and initiate payments for approval.


 View due events

 Initiate payments for approval

NOTE What if amending the payable and non-payable periods results in an overpayment?

If you don't have all of the information to establish the true overpayment for the period, then apply a Calculate and Hold period for the period that you are waiting to confirm.

Note that [Calculate] and [Hold] periods must be applied to full weeks only. Advise case manager that you have placed a hold on payments.

 Add a payment period

- e Once you have initiated payments for approval transfer the task to the Centralised Weekly Compensation Approval queue.

NOTE What if a fast track payment is required?

Update task description to request payment be fast tracked during approval.

NOTE What if the task is about a sensitive claim?

If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims Approvals queue.

RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

The IRP contains information about the treatment, social rehabilitation and vocational rehabilitation a client needs to restore their health, independence and participation in society to the highest possible level.

An IRP is a legal document under the Accident Compensation Act 2001 (AC Act), ie:

- ACC must provide or do what has been agreed to in an IRP
- the client cannot unreasonably refuse to complete an intervention that has been agreed in the plan.

An IRP must be updated when the client's circumstances change and the agreed interventions no longer apply or cannot be completed.

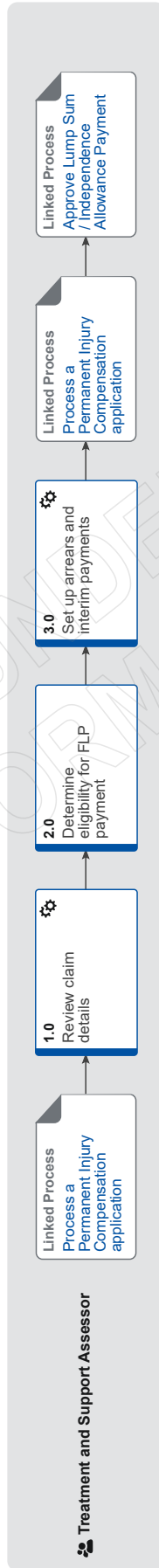
- 1) Individual Rehabilitation Plan (IRP)
- 2) When ACC and the client must negotiate and agree upon an IRP
- 3) Recording social rehabilitation on the IRP
- 4) Providing assistance without an IRP
- 5) Exclusions
- 6) Paperless IRPs
- 7) Participant's Rights
- 8) 8. Legislative Requirements

Owner Needs to be reassigned N/A

Expert Needs to be reassigned N/A

Policy

Make Functional Limitations Profile Independence Allowance Payments v7.0



Make Functional Limitations Profile Independence Allowance Payments v7.0



Summary

Objective

To assess whether the client is eligible to receive a backdated Functional Limited Profile Independence Allowance payment.

You will only need to determine if the client is due an arrears payment if previous FLP IA payments are indicated on the 4.09 LSIA Payment Report and these payments have been stopped.

Background

When American Medical Association Whole Person Impairment assessments were introduced in 1997 clients receiving Functional Limitations Profile Independence Allowance payments were required to be reassessed under the new assessment model. If the client didn't respond to ACC to arrange a reassessment within 12 months, they may have had their Functional Limitations Profile Independence Allowance payments stopped without being reassessed under the new guidelines.

Owner

[Out of Scope]

Expert

Procedure

PROCESS Process a Permanent Injury Compensation application Treatment and Support Assessor

1.0 Review claim details

Treatment and Support Assessor

- a** In Eos, review the claim documents and activity logs to locate the following information to complete your assessment:
- Independence Allowance Running Sheet
 - letters to the client requesting that they visit their GP and complete an Independence Allowance application
 - medical certificate
 - letters to client following up application and cancellation of Independence Allowance payments.

NOTE **What if I can't locate any activity logs relating to previous Functional Limitations Profile Independence Allowance payments in Eos?**

Refer to Pathway and check if there are any activity logs referring to Functional Limitations Profile Independence Allowance payments.

NOTE **What if I can't locate all of the information I require?**

Contact Technical Services and seek advice.

2.0 Determine eligibility for FLP payment

Treatment and Support Assessor

- a** Review the information you've gathered to request advice from Technical Services on whether the client is eligible for a backdated Functional Limitations Profile Independence Allowance payment.
- b** Obtain Written Guidance from Technical Services, referencing the information you've prepared to support your findings that the client may or may not be eligible to receive backdated Functional Limitations Profile Independence Allowance payments.

NOTE How do I make a referral to Technical Services?

PROCESS Seek Internal Guidance

3.0 Set up arrears and interim payments

Treatment and Support Assessor

- a** Once you've received advice back from Technical Services, review their comments in the internal referral task.

NOTE **What if you recommended not to pay a backdated payment and Technical Services have agreed?**

Make a note of the physical file and page number on the Overview tab on the Permanent Injury Compensation subcase that there is no eligibility to backdated payments and resume processing the Lump Sum / Independence Allowance application as normal.

Return to the Process a Lump Sum / Independence Allowance Application linked below and continue to process the client's application as normal.

PROCESS Process a Permanent Injury Compensation application

- b** In Eos, calculate and set up the arrears payment ready for approval.

Enter Impairment Assessment percentage in Eos

Set up Functional Limitations Profile payment

Manually Override IA Payment Start Date

- c** Set up Functional Limitations Profile Independence Allowance interim payments in Eos to ensure the client receives the correct payments until their Whole Person Impairment assessment is completed.

Set up Functional Limitations Profile payment

- d** Add 'Approve IA Entitlements' task.

Create a Permanent Injury Compensation approval task

- e** Contact the client and let them know that they will receive an arrears payment and interim quarterly payments until the outcome of the Impairment Assessment is received.

- f** Return to the Process a Lump Sum / Independence Allowance Application linked below to continue processing the client's application.

PROCESS Process a Permanent Injury Compensation application Treatment and Support Assessor

PROCESS Approve Lump Sum / Independence Allowance Payment Treatment and Support Assessor



Summary

Objective

A service provider may arrange a case conference with ACC and other relevant treatment providers to discuss the care of a client and their rehabilitation goals. After the case conference the service provider will send brief a report to ACC with any outcomes or recommendations.

If you need to involve a Vocational Medical Services (VMS) provider to help solve a particular issue with the client's VR progress, then see Vocational Medical Assistance (VMA) Case conference.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** The service provider must have ACC's approval to arrange a case conference.

The case conference:

- must include all relevant treatment providers
- may include the client and involve family members, if appropriate.

The case conference should:

- address any barriers
- discuss the client's progress
- plan for ongoing management.



Table of Contents

Create Request for Written Guidance – Recovery Team Member.....1

Create Request for Written Guidance – Recovery Team Member

SYSTEM STEPS - Create Request for Written Guidance

- 1 Check whether a **Recovery Support** Sub-case has been created

You can see whether a **Recovery Support** Sub-case has been created by looking at the **Case Summary Panel** from either the **ACC45 Claim** or the **Recovery Plan** Sub-case.

 - If a **Recovery Support** Sub-Case hasn't been created - Go to **Step 2**
 - If the **Recovery Support** Sub-Case has been created - Go to **Step 3**
- 2 Create a **Recovery Support** Sub-Case:
 1. From the **ACC45 Claim** select **Add Sub Case**
 2. Select **Recovery Support**

*A **Recovery Support** Sub-case will now be available from the **ACC45 Claim > Case Summary Panel***
- 3
 1. Select the **Recovery Support** Sub-case
 2. Select **Add Activity**
 3. Select the **New Request for Written Guidance** option
- 4
 1. Complete the **Written Guidance Eform** presented, including all mandatory fields. Do **not** use N/A or Hyphen (-) in the mandatory fields. This will prevent the request from going to the correct queue for triaging.

NOTES:

 - In the **Written Guidance Eform** the following fields will populate:
 - **Client Name** (automatically populates)
 - **Client Summary** (automatically populates with the following details: Age, Provisional Injuries, Accident Description, Previous Hotline Guidance, Previous Written Guidance, Occupation, Lodgement Provider and Date the ACC45 form was signed)
 - **Previous covered injuries at the same site** (for Mental Injury claims, any prior claims with MI cover)
 - **Case Owner Summary** (mandatory)
 - **Question(s) for Guidance** (**NOTE:** You need to select at least one)
 - **Rationale for Question(s)** (mandatory)
 - If you start a request for Written Guidance and decide you no longer need to request Written Guidance select **Cancel** and an eform will not be created
 2. Select **Next**
- 5
 1. Select appropriate next **Step** and **Reason**
 2. Select **OK**
 3. Select **Close**

SYSTEM STEPS - Create Request for Written Guidance

4. Select **Close**

If you select Step:	With Reason:	Task Created:	Task Automatically Routes to:
Provide Guidance	Clinical	NGCM - Triage Request for Clinical Guidance	Centralised Clinical
Provide Guidance	Technical	NGCM - Provide Guidance	Centralised Technical
On Hold	Information Required (Task Required)	NGCM – Review On Hold Written Guidance Request	Department Queue the Claim is assigned to
NOTE: Do not select 'Quality Review' as this will delay your request for Written Guidance.			

NOTES:

- If you start a request for Written Guidance and discover you need further information before you can complete the eform select **On Hold** then:
 - Select **OK**
 - Select **Close**
 - Go to the **Recovery Support >Task Tab**
 - Open the **NGCM – Review On Hold Written Guidance Request** Task
 - Edit the **Target Date**
- How to action a **NGCM – Review On Hold Written Guidance Request** task:
 - Open the **NGCM – Review On Hold Written Guidance Request** task
 - Go to the **Add. Info** tab and select **Change**
 - Add further information into the **Written Guidance** eform
 - Select **OK**
 - Select **Close**
 - **Close** the **NGCM – Review On Hold Written Guidance Request** task and select the appropriate step

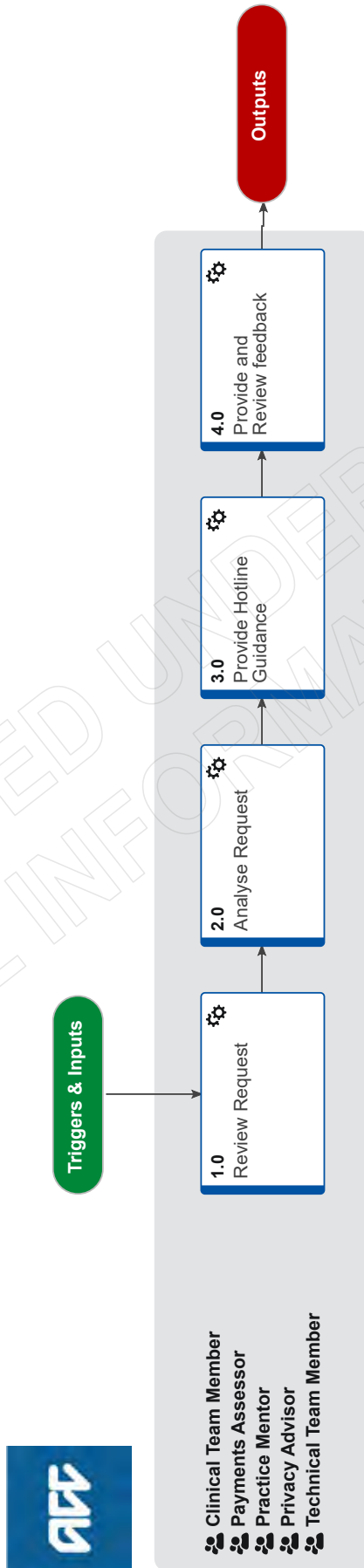
[BACK TO TOP](#)

Document Control

Date	Version	Author	Change Notes
07/06//2019	0.6	[Out of Scope]	System Steps required for August Rollout
11/02/2019	0.5		Screenshots updated to Eos 8.8 version
05/11/2018	0.4		Updated content as requested by Production Solution Team
19/10/2018	0.3		Corrected document control and table heading
18/10/2018	0.2		Transferred from information on the Promapp page into System Step Format
	0.1		Created document content

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OFFICIAL INFORMATION ACT





Summary

Objective

To provide guidance to frontline staff via the Hotline.

Background

Hotline Guidance is available for any of the following areas:

- Clinical Services
- Technical Services
- Practice Mentors
- Payments
- Privacy
- Technical Overpayments

Owner

[Out of Scope]

Expert

Procedure

1.0 Review Request

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** In Salesforce, open the claim using the claim number provided by the frontline staff member.

NOTE What if you are not a Salesforce user?

Open the claim in Eos using the claim number provided.

- b** Listen to the caller's question and confirm the steps that have been taken by the caller to resolve the issue.

NOTE What if you are aware of some self service content in Promapp, CHIPs, or within the decision tree tool?

Still provide your advice to the caller, but inform them that next time, they can refer to this specific process/piece of knowledge or tool to get the information they need.

NOTE What if you've been contacted directly, outside of the Hotline?

If the call is about clarifying advice you've already provided, this is appropriate.

If not, and this is the first time the staff member has done this, resolve their query and request that they use the Hotline next time. Advise that you won't be able to resolve their query next time if they call you directly.

If a staff member repeatedly calls the same advisor, redirect them to the Hotline and inform their Team Leader.

- c** Determine if you're the correct person to provide guidance.

NOTE What if you're not the correct person?

Decide who would be the correct person/advisor hotline and transfer the call. If you are unable to transfer the call to another person/advisor, suggest to the frontline staff member to call back later.

Refer to the guide below on how to transfer calls.

[Skype Calling and Call Functionality](#)

2.0 Analyse Request

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** Assess whether the issue can be answered during the call (ie you can provide guidance within 15 minutes).

NOTE What if you're unable to provide guidance within 15 minutes?

If you're unable to provide guidance, recommend that the staff member requests Written Guidance

Ensure you document this in Salesforce by selecting "Create Guidance", "Hotline Guidance", and complete the mandatory fields.

For Payments, Privacy, and Technical Accounting services (TAS), if any guidance was provided, ensure you document this in Eos, in the "Add eForm" section of the Recovery Support subcase.

- b** Review the claim background information, including prior claims, if the frontline staff member has not already provided this.

NOTE What if you need more time to review information prior to providing guidance?

Inform the staff member that this will be the case, providing them with an idea of when they can expect you to get back to them, and how you will do this (Skype, Teams, Phone call etc).

3.0 Provide Hotline Guidance

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** Provide guidance to the staff member

NOTE What if the issue needs additional guidance from a different Advisor, Specialist or Assessor?

Refer to the guide below for information on how to transfer calls to another Advisor, Specialist or Assessor or how to initiate a conference call with them.

[Skype Calling and Call Functionality](#)

- b** Agree next steps with the staff member. Ensure there is an agreed understanding of the next steps before the call comes to an end.

NOTE What if you need more time to consider information and/or type up your guidance?

Set the expectation with the frontline staff member how long this will take, so they can prioritise other work whilst waiting for this guidance if needed. Give them the option of going on hold or ending the call and getting back to them once this guidance is completed, ensuring there is an agreed understanding of how you will do this.

- c** In Salesforce, record the guidance provided within the 'Recovery Support' tab, create the Hotline guidance form and fill in the fields.

NOTE What if you are a Clinical Advisor and you have received a request regarding Surgical guidance via the clinicaladvisorsurgery@acc.co.nz inbox?

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

NOTE What if you are in Privacy, Payments, or TAS?

In Eos, record the guidance provided within the Recovery Support sub-case by selecting "add eForm" and completing the fields.

NOTE What if you need to edit or delete the Hotline Guidance you created?

In Salesforce open the hotline guidance:

- If you need to edit the hotline guidance to add/remove information, select 'Edit Hotline Guidance'
- If you need to remove hotline guidance entered on the wrong claim, select 'Delete'

If you are not a Salesforce user, you can edit your guidance in Eos via the Recovery Support sub-case for the above reasons.

NOTE What if there is no Recovery Support sub-case? (Privacy, Payments, TAS)

From the ACC45 claim select "Add Sub Case", then select Recovery Support.

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

Complete the steps below in Salesforce:

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

4.0 Provide and Review feedback

Clinical Team Member, Payments Assessor, Practice Mentor, Privacy Advisor, Technical Team Member

- a** If applicable, provide feedback on the guidance request.

NOTE How do you provide feedback on the guidance request?

In Salesforce, navigate to the Recovery Support tab and select the 'Provide Feedback' option. On the Provide Feedback form, complete the mandatory question and comments sections, and submit your feedback.

- b** If applicable, review feedback on the guidance provided.

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

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

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

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



Summary

Objective

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

Background

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

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

[Out of Scope]

Owner

Expert

Policy

1.0 Mental injury without a covered physical injury

- a** In most instances ACC does not provide cover for mental injury in situations where no physical injury is covered, eg:

- a mental injury to a person witnessing a car accident but who does not sustain physical injuries
- mental injury to a mother learning of her child's death.

However, there are some situations where ACC will provide cover for mental injuries not caused by a physical injury, eg:

- mental injuries caused by an AC Act 2001, Schedule 3 sexual offence are covered, even if there are no physical injuries involved
- work-related mental injuries caused by witnessing traumatic events are covered
- mental injuries caused by a non-covered physical injury sustained in a treatment context.

NOTE Exception - physical injury in New Zealand not yet lodged

While most physical injuries that occurred in New Zealand will have a claim (if a client sought treatment for their injury claims would automatically be lodged via their GP, medical health centre or District Health Board), where a request for cover has not been made clients will be requested to also lodge a claim for this. The evidential requirements for the physical injury in these cases are not high, but there must be clinical evidence which notes a condition akin to a physical injury that ACC would cover and links causation of a mental injury because of a physical injury. This information must be provided when a claim is made.

- b** Assess cover for mental injuries caused by a physical injury overseas - interim approach

High Court decision of ACC v D:

This decision found that that for the purposes of cover a person could suffer a mental injury in New Zealand where the physical injury occurred outside New Zealand and is not covered. Until the appeal process is finalised there will be an interim application of ACC v D.

While these clients do not need to have a covered physical injury, there must be clinical evidence which notes a condition akin to a physical injury that ACC would cover and links causation of a mental injury because of a physical injury. This information must be provided when a claim is made.

Evidence that details the non-covered physical injury is preferred but not essential for determining cover for the mental injury. A degree of pragmatism is required when seeking evidence for an injury that occurred overseas as it would be unlikely to be available in some instances. ACC would not accept cover for mental injury arising from conditions that are not physical injuries for example degenerative conditions, pain syndromes and non-industrial diseases.

- Accident Compensation Act 2001, Schedule 3, Cover for mental injury caused by certain acts dealt with in Crimes Act 1961
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- Treatment injury mental injury Policy

2.0 Mental injury because of a physical injury


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


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

3.0 Criteria for assessing mental injury because of a physical injury


- a** A cover decision for a mental injury because of a physical injury can often be considered 'simple' or 'complex'. The attached table shows the criteria for simple and complex mental injury because of physical injury decisions.

A decision is...	when...
simple	<p>either</p> <ul style="list-style-type: none"> the criteria for personal injury have been met and <ul style="list-style-type: none"> there is cover for the physical injury claim there is a clinically significant mental condition identified the physical injury is the material cause of the mental injury. the criteria for personal injury have not been met, ie there is no cover for a physical injury claim, but the situation meets the criteria where ACC will cover mental injury not caused by physical injury.
complex	<ul style="list-style-type: none"> it may not be clear if the mental injury is attributable to the physical injury there is uncertainty about whether there is a clinically significant mental condition there may be a combination of factors contributing to the mental injury including the physical injury the injury report may require the expertise of the Complex Mental Injury Panel for interpretation or guidance, for example where the diagnosis is chronic traumatic encephalopathy. See Assessing a claim for mental injury the request is for cover of schizophrenia as a mental injury caused by physical injury. These must all be referred to the Complex Mental Injury Panel (CMIP) a recommendation of a branch medical advisor (BMA), branch advisory psychologist (BAP), team manager or technical claims manager (TCM) is needed.

 Criteria for assessing mental injury caused by physical injury (MICPI).PNG

 Assessing a claim for mental injury

Consider a threat of serious injury to have been made where...	and...
the injury is sustained directly from the threat, eg hit by person who verbally threatened harm, rather than incidentally to it, eg twisting ankle while running from perceived threat.	<p>the threat is direct rather than witnessed or inferred, and there was a real risk of it happening. The threat is considered direct and real if:</p> <ul style="list-style-type: none"> an explicit verbal threat of serious injury is made by someone known or reasonably believed to be capable of carrying it out weapons are involved in an assault, even if not used to inflict the actual injuries a clear threat is inherent in the nature of the event, eg, serious car accident, fire, animal attack, or war.

 consider a threat of serious injury table.PNG

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

4.0 Traumatic injury circumstances

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

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

5.0 Special case: Post-traumatic stress disorder

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

- serious
- accompanied by a threat of serious injury.

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

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

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



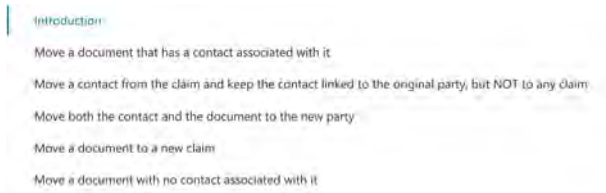
Move documents

Published 28/02/2023

Introduction

There will be times when you want to move one or more documents from one party to another, or from one claim to another. Documents that have a contact associated with them must be moved from the **Contacts** tab.

How to: Move documents



Staff roles with security access to move a document, or move a contact associated with a document are restricted by delegation.

Moving contacts doesn't apply to emails filed away to Eos using Email Toolset, for more information see email toolsets 'File an inbound email' page.

If a document is included in a Bulk Print and it is moved the details in the Bulk Print contents page will update the Claim ID to reflect the new location of the document.

Move a document that has a contact associated with it

This action moves both the contact and the document to a new party and/or a new claim.

This activity is restricted by delegation.

Move a contact from the claim and keep the contact linked to the original party, but NOT to any claim

Step 1

Open the claim or party record and go to the **Contacts** tab.

Step 2

Select the contact associated with the document and click **Move**.

Step 3

At the bottom of the screen under 'Claim' click 'Clear the Case'.

Leave the party selection as 'Remain linked to current Party'.

Step 4

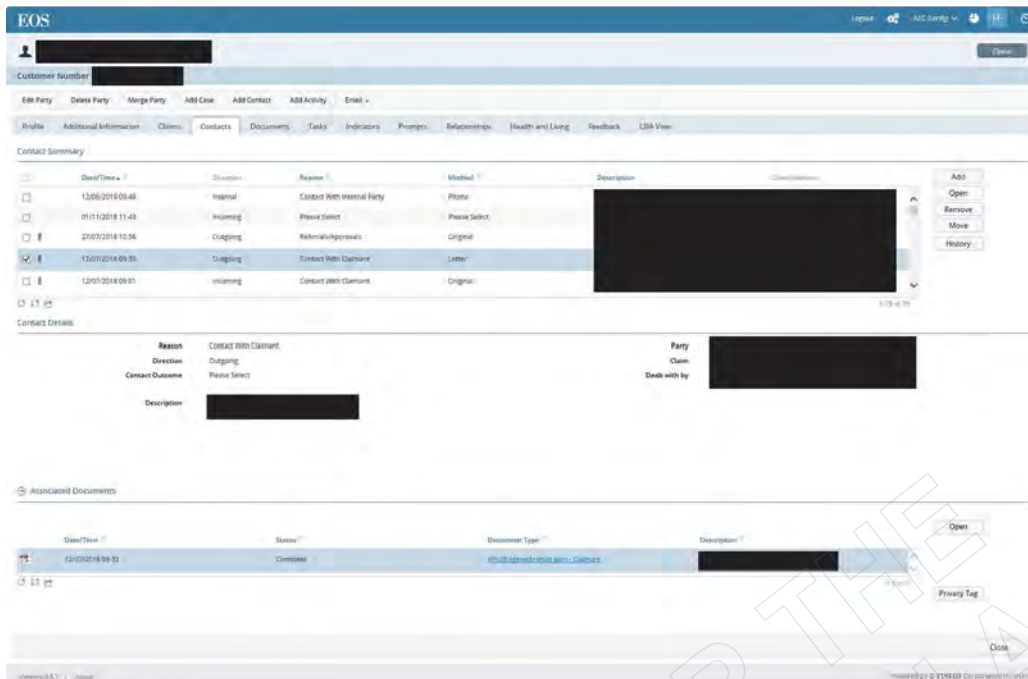
Click **OK** in the resulting pop up window.

Move both the contact and the document to the new party

Step 1

Open party record and go to the **Contacts** tab.

Party Contacts Tab to move TS101531



Step 2

Select the **contact**. To move contact to:

- a new party and then a new claim go to Step 3.
- another claim for the same party go to [Move a document to a new claim](#).

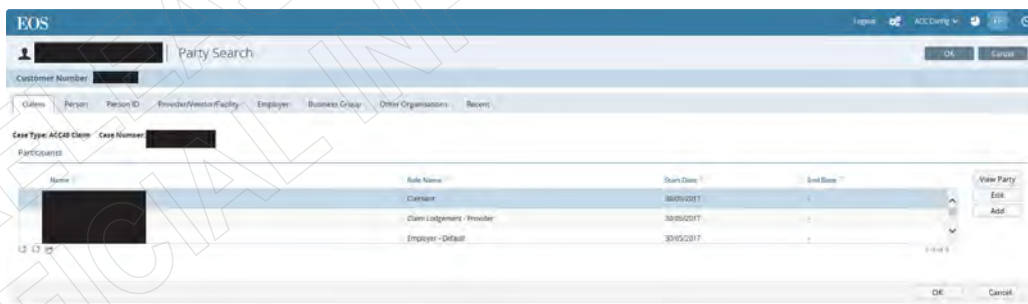
Step 3

Click **Move**.

Step 4

Click 'Move to another party' then the magnifying glass (search icon) and select the new party.

Move to another Party - Party Search TS101532



Step 5

Click **OK** to move both the contact and document to the new party.

Move a document to a new claim

Step 1

Open claim or party record and go to the **Contacts** tab.

Step 2

Select the contact associated with the document and click **Move**.

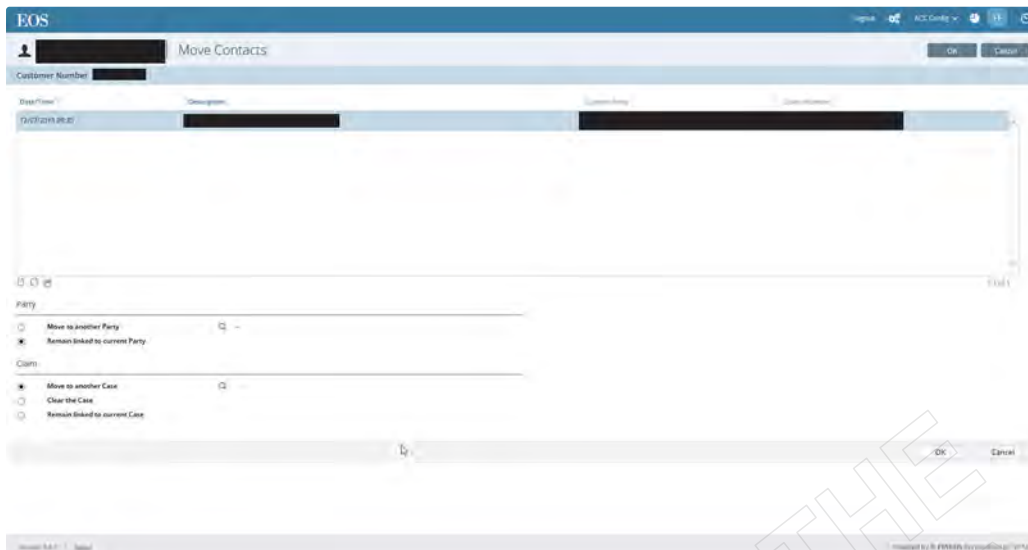
Step 3

Click 'Move to another Case' then the magnifying glass (search icon) and select the new claim.

Step 5

In the **Move Contacts** screen, both the party and the claim are selected.

Click **OK** to display the confirmation screen, the contact and its related document is now associated with the specified claim.



Move a document with no contact associated with it

When moving a document with no contact attached to it, you will use the Documents tab.

Step 1

Open claim and go to the Documents tab, then Documents for Claim sub-tab.

Step 2

Select the document(s) from the document list. You can tick the box, use the MultiSelect icon or [CTRL]+Click to move more than one item.

Step 3

Click Move.

Step 4

Click 'Move to another Party' to move the document to a new party or 'Move to another Case' to move the document to a new claim.

Step 5

Click the magnifying glass (search icon). Enter the relevant details and click Search.

Click OK to move the document(s) listed. A confirmation screen will pop up advising that records have been moved. Click OK.

[Out of Scope]

Claims

Information Type

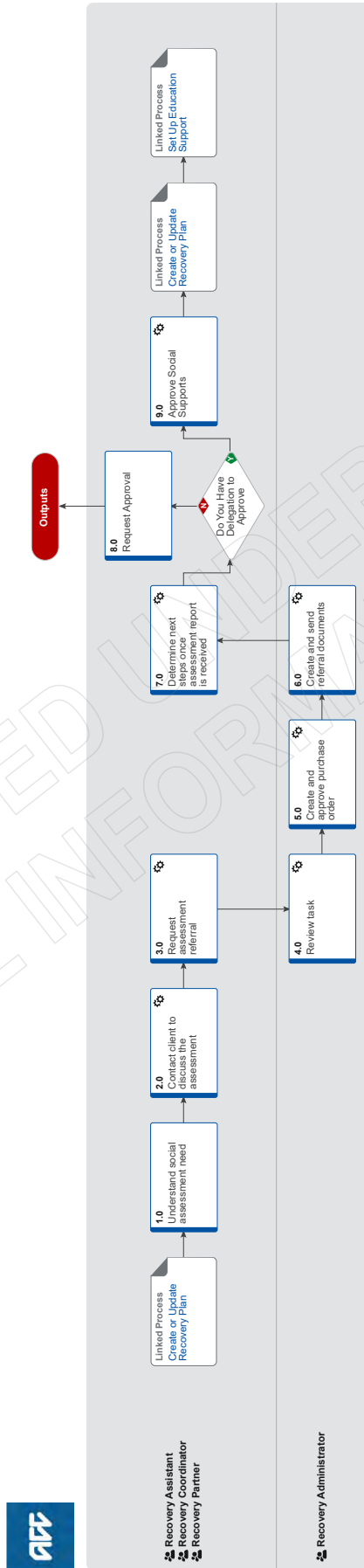
System Steps

Relates To

Claim



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Summary

Objective

To arrange an Education Based Rehabilitation Assessment (EBRA). This assessment is used to determine the child or young person's injury-related education support needs and to identify options for addressing these needs.

Background

This assessment is part of the Social Rehabilitation Assessments contract. For more details about this service refer to the service page.

This service is to provide support that contributes towards improved functional outcomes for the client. Services are to be provided in a client appropriate, timely manner and may include:

- Assessment of clients support needs
- Trialling of equipment where equipment has been identified as being appropriate
- Providing recommendations to ACC based in that assessed need.

Owner

[Out of Scope]

Expert




Procedure

PROCESS Create or Update Recovery Plan Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Understand social assessment need Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Confirm client's need for the assessment.

For more details about this assessment go to the information below:

-  Education Based Rehabilitation Assessment Service Page
-  Types Of Assessment Service Page
-  Needs assessment for social rehabilitation Policy

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


2.0 Contact client to discuss the assessment Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Check that the legal guardian has Authority to Act on behalf of the client.

-  View Client Consent

NOTE What if the legal guardian has not been granted authority to act?


Is there an interim legal guardian appointed?

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

- b** Contact the legal guardian and confirm you are speaking with the right person by asking ACC's identity check questions.

-  Identity Check Policy

- c** Explain that you are referring the client for this assessment, why the assessment is required and what the client's rights and responsibilities are. Make sure the legal guardian understands and agrees with the referral.

-  Client Legislative Rights and Responsibilities Policy

NOTE What else do you need to discuss with the legal guardian?


- the provider will be in touch to arrange a suitable appointment
- they are welcome to have a support person accompany them
- the provider will send us a report which we will send them a copy of.

- d** In Salesforce, add a contact to record the conversation and the agreement to participate.

- e** Add the assessment as an agreed intervention in the Recovery Plan.

NOTE How do you update the Recovery Plan?


Go to Create or Update Recovery Plan.

-  **PROCESS** Create or Update Recovery Plan

- f** Contact the client's GP or relevant specialist (if necessary) to request relevant medical information needed to send to the assessor, refer to the process below.

NOTE How do you request medical records?

Refer to Request Clinical Records.

-  **PROCESS** Request Clinical Records

- g** In Salesforce, add a contact to record the conversation.

3.0 Request assessment referral Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, find all the documents that need to be sent along with the referral.


NOTE What documents do you need to include?

- Relevant clinical history
- Copies of any previous, relevant, assessment reports
- Attendance records
- Most recent Individual Education Programme (IEP)
- Most recent school report
- Behavioural Support Services reports (if on file)

NOTE: Make sure you exclude any unnecessary sensitive personal information.

NOTE What do you do if you don't have all the information to complete the referral?

Request the additional information required. Once you have requested the additional information, create a reminder action, set the target date for when you expect to receive the information. If you require further information, follow the process link below.

-  Gather Additional Information or Advice

- b** Perform privacy checks on documents.

Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

Check documents:

- are relevant to the referral
- do not contain any third-party information
- do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

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, before adding the document to the document group.

NGCM - Redact information from PDF documents

c Create a referral-specific document group and enter 'Education Based Rehabilitation Assessment' and today's date in the document group description field.

d If required, add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?

When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files. E.g. Medical records and reports from claim: 100XXXXXXXX

Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

Manage document groups

e Generate a Social Rehabilitation Referral task for Recovery Administration for a 'Education Based Rehabilitation Assessment'.

Referring Tasks to Recovery Administration - Principles

Creating Manage Referral Tasks - System Steps

Contracted Suppliers by Geographic Area of Coverage

NOTE What information do you need to include in the task/e-form?

Refer to the 'Manage Referral Task Templates document'

Manage Referral Task Templates

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

- Call Recovery Administration
- Give the Recovery Administrator who answers the call the claim number
- The Recovery Administrator will open the claim in Eos and find the task on the claim
- Transfer the task into the Recovery Administrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.

NOTE What if the request is required in the future?

If the request is required in the future, set a reminder task for the future date when the service will be required. When the reminder task comes up send a task to Recovery Administration to continue with the process. Consider the contract timeframes and SLAs as specified in the service page

NOTE What are the SLAs?

The referral tasks route to the Administration team with an SLA of 24 hours.

NOTE What if your client has a Care indicator?

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

Disclosure of Care Indicator Information to Third Parties Policy

4.0 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 the required information to complete the referral form.

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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below.

Principles of Working in the Administration Team

5.0 Create and approve purchase order

Recovery Administrator

a In Eos, generate a Purchase Order for the specified referral.

Creating purchase orders using general + QE

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

NG GUIDELINES Purchase Order Details - Educational Based Rehabilitation Assessment

Service codes.pdf

b Identify and select vendor.

Service Contracts and Contracted Providers - MFP spreadsheet

NOTE What if a preferred vendor has not been specified?

If no vendor has been specified, select an appropriate contracted vendor for the referral type and client's geographic area.

NOTE Social Rehabilitation Providers


Suitable providers will be geographically close to the client and capable of providing the assessment. Take the client's cultural or other needs into consideration.

- Load the "vendor/provider" as a participant. This enables the Recovery Administration to validate the email and then email the purchase order directly from Eos if required.

- Ensure all known participants are loaded on the file and then removed when no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)


- c** Locate contracted vendors via the Geographic Location search, this must be done even if the vendor details are provided in the task. Once selected add the vendor as a 'Vendor - Contracted' participant in EOS.

 Contracted Suppliers by Geographic Area of Coverage

- d** Approve the Purchase Order.

NOTE What if the purchase order requires a higher delegation?

Refer to the system steps below.

 Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.


- 1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2). Select 'OK'.
- 3). Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

6.0 Create and send referral documents

Recovery Administrator

- a** In Eos, generate the referral document for the Education Based Rehabilitation Assessment.

 ACC081 Social rehabilitation assessment referral-vendor

- b** Populate with any extra information noted on the referral task. Ensure you have checked that all the relevant information within the task has been captured.

NOTE What does a quality referral look like?


Refer to Admin template - Education Based Rehabilitation.

 Admin Template - Education Based Rehabilitation


- c** Ensure you have completed the document (to convert the document into a non-editable pdf).

- d** Link the referral document to the document group already created.

- e** Perform privacy checks using Inbound and Outbound Document Checks.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks


- f** Create email using the Requests and referrals template, attach the referral and documents from group and select the most appropriate email address (commonly listed under General Purchasing).

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

- g** Send the referral to the vendor.

NOTE What if the Vendor requires the documents to be sent via courier?

Go to Prepare and Send Client Information by Courier process.

 **PROCESS** Prepare and Send Client Information by Courier

- h** In Salesforce, close the assigned referral task

NOTE What if you are advised by a Provider they are unable to accept a referral?


Go to Activity 5.0 (a) and complete a re-referral.

7.0 Determine next steps once assessment report is received

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive notification that the ACC345 Education Support Assessment Report has been received and is attached to the claim.

- b** Perform privacy and relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c** Check the quality of the report. Request further information if required.

NOTE What if the Assessment report is not of an appropriate standard or further information is required from the assessor?


Request further information and discuss the information lacking with the assessor. If the initial report was unsatisfactory, assessors must resubmit the report at no extra cost to ACC.

NOTE What if the quality of the report(s) is still unsatisfactory?

Talk to the local Engagement and Performance Manager if there are ongoing issues with the quality of a Provider's reports.

- d** Review the Assessment report and decide with the client the most appropriate cost-effective option based on the Assessor's report.

- e** Contact the legal guardian and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- f** In Salesforce, add a contact note as a record of the conversation.

- g** Decide level of support needed to meet the client's injury-related condition.

NOTE What if an additional assessment is required?

If another assessment is required to make a decision on supports required, identify the assessment type and request the assessment.

? **Do You Have Delegation to Approve Supports?**
Recovery Assistant, Recovery Coordinator, Recovery Partner

YES.... Continue

NO....  NEXT ACTIVITY

8.0 Request Approval

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Send approval request to the appropriate approver.

9.0 Approve Social Supports

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Contact the legal guardian and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- b** Discuss report and next steps with client.

- c** In Salesforce, add a contact note as a record of the conversation.


- d** If required, provide a copy of the report to the client and key stakeholders, as per their preferred contact method.

 NGCM - FINAL Emailing from Eos - System Steps

NOTE What if the client requests that the report is changed or incorrect?


A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.


Refer to the 'Managing a client's request to change personal information' process below.


 Managing a client's request to change personal information

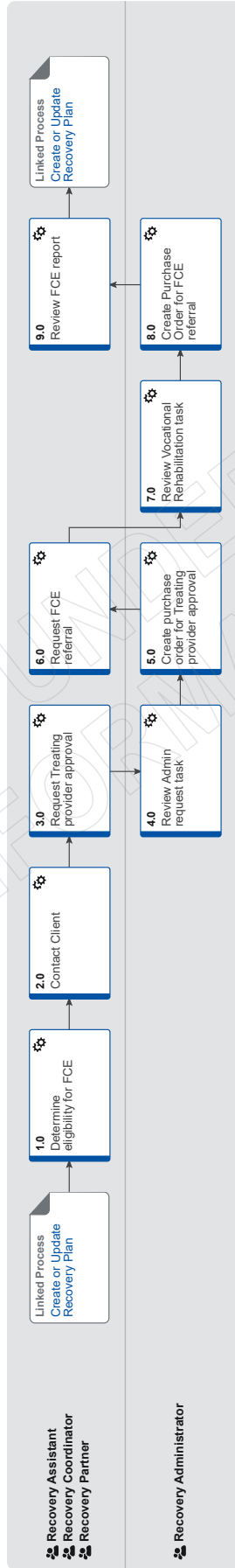
- e** Update the Recovery Plan.

- f** Approve the supports recommended by the Assessor and set up the support.

 Manage Social Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/fde996>

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Set Up Education Support**
Recovery Assistant, Recovery Coordinator, Recovery Partner



REL. ASSED UNDER THE OFFICIAL INFORMATION ACT

Summary

Objective

To generate Functional Capacity Evaluation (FCEs) referrals.

An FCE is an objective measure of a client's current functional ability (an injured person's ability to perform meaningful tasks safely and independently) versus subjective self reporting. It can identify sub optimal effort which raises the possibility of any non injury related factors in the mix. An FCE assists with ACC's vocational or social rehabilitation planning.

Background

An FCE will provide you with information to help you plan a client's rehabilitation when there is insufficient information on file about their physical capacity to perform:

- task specific activities needed for a work type eg lifting objects, climbing stairs, prolonged standing etc
- tasks needed for a specific daily living activity eg vacuuming
- general functional tasks eg general mobility.

The FCE can help you:


- determine the occupational functional ability, strengths, skills and capability of the individual Claimant to perform specific tasks and safely return to suitable work;
- identify the maximum level of functional ability from which to build rehabilitation.
- assist vocational and social rehabilitation planning and implementation, by providing additional specific information to assist with development of a Rehabilitation Plan;
- to enhance objectivity in the rehabilitation and return to work/independence process.

Owner

[Out of Scope]

Expert

Procedure

-  **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner


1.0 Determine eligibility for FCE

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, open Te Kete and review the client's current circumstances.

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

- b** Check if one or more of the following applies to the client:

- They don't require vocational and/or social rehabilitation
- They have completed their rehabilitation and/or treatment and are ready to commence the Vocational Independence
- They have acute symptoms of inflammation, radiating nerve pain or have recently had an illness
- Surgery is pending.

NOTE **What if one or more of these applies?**

It is not appropriate for your client to be referred for an FCE.

This process ends.

- c** Consider the following to determine if an FCE is appropriate for your client:

- They have an accepted claim for cover for a personal injury
- A physical limitation is preventing the client from progressing a Stay at Work (SAW) programme
- The client has had an Individual Medical Assessment (IMA) or has been referred for a Medical Case Review (MCR). An FCE will help assessors consider the client's job options
- The client has been referred for a work trial. An FCE will help the vocational assessor to understand the client's current physical abilities and match the client's physical abilities to job tasks they can safely undertake in a work trial
- The client is experiencing problems at home or work. An FCE will be able to define the task-specific problems and to inform their rehabilitation requirements.

Refer to the Functional Capacity Evaluation (FCE) Service Page below for more information.

-  [Functional Capacity Evaluation \(FCE\) Service Page](#)

NOTE **An FCE must only be used to add to or clarify other information about the client. It must not be viewed in isolation to rehabilitation recommendations.**

NOTE **What if an FCE is not appropriate at this time?**

Consider obtaining Hotline guidance to determine next step.

This process ends.

- d** Consider the most appropriate type of FCE, there are three different types of assessments.

TASK-SPECIFIC Evaluation:

- The client needs to perform a specific task or tasks

STANDARD Evaluation covers a client who has one of the following:

- Two or less musculoskeletal injuries
- A single non-musculoskeletal covered injury
- No covered claims for mental/behaviour disorders
- A claim that is not categorised as a 'sensitive claim'.

COMPLEX Evaluation covers a client who has one of the following:

- The client needs to respond to a range of physical demands
- Three or more years on weekly compensation
- Three or more musculoskeletal injuries
- Two or more non-musculoskeletal injuries
- Significant mental/behaviour disorder
- A covered sensitive claim.

2.0 Contact Client

Recovery Assistant, Recovery Coordinator, Recovery Partner


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

NOTE What if you are unable to contact the client?

Refer to the Welcome Conversation Call Attempts information sheet for next steps.

 Welcome Conversation Call Attempts

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

 Identity Check Policy

- c** Check that the client has granted ACC the authority to collect medical and other records.

 View Client Consent


NOTE What if the client has not granted consent?

Go to Obtain Client Authority to Collect Information.

 **PROCESS** Obtain Client Authority to Collect Information

- d** Discuss with your client:

- Why you are referring them for this evaluation
- What an FCE is, ie an up to date assessment of their current functional abilities including physical strength, skills and capacity to perform tasks related to employment or daily living
- Their rights and responsibilities
- ACC will be seeking approval from their GP or Specialist prior to attending
- Offer to send the fact sheet FCEIS01 All about Functional Capacity evaluation via their preferred method.

 Client Legislative Rights and Responsibilities Policy

 FCEIS01 All about Functional Capacity Evaluation

- e** Confirm your client understands the purpose of the evaluation and agrees to attend.

NOTE What if the client does not agree to participate?

- Find out why the client does not want to participate, consider their reasoning and alternatives.
- In Salesforce record the discussion as a Contact Action.
- If you are unsure how to proceed, obtain guidance, refer to Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance

- f** Advise the client the following:

- The provider will be in touch to schedule an appointment
- They are obliged to give the provider at least 1 days notice if an appointment cannot be kept and failing to attend could risk suspension of entitlements
- They are able to have a support person with them
- There is no cost
- ACC can contribute to travel
- The provider will send ACC a report which they can request a copy of.

NOTE Who are the contracted providers for this assessment?

Use the Contracted Suppliers by Geographic Area of Coverage, confirm the provider is contracted for this service and add as a participant on the claim.

 Contracted Suppliers by Geographic Area of Coverage


 Manage Participants (Eos Online Help)

- g** In Salesforce, record the conversation as a Contact Action on the claim.

- h** Add the Agreed Intervention to the Recovery Plan ie Functional Capacity Evaluation.

NOTE What if you are unsure how to add an Agreed Intervention?

Go to Create or Update Recovery Plan, then return to this process.

 **PROCESS** Create or Update Recovery Plan

3.0 Request Treating provider approval

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Create a 'NGCM - Admin request' task, asking Admin to create the GP approval letter for FCE using the GT01a letter to vendor including PO.

NOTE What information do you add into the task?

- GP Name and Vendor ID
- PO code: MEDR
- Rehab action: Treatment
- Frequency: 1 per quarter from today's date.

- b** In Salesforce, add NGCM Reminder task and set the date for 2 weeks from today to check if the response has been received from the treating provider.

4.0 Review Admin request 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 the required information to seek GP/Specialist confirmation for a FCE.

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


If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below

 [Principles of Working in the Administration Team](#)

5.0 Create purchase order for Treating provider approval

Recovery Administrator


a In Eos, generate a Purchase Order using the admin template below.

 Functional Capacity Evaluation approval - admin template

 Manage Participants (Eos Online Help)

b Approve the purchase order.

c Create and send an email using 'Requests and referrals' template and attach the documents.

 Emailing from Eos using a template - System Steps

d In Salesforce, close the task.

6.0 Request FCE referral

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Receive notification that GP/Specialist has approved client to attend FCE.

NOTE What if the GP or Specialist hasn't provided confirmation to attend the FCE?

- Do not refer the client for an FCE
- Contact the client to explain the GP/Specialist's response
- In Salesforce, record the conversation as a Contact Action
- Update the Agreed Intervention in the Recovery Plan to reflect the GP/Specialist response
- Consider obtaining guidance to determine next steps ie obtain Hotline guidance to next steps/ barriers to rehabilitation or Clinical guidance for any medical issues.
- If seeking an FCE prior to entering the Vocational Independence process, consider continuing with the VI assessment process, go to 'Arrange Vocational Independence Occupational Assessment' process and continue.

This process ends.


 **PROCESS** Seek Internal Guidance

b Check the following documents are on the claim (if applicable):

- GP/Specialist approval
- A copy of the Initial Occupational Assessment and Initial Medical Assessment
- Work Type Details sheets
- ACC188 Job Task Analysis form
- Initial Stay at Work or Standalone Workplace Assessment reports
- Medical assessments
- Medical reports.

NOTE What if there is information missing?

Go to Request Clinical Records. Once received, return to this process and continue.

 **PROCESS** Request Clinical Records

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

NOTE What if there are documents on other claims that are relevant to the evaluation?


Create a copy and transfer to the other claim:

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


Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg. Medical records and reports from claim: 100XXXXXXXX

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

d In Eos, create a document group titled 'Functional Capacity Evaluation' and add the documents to the group.

 Manage document groups

e Perform privacy checks on the documents.


 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks


 Privacy Check Before Disclosing Information Policy

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.

f In Eos, generate a Vocational Rehabilitation referral task for a 'Functional Capacity Evaluation'. For further information refer to Referring Tasks to Recovery Administration - Principles.

 Referring Tasks to Recovery Administration - Principles


 Creating Manage Referral Tasks - System Steps

g Complete the mandatory fields in the e-form.

NOTE What information do you need to include in the task/e-form?

Refer to the 'Manage Referral Task Templates document'

 Manage Referral Task Templates

 Disclosure of Care Indicator Information to Third Parties Policy

h Consider the timing of the task. The tasks route to the Recovery Administration team with an SLA of 24 hours.

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

Call Recovery Administration and provide the claim number to the Recovery Administrator requesting 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 3.0 Request Evaluation referral.

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


7.0 Review Vocational Rehabilitation 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 the required information to complete the referral form.

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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below

 Principles of Working in the Administration Team

NOTE What if you receive a NGCM - Admin Request task for a re-referral as the Provider is unable to accept a referral?

Continue to Activity 8.0 Create Purchase Order.

8.0 Create Purchase Order for FCE referral

Recovery Administrator


- a In Eos, generate a Purchase Order using referral type Functional Capacity Evaluation.

NOTE What if this is a re-referral?

Locate the original Purchase Order and continue with this process.

 Service Contracts and Contracted Providers - MFP spreadsheet

 Creating purchase orders using general + QE


 NG GUIDELINES Purchase Order Details - Functional Capacity Evaluation

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

- b Identify and select a FCE contracted vendor in the client's geographic area

NOTE What if this is a re-referral?

Update the original Purchase Order with the new Provider.

 Contracted Suppliers by Geographic Area of Coverage

NOTE What if a preferred Vendor has been specified in the task?

Select the vendor from the Contracted Supplier by Geographic Area Coverage list.


- c Add the selected Vendor as a participant on the claim.

 Manage Participants (Eos Online Help)


- d Approve the purchase order.

- e Select 'Add documents' and generate the ACC98 referral for Vocational Services.

- f Add additional information received in the task to the referral. For guidance refer to the Admin Template - ACC98 Functional Capacity Evaluation.


 Admin Template - ACC98 Functional Capacity Evaluation

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

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Privacy Check Before Disclosing Information Policy

- h Create and send an email using 'Requests and referrals' template and attach the documents.

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

- i In Salesforce, close the referral task.


NOTE What if you are advised by a Provider they are unable to accept a referral?

Go to Activity 8.0a and complete a re-referral.

9.0 Review FCE report


Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review the report. Refer to Functional Capacity Evaluation (FCE) Service Page for guidance.

 Functional Capacity Evaluation (FCE) Service Page

NOTE What if the Provider has advised the client failed to attend?

Go to Manage Non-Compliance.


 **PROCESS** Manage Non-Compliance

NOTE What if you are unsure what to do next?


Obtain guidance from an Advisor in Recovery Support to confirm next step.

 **PROCESS** Seek Internal Guidance

- b Perform Privacy checks on the report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- d Discuss the report and next steps with the client. Consider the need for a face-to-face meeting.

 NG GUIDELINES Client Face to Face Meetings

NOTE What do you need to discuss?


- Why the assessment was needed
- Discuss the content of the report
- Explain what will happen next, any support arrangements that may be affected and the various options available.

- e Provide a copy of the report to the client and key stakeholders, as per their preferred contact method.

NOTE What if the client requests that the report is changed or incorrect?


A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Refer to Manage a client's request to correct personal information.

 **PROCESS** Manage a client's request to correct personal information

f In Salesforce, add a Contact Action as a record of the conversation.

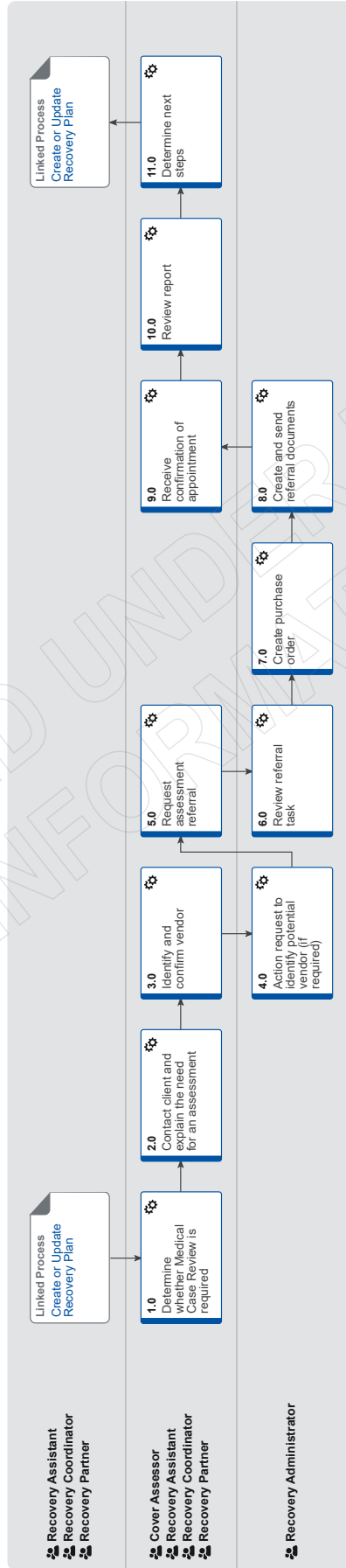
g Update the agreed intervention in the Recovery Plan.

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

RELEASED UNDER THE OFFICIAL INFORMATION ACT



REL. ASSED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

To clarify diagnoses and the cause of a client's injury or current condition and get recommendations for further investigations, treatment or rehabilitation.

To create and send a medical assessment referral in order to provide the most appropriate support for our clients throughout their recovery.

Background

Medical Case Reviews (MCR) are used to obtain an opinion from a non-treating practitioner or a second opinion from a suitably qualified assessor.

Key features:

- Only ACC can refer for an MCR
- An MCR can be used to help determine cover and ongoing entitlements
- The provider must be a non-treating practitioner who is a medical specialist
- The provider may order tests or investigations if necessary for them to be able to provide an opinion. They can also make recommendations for tests or investigations.
- MCRs are purchased either under the Clinical Services contract or by letter of agreement where the provider does not hold this contract.

Owner

[Out of Scope]

Expert

Procedure

- PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine whether Medical Case Review is required

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Confirm client's eligibility for the Medical Case Review (MCR) assessment.

NOTE You must Seek Recovery guidance from a Clinical Advisor before arranging an MCR.

NOTE What if the request/referral is to a specialist who is the treating practitioner or will become the treating practitioner?

In this case MCR codes are not appropriate.

If the provider holds the clinical services contract then they need to bill under this using the standard codes which do not need prior approval.

If the provider does not hold the clinical services contract then consult the "manage non contracted purchasing" process. (see activity 3.0 for how to confirm if they hold the clinical services contract.)

Seek support from your Team Leader and Engagement and Performance Advisor if the provider continues to request MCR codes.

NOTE Who will identify the need for an MCR?

The need for an MCR will be identified as part of written guidance from Recovery Support.

Where there are clinical questions, or where required for medicolegal reasons and Clinical Services or the treating practitioner are unable to address these, written guidance from Recovery Support will confirm and support the need for obtaining an independent expert opinion from a non-treating specialist. The written guidance will include tailored questions for the MCR provider to respond to.

For how to obtain written guidance, refer to Seek Internal Guidance.

- PROCESS** Seek Internal Guidance

NOTE What do you need to consider when deemed cover exists?

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

- Deemed Cover and Entitlements Policy

NOTE What if the client has not granted ACC authority to collect medical and other records?

See step 2a below

NOTE What if the MCR request has come from a Review Specialist?

If the MCR is being requested by a Review Specialist as the result of a review hearing or resolution agreement then you do not need to Seek Internal Guidance. Review Specialists have delegation to authorise an MCR without referring to Clinical Advice. This may be the result of an overturned or revoked decision.

NOTE What are the different types of MCR you can refer a client for?

- Standard
- Complex

NOTE When would you refer for or agree to a request for a complex MCR?

- the client's injury is of unusual complexity
- there are co-morbidities that appear to be affecting the client's recovery from injury
- the review or assessment will be undertaken in two parts while results of investigations are obtained.

NOTE When would you use an 'exceptional code' in MFP?

This is usually initiated after discussion with the provider. The 'complex' code plus an hourly rate payable under the Clinical Services Contract (all codes are in MFP). ie large volume of reading required, complex injury/non injury factors.

- Identify Claims for Rapidly Deteriorating Clients

- b** Ensure current medical notes are on file so they can be sent to the MCR assessor.

NOTE What if the current medical notes are not on file?

You will need to obtain these before the referral is sent to the provider. Refer to (NGCM) Request Clinical Records.

- PROCESS** Request Clinical Records

NOTE What if you need clarification of an answer following the MCR assessment?

Following the initial MCR assessment, you may need to clarify something in the report or have a follow up a question from Recovery Support. In this case ensure you use the PO code MEDR.

Send an NGCM - Admin Request Task to Recovery Admin to update the PO.

NOTE What if you require a supplementary report following the MCR assessment?

Following the initial MCR assessment, you may be required to request a supplementary report. This may be because you have additional questions for the assessor.

- 1) Use the PO code CSM3 and specify the number of hours required.
- 2) Send an NGCM - Admin Request Task to Recovery Admin to update the PO.


NOTE What if the client needs requires a second MCR assessment?

Following the initial MCR assessment, you may be required to request a additional MCR assessment. This may be due to receiving new medical information.

Follow the same steps below as arranging the initial MCR and ensure you use the appropriate contracted or non-contracted purchase order code. Go to 2.0 Contact client and explain need for assessment.

NOTE What if you are assessing a Work Related Gradual Process (WRGP)?

Refer to the Medical Case Review Providers list to identify who can conduct this type of assessment for WRGP claims. See link to the Te Whariki page below

 [WRGP | Medical Case Review Providers](#)


2.0 Contact client and explain the need for an assessment

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner


- a** Check that the client has granted ACC the authority to collect medical and other records.

NOTE What if the client has not granted ACC authority to collect medical and other records?

You will need to consider if authority is needed. Refer to (NGCM) Obtain Client Authority to Collect Information.

 **PROCESS** Obtain Client Authority to Collect Information

- b** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 [Identity Check Policy](#)

- c** Explain that you are referring them for the assessment, the purpose and any potential implications, as well as what their rights and responsibilities are.

NOTE What else do you need to discuss with the client?

- that the specialist may suggest a telehealth (virtual) assessment if it is clinically appropriate - the client must give their consent for this, otherwise it should be in person. Explore any concerns about a potential virtual assessment and confirm their agreement/disagreement at this point.

- ask what their availability is to attend the assessment, do they have a preferred time during the day?

- we will send the appointment details through to them

- that there is no cost for the appointment, that we can contribute or arrange travel

- they are welcome to have a support person accompany them

- the specialist will send us a report which we will send to appropriate parties. Confirm they are happy for the report to be sent to the key parties, including their GP and record this in your contact.

- make them aware that some providers will ask to review the referral documents before accepting the referral and confirming they can undertake the assessment. Explain that this is to assist the provider in deciding whether they are the right clinician for the client, and that any providers that do not accept the referral will be asked to delete the referral documents. Confirm that they are informed of this process, consent to the referral documents being shared and note this in the client contact record.

Ensure your client understands the purpose of the assessment and the possible outcomes.

NOTE What if you are booking an MCR with an Occupational Physician via the Vocational Medical Services (VMS) Centralised Booking System spreadsheet?

Some Occupational Physicians hold the Vocational Medical Services (VMS) contract to conduct an MCR, if you use these assessors they can be booked using the VMS Centralised Booking System spreadsheet. Follow the steps below when booking an assessor via the VMS spreadsheet:

- Open the VMS Centralised Booking System and identify the provider, for information and guidance refer to VMS Centralised Booking System.


- Create a reminder action to notify the client of appointment details the day prior to the appointment.


- In Salesforce, add a contact as a record of the conversation.


- Add the agreed intervention to the Recovery Plan.

- Go to step 5.0

 [Group VMS SharePoint site](#)

 [Medical Case Review and Medical Single Discipline Assessment Service Page](#)

 [Client Legislative Rights and Responsibilities Policy](#)

 [Client choice of providers Policy](#)

NOTE What if the client does not agree to participate or does not want a telehealth assessment if that has been suggested?
Find out why the client does not want to participate and consider their reasoning and alternatives. Go to (NGCM) Seek Internal Guidance if you are unsure how to proceed. If the client wants to be seen in person, let the assessor know.


 **PROCESS** Seek Internal Guidance

d In Salesforce, (or EOS if your role does not use Salesforce) add a contact as a record of the conversation.

e Add the agreed intervention to the Recovery Plan.

NOTE How do you update the Recovery Plan?

Go to (NGCM) Create or Update Recovery Plan

 **PROCESS** Create or Update Recovery Plan

NOTE What if you are a cover assessor and there is no Recovery Plan?

Add an EOS task to remind yourself to follow up on the report if it has not been received in a timely manner amending the date once you have confirmation of the assessment date.

3.0 Identify and confirm vendor

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

a Contact the vendor to check they are able to take the referral

NOTE How do you find potential vendors?

Go to Activity 4.0c and 4.0d for ways to locate suitable vendors.

NOTE What if you would like Recovery Administration to find or confirm a vendor for you?

Send an NGCM - Admin Request Task to Recovery Administration

Enter the following information into the task:

"Find Vendor for MCR"

- Type of provider eg neurologist, orthopaedic (and body area eg spinal) or pain specialist
- The questions you want them to address and a brief summary of the client and the relevant background
- any special client requests/needs eg if the client prefers a morning or afternoon appointment, the date range, if the client can travel and if so, how far.
- timeframe for the report if urgent
- which type of referral this is - complex or standard (for definitions see page 24 of "Clinical Services Service Schedule linked below.)
- confirm your client is aware that supporting information may be sent to the vendor prior to the referral being accepted.

Create your relevant document group and note the name of it in your task (this is so Recovery Admin can send it if a provider requests to see the referral documents prior to accepting the referral.)

See Activity 5 a-d for how to create and name the relevant document group.
Ensure your client is aware that the documents may go out prior to the referral.

NOTE What if you already know which vendor you want to use?

Go to activity 5 if they are contracted or Use the steps in the note below ("What if you need to refer to a non-contracted provider and how do you confirm the price?") for non-contracted vendors

NOTE How do you know if a vendor is contracted or non-contracted?

You can use the Service Contracts and Contracted Providers - MFP spreadsheet to confirm whether a vendor holds the clinical services contract. (see link below). Change the yellow box to show Clinical Services and search within the green vendor column.

Remember that some specialists work under multiple vendors so you may need to contact them directly to confirm whether they hold the clinical services contract and if so which vendor ID.

 Service Contracts and Contracted Providers - MFP spreadsheet

NOTE What if you need to refer to a non-contracted vendor and how do you confirm the price?

Send the vendor the "SMR15 - Medical case review non-contracted agreement - vendor letter" once discussion and agreement is made on rates.

Amend the letter to include the relevant service codes and the price of the assessment. Service codes for non contracted MCR's can be found in the link below NG GUIDELINES Purchase Order Details - Medical Case Review. Remove the client's address from the top if it has prepopulated and add MCRD as the service code for the disbursements line.


What is the price? Offer the same rate as a contracted MCR - See CSM codes on page 5 of the "Clinical Services Schedule" linked below.


If there is excessive relevant information and the vendor requests additional reading time it would be appropriate to use MCR13 (Exceptional rate) to cover this. These requests do not need to be approved by Elective Services.

Any requests for a rate higher than the contract must be referred to the Portfolio Manager in the Provider Service Delivery.

Email elective.services@acc.co.nz and use the subject "Approval for exceptional non contracted MCR/MSDA".

The signed letter of offer MUST be returned prior to sending a referral task to Recovery Admin.

 Clinical Services Service Schedule (Service Codes and Pricing)

 NG GUIDELINES Purchase Order Details - Medical Case Review

NOTE How do you create the SMR15 letter from outside the purchase order?

From the Documents tab at ACC45 claim level, complete the following:

- Add Document
- From the "search" tab, enter SMR15 in the document type field and click search
- Select SMR15 Medical Case Review non-contracted agreement - vendor and click OK
- Add the client's NHI number to this letter
- Codes are MCR11 (standard) or MCR12 (complex)
- Use the rates as instructed in the note above

 SMR15 Medical Case Review non-contracted agreement - vendor

NOTE What if the vendor wants to see the referral documents prior to accepting it?

Some vendors may request information about the referral prior to accepting it. Confirm that the client has given consent for supporting information documents to be sent to potential vendors.

If you would like Recovery Administration to do this for you, create an NGCM Admin task stating the action required. Note the Vendor ID & Name, email address or physical address (if the documents need to be couriered) and the document group needing to be sent.

Ensure the email address is verified and able to be emailed out of EOS. Recovery Administration will only send supporting information if consent has been given and the vendor makes this request.

- b** Add the vendor as a participant on the claim once they confirm they can undertake the assessment and have returned their signed letter of agreement where they are non-contracted. Then go to activity 5.0 Request Assessment Referral.

NOTE How do you manage participants on a claim?

The Recovery Team Member must ensure all known participants are loaded on the claim and then removed when they are no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

4.0 Action request to identify potential vendor (if required)


Recovery Administrator

- a** Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.
- b** Review the NGCM Admin Task and ensure it contains the following information:
- Type of provider
 - Standard or complex
 - Client injury history
 - Referral questions
 - Client consent (if given) for supporting information to be sent
 - Name of the document group
 - Client's location or distance they can travel
- If this is not included follow the process as per Activity 6.0.
- c** Use the MCR MSDA provider search tool to search for potential vendors with the required specialty.

 MCR MSDA provider search tool


NOTE What if a suitable contracted vendor cannot be identified?

Refer to the Medical Council of New Zealand's Register of Doctors and the Dental Council's Register of Oral Health Practitioner to search for potential providers with the required specialty in the links below.

 Medical Council of New Zealand's Register of Doctors
<https://www.mcnz.org.nz/registration/register-of-doctors>

 Dental Council's Register of Oral Health Practitioner
<https://www.dcnz.org.nz/practitioners>

- d** Contact potential vendors (local first) to check their availability either by sending the Medical Case Review and Medical Single Discipline Assessment - Vendor Email Template or by phone.

 Medical Case Review and Medical Single Discipline Assessment - Vendor Email Templates

NOTE How long do you hold on to the task?

Try additional vendors, until you do have a response

Hold on to the task till the end of the day to allow time for responses.

NOTE What if the vendor requests supporting information prior to accepting the referral?


Some may ask to see supporting information before they will accept the referral or sign the SMR15. Generally, this is because they want to confirm if they are the right clinician for this client.

This information can be sent to potential vendors via email or couriered as a final option.

Confirm the client has provided consent for the information to be released (the Recovery Team Member will note this in the task).

Email vendors using the email template link below.

Recovery Team Members should have named the relevant document group in the task. If this is not included and the vendor is requesting this follow the process as per Activity 6.0

 Medical Case Review and Medical Single Discipline Assessment - Vendor Email Templates

- e** Close the NGCM – Admin Request task once the vendors have been identified.

NOTE TIP: If potential vendors have been identified in the task description copy this before you close the task.

- f** Create a Contact Party (Case Owner) Task to the Recovery Team Member/Team.

In the task description enter the following 'Potential Vendors Identified'

- Vendor names and dates available (include if the vendor is suggesting telehealth (virtual) assessment) or
- No vendors available

If the request to arrange an MCR is urgent change the priority to 'High' before transferring the task back to the Recovery Team Member/Team

5.0 Request assessment referral

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Find all the documents that need to be sent along with the referral.

NOTE What if the signed letter of agreement has not been received for a non-contracted service?

The process cannot proceed to referral without the signed letter of offer being returned from the vendor. The Recovery Team member is responsible for ensuring this is returned.

NOTE What documents should be considered?

It is important that you send only the relevant information to the specialist. Consider the questions you are asking them to answer.

- A current medical certificate
- Schedule relevant to the client's function
- Schedule of Claimant Injuries (if deemed applicable)
- Most recent/current Back to Work, Stay at Work, Standalone Workplace Assessment Reports
- GP notes
- Specialist notes
- Imaging results
- Physio notes
- All medical notes and any relevant vocational notes eg a Standalone Workplace Assessment if the specialist has been asked to consider s103
- Any written guidance information from Recovery Support
- Signed ACC6300 or ACC6300D Authority to collect medical and other records. NOTE: If verbal consent was provided please note this in the task eform for Recovery Admin.


NOTE What do you do if you don't have all the information to complete the referral?

If you require further information, refer to Gather Additional Information or Advice.

Once you have requested the required information, create a reminder action and set the target date for when you expect to receive the information.

NOTE What if the document group created is larger than 250 pages?

This may indicate that there is irrelevant information being included. We should only be sending the relevant documents to the assessor so please discuss what can be redacted with your Team Leader prior to sending it to Recovery Administration.

-  Gather Additional Information or Advice


- b** Perform privacy checks on documents.

NOTE What do you need to check?

Check documents:


- are relevant to the referral
- do not contain any third party information
- do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

-  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, before adding the document to the document group.

-  NGCM - Redact information from PDF documents

- c** Create a referral-specific document group with today's date and name it 'Medical Case Review'.

- d** Add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?


Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description

- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims


The PDF should also be renamed to identify which claim number the information came from, so it is included/printed in further referrals or copy files. e.g. Medical records and reports from claim: 100XXXXXXXX

This will ensure the notes remain on the correct claim but a copy can accompany the referral, while clearly identifying which claim they belong to.

Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

-  Manage document groups

- e** Generate a Medical Assessment referral task for Recovery Administration for a 'Medical Case Review'.

-  Referring Tasks to Recovery Administration - Principles

NOTE How do you generate and send a referral task to Recovery Administration?

Go to NGCM Create a Referral Task.


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

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

-  Creating Manage Referral Tasks - System Steps

NOTE What information do you need to include in the referral task?

- Type of MCR (standard/complex)
- Vendor
- Address for clinic/appointment (if known)
- If non contracted confirm that the signed SMR15 (letter of agreement) is on file
- Recommendations from Recovery Support, including any questions
- Reason for the referral
- Vendor's delivery method (email/courier)
- Provide the correct service code. Refer to the Purchase Order guidelines linked below
- The client's NHI number
- Confirm whether or not the client has consented to telehealth if this was requested
- Details of care indicators if applicable
- In the VMS box write NA if it not a vocational assessment.


 NG GUIDELINES Purchase Order Details - Medical Case Review

- f** Complete all the mandatory fields and any additional information to be included in the referral form including questions received via written guidance from Recovery Support.


 Identify Claims for Rapidly Deteriorating Clients

NOTE What if your client has a Care indicator?
You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of Care Indicator Information to Third Parties Policy

- g** Review "When to use 'high' priority indicator on the tasks sent to Recovery Administration" rules to determine priority of the task.

 When to use 'high' priority indicator on the tasks sent to Recovery Administration

NOTE What if your scenario meets the 'high' priority rule for this task?

- If your scenario meets the priority rule for this task, change the priority indicator to 'high'.
- If your scenario doesn't meet the priority rule for this task, leave the priority indicator at 'low'.

6.0 Review referral 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 the referral is for a non-contracted service?

The process cannot proceed to assessment without the signed letter of offer (SMR15) being returned from the vendor. The Recovery Team member is responsible for this so if it's not linked to the task then you should follow the note below.

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


If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below.


 Principles of Working in the Administration Team

7.0 Create purchase order

Recovery Administrator

- a** In Eos, create a purchase order for the MCR referral.

 Create a purchase order

 NG GUIDELINES Purchase Order Details - Medical Case Review

- b** Identify and select the vendor as specified by the Recovery Team Member.

NOTE What if you need to locate the vendor via the VMS Booking sheet?

Once selected add the vendor as a 'Vendor' - participant in Eos.

 Group VMS SharePoint site


- c** Locate the vendor via the Geographic Location search, once selected add the vendor as a 'Vendor' participant in Eos.

- d** Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Save the purchase order. Create and send a Request Authorisation task to a Recovery Leader for a purchase order approval.

Refer to the link below.

 Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.


- 1) In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2) Select 'OK'.
- 3) Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

8.0 Create and send referral documents

Recovery Administrator


- a** Create an ACC7395 referral document for the MCR assessment.

 ACC7395 Referral for medical single discipline assessment or medical review - PO - vendor

- b** Populate with extra information noted on the referral task. Ensure you have checked that all the relevant information within the task has been captured.

NOTE What does a quality ACC7395 look like?


Refer to Admin Template - Referral for medical single discipline assessment or medical review

 Admin Template - Referral for medical single discipline assessment or medical review

- c** Ensure you have completed the document (to convert the document into a non-editable pdf).

- d** Link the referral to the document group 'Medical Case Review'.


- e Perform privacy checks using Inbound and Outbound Document checks

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- f Call the vendor to confirm how they want to receive the referral documents (if email, ensure it is verified and if they prefer documents to be emailed separately or as a bulk print).

NOTE What if the Provider and/or Vendor email address has not been verified?

Go to Verify Provider and Vendor email addresses process.

 **PROCESS** Verify an Existing Provider, Vendor or Facility Email Address

NOTE What if the vendor has been booking via the VMS booking sheet?

Update the VMS booking sheet with the date the referral is sent.

 VMS Centralised Booking System Service Page

- g Generate a Bulk Print of the "Medical Case Review" Document Group by following the system steps below.


 Create Bulk Print

- h Generate the Bulk Print Index.

NOTE How do you generate the Bulk Print Index?

- Click properties
- Click view contents less
- Right click convert to PDF
- Save to desktop
- Upload to Claim using document type VCF006
- Label as Bulk Print Index
- Delete file from desktop

- i If email is the preference, create email using the requests and referrals template and attach the referral and bulk print and save the bulk print to desktop and attach to the email. Use the email address as confirmed by the vendor.

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

NOTE What if you identify the documents you're sending exceed 10MB?

Use Adobe Pro to

Reduce file size:

- Select Optimize PDF
- Select Reduce File Size

Or

Split document


- Select organize page
- Select Split
- Select Split by File Size (up to 10MB)

The document will save in the same location and the original document and will be name PART1, PART2 (depending in the size of the file being split).


- j Send the referral to the vendor.

NOTE What if the Vendor requires the documents to be sent via courier?

Go to Prepare and Send Client Information by Courier process.

 **PROCESS** Prepare and Send Client Information by Courier

- k Send the appointment and information sheet to the client via the preferred contact method. Ensure they contain the relevant dates/times/locations where these are available and ensuring any vendor phone numbers are not personal ones.

 SMR12 Medical case review appointment - client

 SMRIS02 Medical case reviews - client

- l in Salesforce, close the assigned referral task.

9.0 Receive confirmation of appointment

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive confirmation of the appointment from the provider and file the email away to Eos.

NOTE What if the vendor is unable to accept the referral?

If the vendor is unable to accept the referral, resubmit the request with a new vendor.

NOTE What are the timeframes?


- A vendor who has agreed to provide the MCR must perform a clinical examination within eight business days of receiving a referral, unless otherwise agreed by ACC

- If they are unable to meet the eight day timeframe to see a client, you can negotiate a timeframe which is acceptable to both parties

- The vendor must provide a copy of the report to the case owner within eight business days from the date of the clinical examination.

NOTE What if the client refuses or fails to attend and/or participate in the MCR?

If the client refuses or fails to attend or take part in the MCR you should find out why. In some cases, you may need to consider the non compliance process. Refer to the Policy below.

 **PROCESS** Decline Entitlement when Client is Non-compliant Policy

NOTE What if the client wants to change to appointment date?

Contact the vendor and discuss and confirm new appointment details.

10.0 Review report

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive notification that the MCR report has been attached to the claim.

NOTE What if there are quality clinical issues or concerns?

If you have any concerns relating to the clinical quality of any VMS reports, please email the case through to clinicalquality@acc.co.nz. You are encouraged to deal directly with the vendor where you can, particularly if the concerns are around the completeness of the report or omissions.

However, the clinical quality team are particularly interested regarding any reports which lack clinical quality. Not only will the clinical quality team help you by reviewing the report with the Engagement and Performance Management team (EPM) talking with the vendors, learnings will be provided to all Providers through the regular newsletters.

- b Perform Privacy and Relevancy checks on the received report.

11.0 Determine next steps

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Follow the advice and recommendations in the MCR. If the report answers your questions clearly then act on those answers and in these cases there is no need to seek internal clinical advice. The only exception to acting on the recommendations of the report without any further advice is if the next step is a section 117 suspension or revocation of cover, then seek advice from Technical Services.

NOTE What if the MCR report is not clear?

Seek guidance from your Team Leader initially, escalating to Practice Mentor if required. If you are still not clear what the next steps are then seek internal guidance to confirm.

The referral for guidance must explicitly state what exactly in the report you need assistance understanding.

NOTE Refer to (NGCM) Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance

NOTE What if you need clarification of an answer following the MCR assessment



Following the initial MCR assessment, you may need to clarify something in the report or have a follow up a question from Recovery Support. In this case ensure you use the PO code MEDR. Send an NGCM - Admin Request Task to Recovery Admin to update the PO.

NOTE What if you require a supplementary report following the MCR assessment?

Following the initial MCR assessment, you may be required to request a supplementary report. This may be because you have additional questions for the assessor. Ensure you use the PO code CSM3 and specify the number of hours required. Send an NGCM - Admin Request Task to Recovery Admin to update the PO.

NOTE What if the client needs requires a second MCR assessment?


Following the initial MCR assessment, you may be required to request an additional MCR assessment. Follow the same steps as arranging the initial MCR and ensure you use the appropriate contracted or non-contracted purchase order code. Go to 2.0 Contact client and explain need for assessment.

- b Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.
 -  Identity Check Policy
- c Discuss the report, the outcome of the guidance and the next steps. Consider if a face-to-face meeting is required.
 -  NG GUIDELINES Client Face to Face Meetings


NOTE What if the client requests that the report is changed or incorrect?

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Refer to Managing a client's request to change personal information

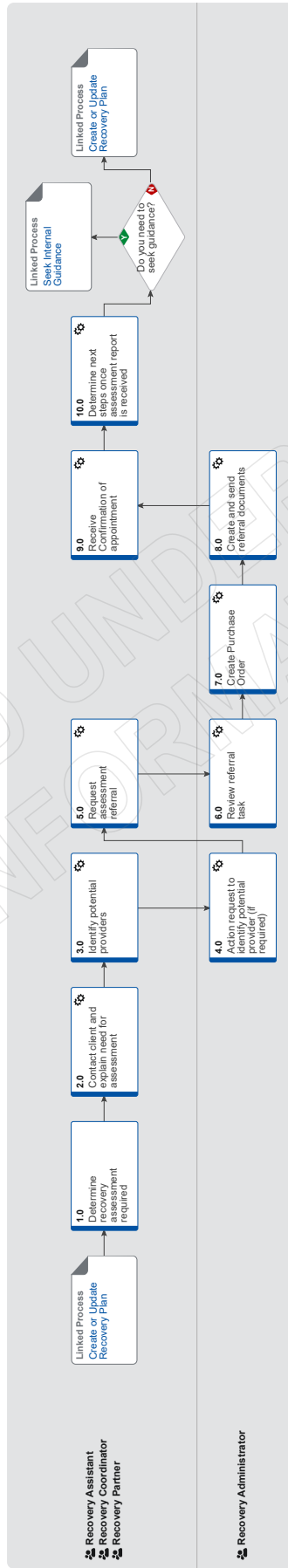
 Managing a client's request to change personal information

- d Provide a copy of the report to the client, their GP (ensuring the client has given permission) and any other stakeholders as you consider appropriate or if internal advice was sought then also as recommended by recovery support.
- e In Salesforce, add a contact note as a record of the conversation.
- f Update the Recovery Plan with the outcome of the intervention.

 **PROCESS** Create or Update Recovery Plan
Recovery Assistant, Recovery Coordinator, Recovery Partner



REL. ASSED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

To create and send a medical assessment referral in order to provide the most appropriate support for our clients throughout their recovery.

A medical assessment is a way to establish if the treatment/rehabilitation for the clients injury that they have been receiving is suitable. It nominates a doctor who specialises in that specific area to assess what the most appropriate treatment and rehabilitation options ACC should be offering.

Medical Single Discipline Assessments (Medical SDA) are used to obtain an opinion from an alternative practitioner when we're unable to get this from the client's current treating practitioner.

Key features:

- MSDA is used when:

- Cover or entitlement is not in question
- Where treatment options are not clear or rehabilitation has stalled despite input from the treating practitioner

- The provider must be a different treating practitioner who is a medical specialist

- The provider may order tests or investigations if necessary for them to be able to provide to an opinion. They can also make recommendations for tests or investigations

- Provides treatment and rehabilitation recommendations from a specialist outside of that available from the treating practitioner

- Medical SDAs are purchased under the Clinical Services contract.

Owner [Out of Scope]
Expert [Redacted]

Procedure

PROCESS **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine recovery assessment required

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Confirm client's eligibility for the Medical Single Discipline (MSDA) assessment.

NOTE Referrals for an MSDA must be supported by Recovery Support (Clinical Services).

NOTE What if the request/referral is for a treating practitioner or they will become the treating practitioner?

In this case MSDA codes are not appropriate.

If the vendor holds the clinical services contract then they need to bill under this using the standard codes which do not need prior approval.

If the vendor does not hold the clinical services contract then consult the "manage non contracted purchasing" process. (see activity 3 for instructions on how to confirm if they hold the clinical services contract)

Seek support from your Team Leader and Engagement and Performance Advisor if the vendor continues to request MSDA codes.

NOTE Who will identify the need for an MSDA?

The need for an MSDA will be identified as part of written guidance from Recovery Support.

Where there are questions regarding the most appropriate treatment or rehabilitation and Clinical Services or the treating practitioner are unable to address these, written guidance from Recovery Support will confirm and support the need for obtaining an independent expert opinion from a non-treating specialist.

For how to obtain written guidance refer to PROCESS Seek Internal Guidance

PROCESS Seek Internal Guidance

NOTE What do you need to consider when 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 types of MSDA you can refer a client for?

- Standard
- Complex

NOTE When would you refer for or agree to a request for a complex MSDA?

- the client's injury is of unusual complexity
- there are co-morbidities that appear to be affecting the client's recovery from injury
- the review or assessment will be undertaken in two parts while results of investigations are obtained.

NOTE When would you use an 'exceptional code' in the purchase order?

Where the referral/assessment requires a large volume of reading.

Identify Claims for Rapidly Deteriorating Clients

Medical Assessment Quick Ref Guide_updated.pdf

b Ensure current medical notes are on file so they can be sent to the MSDA provider.

NOTE What if current medical notes are not on file?

You will need to obtain these before the referral is sent to the provider. Refer to (NGCM) Request Clinical Records.

PROCESS Request Clinical Records

NOTE What if the client has not granted ACC authority to collect medical and other records?

See step 2a below

2.0 Contact client and explain need for assessment

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Check that the client has granted ACC the authority to collect medical and other records.

View Client Consent

NOTE What if the client has not granted ACC authority to collect medical and other records?

You will need to obtain the client's authority to collect medical and other records. Refer to (NGCM) Obtain Client Authority to Collect Information.

PROCESS Obtain Client Authority to Collect Information

- b** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

Identity Check Policy

- c** Explain why you are referring them to this assessment and what the assessment will do, as well as what the client's responsibilities are. Check for their preference of provider, date, and time.

Medical Case Review and Medical Single Discipline Assessment Service Page

Client Legislative Rights and Responsibilities Policy

Client choice of providers Policy

NOTE What else do you need to discuss with the client?

- that the specialist may suggest a telehealth (virtual) assessment if it is clinically appropriate - the client must give their consent for this, otherwise it should be in person. Explore any concerns about a potential virtual assessment and confirm their agreement/disagreement at this point.

- ask what their availability is to attend the assessment, do they have a preferred time during the day?

- we will send the appointment details through to them

- that there is no cost for the appointment, that we can contribute or arrange travel

- they are welcome to have a support person accompany them

- the specialist will send us a report which we will send to appropriate parties. Confirm they are happy for the report to be sent to the key parties, including their GP and record this in your contact.

- make them aware that some providers will ask to review the referral documents before accepting the referral and confirming they can undertake the assessment. Explain that this is to assist the provider in deciding whether they are the right clinician for the client, and that any providers that do not accept the referral will be asked to delete the referral documents. Confirm that they are informed of this process, consent to the referral documents being shared and note this in the client contact record.

Ensure your client understands the purpose of the assessment and the possible outcomes.

NOTE What if the client does not agree to participate or does not want a telehealth assessment if that has been suggested?

Find out why the client does not want to participate and consider their reasoning and alternatives. Go to (NGCM) Seek Internal Guidance if you are unsure how to proceed. If the client wants to be seen in person, let the assessor know.

PROCESS Seek Internal Guidance

- d** In Salesforce, (or EOS if you role does not use Salesforce) add a contact note as a record of the conversation.

- e** Add the agreed intervention to the Recovery Plan.

NOTE How do you update the Recovery Plan?

Go to (NGCM) Create or Update Recovery Plan.

PROCESS Create or Update Recovery Plan

NOTE What if you are a cover assessor and you do not use Salesforce?

Create an EOS task to remind yourself to follow up on the report in a timely manner.

3.0 Identify potential providers

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Contact the vendor to check they are able to take the referral.

NOTE How do you find potential vendors?

Go to Activity 4.0c and 4.0d for ways to locate suitable vendors.

NOTE What if you would like Recovery Administration to find or confirm a vendor for you?

Send an NGCM - Admin Request Task to Recovery Administration

Enter the following information into the task:

"Find Vendor for MSDA"

- Type of provider eg neurologist, orthopaedic (and body area eg spinal) or pain specialist
- The questions you want them to address and a brief summary of the client and the relevant background
- any special client requests/needs eg if the client prefers a morning or afternoon appointment, the date range, if the client can travel and if so, how far.
- timeframe for the report if urgent
- which type of referral this is - complex or standard (for definitions see page 24 of "Clinical Services Service Schedule linked below.)
- confirm your client is aware that supporting information may be sent to the vendor prior to the referral being accepted.

Create your relevant document group and note the name of it in your task (this is so Recovery Admin can send it if a provider requests to see the referral documents prior to accepting the referral.)

See Activity 5 a-d for how to create and name the relevant document group. Ensure your client is aware that the documents may go out prior to the referral.

 Clinical Services Service Schedule (Service Codes and Pricing)


NOTE What if you already know which vendor you want to use?

Go to activity 5 if they are contracted or Use the steps in the note below ("What if you need to refer to a non-contracted provider and how do you confirm the price?") for non-contracted vendors

NOTE How do you know if a vendor is contracted or non-contracted?

You can use the Service Contracts and Contracted Providers - MFP spreadsheet to confirm whether a vendor holds the clinical services contract. (see link below). Change the yellow box to show Clinical Services and search within the green vendor column.

Remember that some specialists work under multiple vendors so you may need to contact them directly to confirm whether they hold the clinical services contract and if so which vendor ID.

 Service Contracts and Contracted Providers - MFP spreadsheet

NOTE What if you need to refer to a non-contracted vendor and how do you confirm the price?

Send the vendor the "SMR14 - Medical SDA non-contracted agreement - vendor letter" once discussion and agreement is made on rates.

Amend the letter to include the relevant service codes and the price of the assessment. Service codes for non contracted MSDA's can be found in the link below NG GUIDELINES Purchase Order Details - Medical Single Discipline. Remove the client's address from the top if it has prepopulated and add MSDAD as the service code for the disbursements line.


What is the price? Offer the same rate as a contracted MSDA - See CSA codes on page 6 of the "Clinical Services Service Schedule" linked below.


If there is excessive relevant information and the vendor requests additional reading time it would be appropriate to use MSDA3 (Exceptional rate) to cover this. These requests do not need to be approved by Elective Services.

Any requests for a rate higher than the contract must be referred to the Portfolio Manager in the Provider Service Delivery.

Email elective.services@acc.co.nz and use the subject "Approval for exceptional non contracted MCR/MSDA".

The signed letter of offer MUST be returned prior to sending a referral task to Recovery Admin.

 Clinical Services Service Schedule (Service Codes and Pricing)

 NG GUIDELINES Purchase Order Details - Medical Single Discipline Assessment

NOTE How do you create the SMR14 letter from outside the purchase order?

From the Documents tab at ACC45 claim level, complete the following:

- Add Document
- From the "search" tab, enter SMR14 in the free entry field
- Select "SMR14 Medical Single Discipline Assessment non-contracted agreement - vendor" and click OK
- Remove the client's address from the top of the letter
- Add the client's NHI number to the SMR14 letter prior to sending
- Use the rates as instructed in the note above
- The codes are MSDA1 (standard) MSDA2 (complex)

NOTE What if the provider wants to see the referral documents prior to accepting it?

Some vendors may request information about the referral prior to accepting it. Confirm that the client has given consent for supporting information documents to be sent to potential vendors.

If you would like Recovery Administration to do this for you, create an NGCM Admin task stating the action required. Note the Vendor ID & Name, email address or physical address (if the documents need to be couriered) and the document group needing to be sent.

Ensure the email address is verified and able to be emailed out of EOS. Recovery Administration will only send supporting information if consent has been given and the vendor makes this request.

- b** Add the vendor as a participant on the claim once they confirm they can undertake the assessment and have returned their signed letter of agreement where they are non-contracted. Then go to activity 5.0 Request Assessment Referral.

NOTE How do you manage participants on a claim?

The Recovery Team Member must ensure all known participants are loaded on the file and then removed when they are no longer relevant. For information on how to manage participants, refer to the link below.

 [Manage Participants \(Eos Online Help\)](#)

4.0 Action request to identify potential provider (if required)


Recovery Administrator


- a** Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.
- b** Review the NGCM Admin Task and ensure it contains the following information
- Type of provider
 - Standard or complex
 - Client injury history
 - Referral questions
 - Client consent (if given) for supporting information to be sent
 - Name of the document group
 - Client's location or distance they can travel
- If this is not included follow the process as per Activity 6.0.
- c** Use the MCR & MSDA provider search tool to search for potential vendors with the required specialty. Provide direct feedback on this tool to the Portfolio team - their email address is located in the tool.

 [MCR MSDA provider search tool](#)


NOTE What if a suitable contracted vendor cannot be identified?

Refer to the Medical Council of New Zealand's Register of Doctors and the Dental Council's Register of Oral Health Practitioner to search for potential providers with the required specialty in the links below.

 [Medical Council of New Zealand's Register of Doctors
https://www.mcnz.org.nz/registration/register-of-doctors](https://www.mcnz.org.nz/registration/register-of-doctors)

 [Dental Council's Register of Oral Health Practitioner
https://www.dcnz.org.nz/practitioners](https://www.dcnz.org.nz/practitioners)

- d** Contact potential vendors (local first) to check their availability either by sending the Medical Case Review and Medical Single Discipline Assessment - Vendor Email Template or by phone.

 [Medical Case Review and Medical Single Discipline Assessment - Vendor Email Templates](#)

NOTE How long do you hold on to the task for?

Try additional vendors, until you do have a response
Hold on to the task until the end of the day to allow time for responses

NOTE What if the vendor requests supporting information prior to accepting the referral?


Some may ask to see supporting information before they will accept the referral or sign the SMR14. Generally, this is because they want to confirm if they are the right clinician for this client.

This information can be sent to potential vendors via email or couriered as a final option.

Confirm the client has provided consent for the information to be released (the Recovery Team Member will note this in the task).

Email vendors using the email template link below.

Recovery Team Members should have named the relevant document group in the task. If this is not included and the vendor is requesting this follow the process as per Activity 6.0

 [Medical Case Review and Medical Single Discipline Assessment - Vendor Email Templates](#)

- e** Close the NGCM – Admin Request task once the vendors have been identified.

NOTE TIP: If potential vendors have been identified in the task description copy this before you close the task.

- f** Create a Contact Party (Case Owner) task to the Recovery Team member or Recovery Team.

In the task description enter the following:
'Potential Vendors Identified'

- Vendor names and dates available (include if the vendor is suggesting telehealth (virtual) assessment) or
- No vendors available

If the request to arrange an MSDA is urgent change the priority to 'High' before transferring the task back to the Recovery Team Member/Team

5.0 Request assessment referral

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Find all the documents that need to be sent along with the referral.

NOTE What if the signed letter of agreement has not been received for a non-contracted service?

The process cannot proceed to referral without the signed letter of offer being returned from the vendor. The Recovery Team member is responsible for ensuring this is returned.

NOTE What documents should be considered?

It is important that you send only the relevant information to the specialist. Consider the questions you are asking them to answer.

- A current medical certificate
- Schedule relevant to the client's function
- Schedule of Claimant Injuries (if deemed applicable)
- Most recent/current Back to Work, Stay at Work, Standalone Workplace Assessment Reports
- GP notes
- Specialist notes
- Imaging results
- Physio notes
- All medical notes and any relevant vocational notes eg a Standalone Workplace Assessment if the specialist has been asked to consider s103
- Any written guidance information from Recovery Support
- Signed ACC6300 or ACC6300D Authority to collect medical and other records. NOTE: If verbal consent was provided please note this in the task eform for Recovery Admin.

NOTE What do you do if you don't have all the information to complete the referral?

If you require further information, refer to Gather Additional Information or Advice. Once you have requested the required information, create a reminder action and set the target date for when you expect to receive the information.

NOTE What if the document group created is larger than 250 pages?

This may indicate that there is irrelevant information being included. We should only be sending the relevant documents to the assessor so please discuss what can be redacted with your Team Leader prior to sending it to Recovery Administration.

 Gather Additional Information or Advice


b Perform privacy checks on documents.

 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

- Check documents:
- are relevant to the referral
 - do not contain any third party information
 - do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 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, before adding the document to the document group.

 NGCM - Redact information from PDF documents

c Create a referral-specific document group and enter 'Medical Single Discipline Assessment' and today's date in the document group description field.

d Add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?

When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files. E.g. Medical records and reports from claim: 100XXXXXXXX


Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

 Manage document groups

e Generate an NGCM Medical Assessment referral task for Recovery Administration for a 'Medical Single Discipline Assessment'.

NOTE How do you refer a task to Recovery Administration?

Please see Referring Tasks to Recovery Administration - Principles for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

NOTE How do you generate and send a referral task to Recovery Administration for a MSDA?

Go to NGCM Create a Referral Task.


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

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

 Creating Manage Referral Tasks - System Steps


NOTE What information do you need to include in the referral task?

- Type of MSDA (standard/complex)
- Vendor
- Address for clinic/appointment (if known)
- If non contracted confirm that the signed SMR14 (letter of agreement) is on file
- Recommendations from Recovery Support, including any questions
- Reason for the referral
- Vendor's delivery method (email/courier)
- Provide the correct service code. Refer to the Purchase Order guidelines linked below
- The client's NHI number
- Confirm whether or not the client has consented to telehealth if this was requested
- Details of care indicators if applicable
- In the VMS box write NA if it not a vocational assessment.


 NG GUIDELINES Purchase Order Details - Medical Single Discipline Assessment

NOTE What if your client has a Care indicator?
You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of Care Indicator Information to Third Parties Policy

- f** Review "When to use 'high' priority indicator on the tasks sent to Recovery Administration" rules to determine priority of the task.

 When to use 'high' priority indicator on the tasks sent to Recovery Administration

NOTE What if your scenario meets the 'high' priority rule for this task?

- If your scenario meets the priority rule for this task, change the priority indicator to 'high'.
- If your scenario doesn't meet the priority rule for this task, leave the priority indicator at 'low'.

6.0 Review referral 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 the referral is for a non-contracted service?

The process cannot proceed to assessment without the signed letter of offer (SMR14) being returned from the provider. The Recovery Team member is responsible for this so if it's not linked to the task then you should follow the note below.

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


If required information is missing from the task (see Activity 5e. for what should be included) or you need guidance on working within the Administration Team, refer to NG PRINCIPLES Working in the Administration Team.


 Principles of Working in the Administration Team

7.0 Create Purchase Order

Recovery Administrator

- a** In Eos, generate a Purchase Order for the specified referral.

 Request Authorisation for a Purchase Order - System Steps

 NG GUIDELINES Purchase Order Details - Medical Single Discipline Assessment

NOTE What amount do you use for non contracted MSDA codes?

Use the \$ amount that is found in the task.

- b** Identify and select the vendor as specified by the Recovery Team Member.

NOTE What if a vendor not been identified?


Contact the Recovery staff member for the appropriate vendor.

- c** Approve Purchase Order.

NOTE What if the purchase order requires a higher delegation?

Save the purchase order. Create and send a Request Authorisation task to a Recovery Leader for a purchase order approval.

Refer to the link below.

 Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.

1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.

2). Select 'OK'.


3). Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

8.0 Create and send referral documents

Recovery Administrator


- a** Create an ACC7395 referral document for the MSDA assessment

 ACC7395 Referral for medical single discipline assessment or medical review - PO - vendor

- b** Populate with extra information noted on the referral task. Ensure you have checked that all the relevant information within the task has been captured.

NOTE What does a quality ACC7395 look like?


Refer to Admin Template - Referral for medical single discipline assessment or medical review

 Admin Template: Referral for medical single discipline assessment or medical review

- c** Ensure you have completed the document (to convert the document into a non-editable pdf).

- d** Link the referral to the document group 'Medical Single Discipline Assessment'.


- e Perform privacy checks using Inbound and outbound document checks.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- f Call the vendor to confirm how they want to receive the referral documents (if email, ensure it is verified and if they prefer documents to be emailed separately or as a bulk print)

NOTE What if the provider/vendor email address has not been verified?

Go to Verify Provider and Vendor email addresses process.

 **PROCESS** Verify an Existing Provider, Vendor or Facility Email Address

- g Generate a Bulk Print of the "Medical Single Discipline Assessment" Document Group by following the system steps below.

 Create Bulk Print

- h Generate the Bulk Print Index

NOTE How do you generate the Bulk Print Index?

- Click properties
- Click view contents less
- Right click convert to PDF
- Save to desktop
- Upload to Claim using document type VCF006
- Label as Bulk Print Index
- Delete file from desktop

- i Create email using the Requests and referrals template, attach the referral and bulk print and save the bulk print to desktop and attach to the email. Select the most appropriate email address (commonly listed under General Purchasing).

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

NOTE What if you identify the documents you're sending exceed 10MB?

Use Adobe Pro to Reduce file size:

- Select Optimize PDF
- Select Reduce File Size

Or


- Split document
- Select organize page
- Select Split
- Select Split by File Size (up to 10MB)

The document will save in the same location and the original document and will be name PART1, PART2 (depending in the size of the file being split).

- j Send the referral to the vendor.


NOTE What if the Vendor requires the documents to be sent via courier?

Go to Prepare and Send Client Information by Courier process.

 **PROCESS** Prepare and Send Client Information by Courier

- k Send the appointment and information sheet to the client via the preferred contact method. Ensure they contain the relevant dates/times/locations where these are available and ensuring any vendor phone numbers are not personal ones.

 SMRIS05 Medical single discipline assessment - client

 SMR11 Medical single discipline assessment appointment - client

- l In Salesforce, close the assigned referral task.

9.0 Receive Confirmation of appointment

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive confirmation of the appointment from the provider and file the email away to Eos.

NOTE What if the vendor is unable to accept the referral?

If the vendor is unable to accept the referral, resubmit the request with a new vendor.

NOTE What are the timeframes?


- A vendor who has agreed to provide the MSDA must perform a clinical examination within eight business days of receiving a referral, unless otherwise agreed by ACC

- If a provider is unable to meet the eight day timeframe to see a client, you can negotiate a timeframe which is acceptable to both parties

- The provider must provide a copy of the report to the case owner within eight business days from the date of the clinical examination.

NOTE What if the client refuses or fails to attend and/or participate in the MSDA?

If the client refuses or fails to attend or take part in the MSDA you should find out why. In some cases, you may need to consider the non-compliance process. Refer to the Policy below.

 **PROCESS** Decline Entitlement when Client is Non-compliant Policy

NOTE What if the client wants to change to appointment date?

Contact the provider and discuss and confirm new appointment details.

10.0 Determine next steps once assessment report is received

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a Receive notification that the MSDA report has been attached to the claim.

NOTE What if there are quality clinical issues or concerns?

If you have any concerns relating to the clinical quality of any reports, please email the case through to clinicalquality@acc.co.nz. You are encouraged to deal directly with the vendor where you can, particularly if the concerns are around the completeness of the report or omissions.

However, the clinical quality team are particularly interested regarding any reports which lack clinical quality. Not only will the clinical quality team help you by reviewing the report with the Engagement and Performance Management team (EPM) talking with the Providers, learnings will be provided to all Providers through the regular newsletters.

- b Perform Privacy and Relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c** Consider the advice and recommendations in the MSDA. If the report answers your questions clearly then act on those answers and in these cases there is no need to seek internal clinical advice. The only exception to acting on the recommendations of the report without any further advice is if the next step is a section 117 suspension or revocation of cover, then seek advice from Technical Services.

NOTE Refer to (NGCM) Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance


- d** Discuss report and next steps with client. Consider if a face-to-face meeting is required.

- remind them why the assessment was needed
- discuss the content of the report
- explain what will happen next, any entitlements that may be affected and the various options available.

 NG GUIDELINES Client Face to Face Meetings

NOTE What if the client wants to meet face to face?

Refer to (NGCM) Assess Face to Face Client Meeting.

 **PROCESS** Arrange Face to Face Client Meeting

NOTE What if the client requests that the report is changed or incorrect?

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Refer to Managing a client's request to change personal information

 Managing a client's request to change personal information

- e** Provide a copy of the report to the client, their GP (ensuring the client has given permission) and any other stakeholders as you consider appropriate or if internal advice was sought then also as recommended by recovery support.

 **Do you need to seek guidance?**

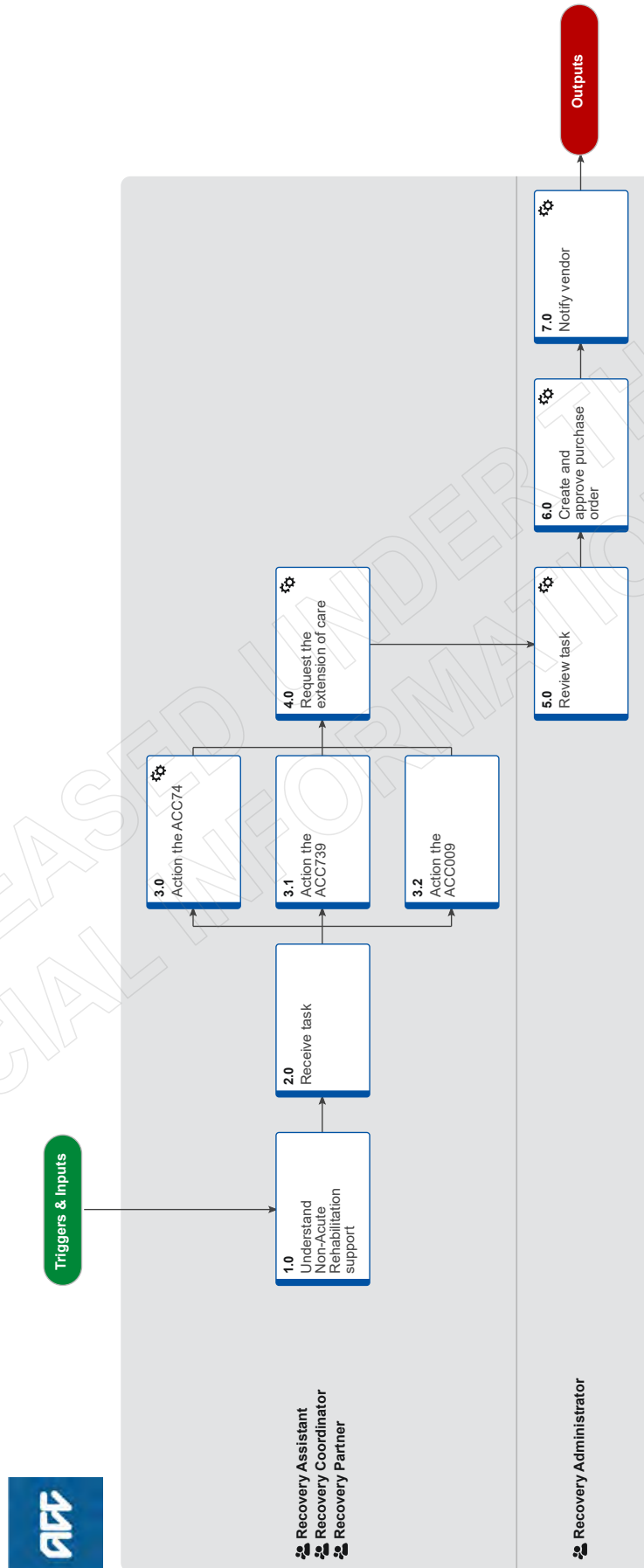
Recovery Assistant, Recovery Coordinator, Recovery Partner

YES....  **PROCESS** Seek Internal Guidance

NO.... Continue

 **PROCESS** **Create or Update Recovery Plan**

Recovery Assistant, Recovery Coordinator, Recovery Partner





Summary

Objective

To action the Non-Acute Rehabilitation service (NAR) request received.

Background

The non-acute rehabilitation service's purpose is to help clients become as independent as possible after an acute period of treatment, or when they are referred for admission by a General Practitioner (GP) or specialist, and reduce the likelihood of further rehabilitation or assistance after discharge.

The NAR service is for clients who need rehabilitation in an inpatient environment before they go back to the community. This is delivered by the 20 District Health Boards (DHBs).

The service is provided to around 5,000 clients a year, most commonly for older people who are recovering from a fracture. On average, clients stay in a NAR ward for between two and three weeks, after which, most return to their own home.

The first 21 days are automatic and are set up as a result of an notification from a DHB via a form.

There are two components: Inpatient Rehabilitation and Community Rehabilitation.

Inpatient Rehabilitation is delivered by all 20 DHBs in their assessment, treatment and rehabilitation units.

The Non-Acute Rehabilitation contract doesn't cover:

- rehabilitation for traumatic brain injury (TBI)
- rehabilitation in a private facility
- an acute medical condition
- moderate to severe traumatic brain injury
- traumatic spinal cord injury.

Owner

[Out of Scope]

Expert

Procedure

1.0 Understand Non-Acute Rehabilitation support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Consider the following information to better understand the support.

- Non-Acute Rehabilitation Services Service Page
- Extension of Care Service Page
- NAR Non Acute Rehabilitation.SS.2018.pdf
- Non Acute Rehabilitation Process Summary FNL.DOCX

NOTE What are the forms for Non-Acute Rehabilitation (NAR) sent by the DHB?

ACC074 NAR Client notification - ACC is notified of the admission to the service for 21 days of Inpatient Rehabilitation, this does not need to be continuous.

ACC739 Inpatient Rehabilitation - Extension of Care - at the expiry of the initial 21 days a request is made for a further 14 days of Inpatient Rehabilitation, this can be over 90 days.

ACC009 Inpatient Rehabilitation - Discharge Report - summarises the rehabilitation provided and the client's outcomes.

- ACC74 – Non-acute rehabilitation (NAR) Client Notification
- ACC739 Non-Acute Rehabilitation - Extension of inpatient care
- ACC009 Inpatient Rehabilitation - Discharge report

2.0 Receive task

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Open and review the task.
- b** Confirm that the client has an injury accepted for cover by ACC.
- c** Determine your next action.

NOTE What if you received an ACC74 NAR Client Notification form?

Go to 3.0 Action the ACC74.

NOTE What if you received an ACC739 Inpatient Rehabilitation - Extension of Care form?

Go to 3.1 Action the ACC739.

NOTE What if you received an ACC009 Inpatient Rehabilitation - Discharge Report?

Go to 3.2 Action to ACC009.

3.0 Action the ACC74

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Send the vendor a confirmation via email that ACC has received the ACC74 NAR Client Notification form. MFP has an automatic 21 days entitlement, therefore no purchase order is required. This process ends.

3.1 Action the ACC739

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the clinical information provided on the ACC739.

NOTE What if there is missing clinical information?

Contact the vendor and request more information.

NOTE What if you don't understand the information provided?

Obtain guidance, refer to Seek Internal Guidance.


PROCESS Seek Internal Guidance

- b** Determine whether the service is approved/declined. Refer to the 'NG Principles Decision Making' document for guidance.

 NG Principles Decision Making

NOTE **How do you determine whether the service is approved/declined?**

- Does the information provided explain why the client requires an extension?
- Decline can only be if the client requires ongoing non-injury related medical treatment that delays discharge.
- To document your decision, refer to Issue Recovery Decisions.

 **PROCESS** Issue Recovery Decision

NOTE **What if the service is declined?**

Email the vendor advising the service has been declined and include rationale. This process ends.

NOTE **What if the request is to extend NAR Community services?**

Do not create a purchase order, as there is no opportunity to extend in the contract.

- c** Go to 4.0 Request the extension of care.

3.2 Action the ACC009

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the discharge report.


NOTE **What if you have concerns?**

Contact the vendor to seek additional information.

- b** Determine if any further action is required. This process ends.

NOTE **What if action is required?**

Check if an ACC705 has been indicated, go to Assess Short Term Home and Community Support :: Assess ST Need.

 **PROCESS** Assess Short-Term Home and Community Support


4.0 Request the extension of care

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Ensure the DHB / requestor is added as a vendor to the EOS claim

NOTE **What if the Vendor hasn't been added as a participant?**


The Recovery Team Member must ensure all known participants are loaded on the claim and then removed when they are no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

- b** In Eos, generate a NGCM Entitlement Task and select the NAR drop down option and fill out the task description box. Include the following information from the ACC739:
Client name:
Client's DOB:
NHI number:
Requestor details:
Date of extension from:
Proposed discharge date:

NOTE **How do you refer a task to Recovery Administration?**

Refer to Referring Tasks to Recovery Administration - Principles for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

NOTE **How do you send a task to Administration for a Social Support?**

Go to Creating Entitlement Requests Tasks - System Steps.

 Creating Entitlement Requests Tasks - System Steps

- c** Complete all the mandatory fields. Provide the correct service code. Refer to the Purchase Order guidelines.

 NG GUIDELINES Purchase Order Details - Non-Acute Rehabilitation

NOTE **What if your client has a Care Indicator?**

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of Care Indicator Information to Third Parties Policy

- d** Consider the timing of the task. The tasks route to the Recovery Administration team with an SLA of 24 hours.

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

- Call Recovery Administration
- Give the Recovery Administrator who answers the call the claim number
- The Recovery Administrator will open the claim in Eos and find the task on the claim
- Transfer the task into the Recovery Administrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.

NOTE **What if the request is required in the future?**

If the request is required in the future, set a reminder task for the future date when the service will be required. When the reminder task comes up send a task to Recovery Administration to continue with the process. Consider the contract timeframes and SLAs as specified in the service page

5.0 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?**

If required information is missing from the task or you need guidance on working within the Administration Team, refer to NG PRINCIPLES Working in the Administration Team.

 Principles of Working in the Administration Team

6.0 Create and approve purchase order Recovery Administrator

a In Eos, generate a purchase order using the entitlement type NAR.

- Creating purchase orders using general + QE
- NG GUIDELINES Purchase Order Details - Non-Acute Rehabilitation
- Purchase Order - Handy Hints on how to create and edit POs

b Locate contracted vendors via the Geographic Location search, this must be done even if the vendor details are provided in the task. Once selected add the vendor as a 'Vendor - Contracted' participant in Eos.

- Manage Participants (Eos Online Help)
- Contracted Suppliers by Geographic Area of Coverage
- Service Contracts and Contracted Providers - MFP spreadsheet

c Approve the purchase order.

NOTE What if you do not have the delegation to approve the purchase order?

Save the purchase order, create request authorisation task and fill out the e-form. Refer to 'Request Authorisation for a Purchase Order - System Steps' for further detail.

- Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.

- 1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2). Select 'OK'.
- 3). Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

Recovery team member advising they will need to re-open the claim so you can complete the request.

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

c Send the email to the vendor.

d In Salesforce, close the assigned task.

7.0 Notify vendor Recovery Administrator

a Generate an email to send to the DHB, include the following information:

Kia ora,

We have approved Non-Acute Rehabilitation as follows:

Patient Name:

Patient DOB:

Patient NHI:

Purchase Order No:

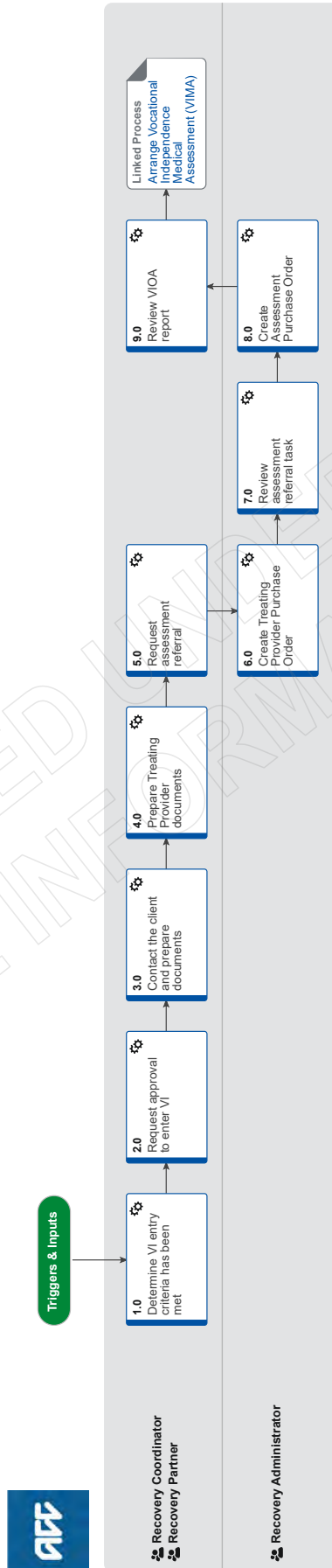
Funding Commences:

Funding Ceases:

Funding Code: NAR01

b Create an email using the relevant email template.

Arrange Vocational Independence Occupational Assessment (VIOA) v26.0



Summary

Objective

To arrange the Vocational Independence Occupational Assessment (VIOA) assessment.

Background

The VIOA is part of the Vocational Independence (VI) Assessment process. This assessment determines a clients' suitability for work types by reason of experience, education or training, or any combination of these. The VIOA is the first assessment and is used to consider whether the work types previously identified are suitable for the client because they match the skills the client has gained through education, training, and experience.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine VI entry criteria has been met

Recovery Coordinator, Recovery Partner

NOTE Where do you find more information about Vocational Independence (VI)?

Refer to About Vocational Independence Policy and Vocational Independence Journey below.

- About Vocational Independence Policy
- Vocational Independence Journey

- In Salesforce, go to the claim and open Te Kete.
- Review the client's current circumstances, medical information and other information on the claim to determine if assessing the client's VI is the appropriate next step.

NOTE What if there is information missing?

Go to Request Clinical Records. Once received return to this process.

PROCESS Request Clinical Records

- Confirm the client's eligibility for VI:
 - In receipt (or be entitled to receive) of weekly compensation
 - Is unable to regain work fitness for their pre-injury employment, or it must no longer be reasonably practical to support them to do so
 - Has completed an Initial Occupational Assessment (IOA) and an Initial Medical Assessment (IMA).

NOTE What if the client is not eligible?

Consider other services which could benefit the client at this time.

This process ends.

- Confirm that the following steps have been completed prior to proceeding:

- Consideration has been given to whether the client may have regained, or be regaining, fitness for their preinjury employment, and if a section 103 assessment might be more appropriate.
- Any current or outstanding cover requests (including deemed cover) have been addressed.
- Updated medical records have been obtained, including records for any new injuries sustained since the IMA was completed.
- The Recovery Plan (IRP) includes the IOA and IMA (including listing the work types identified as currently or likely to be medically sustainable from the IMA).
- The Recovery Plan (IRP) includes all the agreed vocational rehabilitation.
- All the vocational rehabilitation agreed to on the Recovery Plan (IRP) has been completed. If not, the plan has been updated or there is clear evidence to reflect why.

NOTE What if you are unable to obtain a signed Recovery Plan?

A signed copy of the Recovery Plan is not required as long as there is documented evidence on the claim to support that the client has completed all the agreed interventions ie, Back to Work

- RPL07 Deemed plan after discussion - client

NOTE Where do I find more information about the VIOA?

Refer to the Vocational Independence Assessments [VIOA/VIMA] Policy and VIOA Service Page below.

- Vocational Independence Assessments [VIOA/VIMA] Policy
- Vocational Independence Occupational Assessment (VIOA) Service Page

NOTE Where can I find a list of the keys steps required to progress a client through VI assessment?

Refer to the Vocational Independence Assessment Checklist below for a list of the key steps required in progressing a client through VI assessment. This should be used as a reference only to ensure key steps are completed. Please follow the correct Promapp process for details on how to undertake each step.

- Vocational Independence Assessment Checklist
- Vocational Independence Journey

2.0 Request approval to enter VI

Recovery Coordinator, Recovery Partner

- In Eos, generate the ACC191 and complete the Recovery Team Member Summary sections. Be sure to fill in the Clinical Services Bypass Checklist to understand where to send it to next.

- ACC191 Vocational independence assessment: summary, review and quality check

NOTE See the document below for an example of a completed ACC191 form

- Example of completed ACC191.pdf

- b** Obtain approval to enter VI from a Technical Specialist and, if required, a Medical Advisor before contacting the client. This is done by attaching the completed ACC191 to a request for written guidance e-form.

NOTE What if you are unsure how to request written guidance?

Go to Seek Internal Guidance. Once guidance has been received, return to this process.

PROCESS Seek Internal Guidance

- c** In Eos, open the NGCM - Written Guidance task from the Recovery Support subcase.

NOTE What if you have not received approval to proceed with VI?

Action the guidance provided. Go to Create or Update Recovery Plan.

This process ends.

PROCESS Create or Update Recovery Plan

3.0 Contact the client and prepare documents

Recovery Coordinator, Recovery Partner

- a** Consider if it is appropriate to meet the client face to face.

NOTE What if you are unsure how to determine if F2F is appropriate?

Go to Arrange Face to Face Client Meeting, then return to this process.

PROCESS Arrange Face to Face Client Meeting

- b** Check the client has granted ACC the authority to collect medical and other records and signed a ACC165 Declaration of rights and responsibilities.

View Client Consent

NOTE What if the client has not granted ACC authority to collect medical and other records?

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

PROCESS Obtain Client Authority to Collect Information

- c** Contact the client via their preferred communication method and confirm you are speaking with the right person by asking ACC's identity check questions.

Identity Check Policy

- d** Ensure you discuss each of the following with the client:

- That vocational rehabilitation is complete
- VIOA and VIMA assessments and the VI assessment process
- Possible outcomes
- What support is available
- Remind the client of their rights and responsibilities
- Confirm the client understands the purpose of the assessment and agrees to attend
- ACC191 Vocational Independence Assessment: summary, review and quality check form
- VI02 Vocational Independence Assessment - client letter
- VIIS01 Get ready to work again after an injury information sheet
- ACC193 Vocational Independence Assessment client questionnaire
- ACC691 Vocational Independence Assessment readiness check form.

Client Legislative Rights and Responsibilities Policy

- e** Generate and send the following documents on the claim file to the client:

- VI02 Vocational Independence Assessment - client letter
- VIIS01 Getting ready to work again after an injury information sheet
- ACC193 Vocational Independence Assessment client questionnaire
- ACC691 Vocational Independence Assessment readiness check form (ensure section 2 has been completed by the RTM and its this version that is sent to the client).

NOTE What if you are meeting the client face to face?

Provide a copy of the following documents:

- ACC191 Vocational Independence Assessment: summary, review and quality check form
- VI02 Vocational Independence Assessment - client letter
- VIIS01 Getting ready to work again after an injury information sheet
- ACC193 Vocational Independence Assessment client questionnaire
- ACC691 Vocational Independence Assessment readiness check form.

The client will need to return the ACC691 and ACC193 at a later date, however, if they prefer they can complete these at the meeting.

- f** In Salesforce, add the agreed intervention of VIOA and VIMA to the Recovery Plan to confirm the clients agreement to participate. Send a copy of the Recovery Plan to the client via their preferred method of contact.

NOTE What if the client does not agree to participate?

Find out why the client does not want to participate and consider their reasoning and alternatives. If you are unsure how to proceed, refer Seek Internal Guidance.

PROCESS Seek Internal Guidance

- g** Check if the client has a preferred Provider. It is best practice not to sent the client to the same assessor who completed the IOA, however, if this is not possible, you can use the same assessor.

Client choice of providers Policy

NOTE Can you book the VIMA appointment with the client at this time?

Yes, refer to Activity 2.0 in Arrange Vocational Independence Medical Assessment (VIMA).

PROCESS Arrange Vocational Independence Medical Assessment (VIMA)

NOTE What if the client has a preferred provider?

Using the Contracted Suppliers by Geographic Area of Coverage, confirm the Provider is contracted for this service and add as a participant on the claim.

If they are not a contracted provider for this service advise alternative Providers to your client and add as a participant on the claim.

Contracted Suppliers by Geographic Area of Coverage

Manage Participants (Eos Online Help)

- h** In Salesforce, record the conversation as a Contact action.

- i** Add the Agreed Intervention to the Recovery Plan.

NOTE What if you are unsure how to add an Agreed Intervention?

Go to Create or Update Recovery Plan, then return to this process.

- j** Create a Reminder action with a target date of 10 working days to check if the completed ACC193 and ACC691 forms have been returned. This action is not required if the client has already completed these at a face to face meeting.

NOTE What if the ACC193 and ACC691 have not been returned?

Contact the client to remind them to complete and return the forms.
If the client does not return the completed forms this is not a barrier to proceeding with VIOA and VIMA process.

NOTE What if there are documents on other claims?

Create a copy and transfer to the other claim:

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

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg. Medical records and reports from claim: 100XXXXXXXX

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

4.0 Prepare Treating Provider documents

Recovery Coordinator, Recovery Partner


- a** In Salesforce, create a PDF copy of the Recovery Plan by clicking 'Send PDF to Eos'.
- b** Create a NGCM - Admin Request task and request a Purchase Order be created. Add the following information to the task:
- GP Name and Vendor ID
 - Advise how you verified the client was seen at this practice eg: ACC18
 - PO code: MEDR
 - Rehab action: Vocational rehabilitation and independence
 - Frequency: 1 quarter from today's date
 - Link the documents PDF Recovery Plan and VIIS01 Vocational Independence Factsheet to the task
 - Request the following documents are generated and sent to the Treating Provider:
 - VIO1 ACC194 Pack - Vocational Independence assessment GP questionnaire - PO - Vendor.

- c** Create a Reminder action with a target date of 10 working days to check if the completed forms have been received.

NOTE What if the ACC194 has not been received?

Contact the Treating Provider to request the form is completed and returned.
N.B. if the Provider does not return the completed ACC194 this is not a barrier to proceeding to VIOA and VIMA

- c** Perform privacy checks on the documents. These must not contain any injury or medical information. This is crucially important as failure to observe constitutes a privacy breach.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Privacy Check Before Disclosing Information Policy

NOTE Can you provide medical information?

ACC should only provide information that is relevant to the occupational assessor and the assessment that is being completed. If you are providing any medical information or the Initial Medical Assessment report, you should advise the client and seek their consent. You should also provide a copy of the ACC6300 Authority to collect medical and other records and note in the task to Admin that this has been discussed with the client. If unsure, discuss with your Team Leader before sending.

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, before adding the document to the document group.


 NGCM - Redact information from PDF documents

- d** In Eos, create a document group titled 'Vocational Independence Occupational Assessment - Assessor' and add the following documents:

- ACC691 Vocational Independence Assessment readiness check form (if returned)
- Initial Occupational Assessment report/s (IOA Report) and any past VIOA reports
- All Vocational Rehabilitation documents (eg Stay At Work, Back To Work (ensure medical/injury information is redacted) computer training reports etc)
- Recovery Plan/s (IRP)
- Signed ACC6300 Authority to collect medical and other records form.

 Manage document groups

- e** In Eos, generate a Vocational Rehabilitation referral task for a 'Vocational Independence Occupational Assessment'. For further information refer to Referring Tasks to Recovery Administration - Principles.

 Referring Tasks to Recovery Administration - Principles

5.0 Request assessment referral

Recovery Coordinator, Recovery Partner

- a** In Eos, check the following documents are on the claim (if applicable):
- VIO2 Vocational Independence Assessment - client letter
 - ACC191 Vocational Independence Assessment: summary, review and quality check
 - ACC691 Vocational Independence Assessment readiness check form (if returned)
 - Initial Occupational Assessment report/s (IOA Report) and any past VIOA reports
 - Initial Medical Assessment report
 - All Vocational Rehabilitation documents (eg. Stay At Work, Back To Work, computer training reports etc)
 - Recovery Plan/s (IRP)
- b** Check if there are documents on other claims relevant to the assessment.

Creating Manage Referral Tasks - System Steps

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

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

f Complete the mandatory fields in the e-form, including:

- Geographic location
- Vendor preference
- Type of VIOA (Standard/Complex)
- Any referral information if referral is for reassessment (ie for VI deterioration purposes)
- Pre-incapacity earnings (In EOS, go to ACC45 Claim > 'Earnings and Exclusion Periods' > 'Collection Point Data' > earnings information is in the 2nd window, lower half of the screen)
- Advise if you met with the client face to face or phone meeting (Option 1) or; you were unable to contact the client (Option 2)
- Purchase Order code (Standard VIOS1/Complex VIOC1)
- Name of document group
- A link to the VIO2 Vocational Independence Assessment - client letter or state in task that letter has already been provided to the client, ie F2F meeting held.
- 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

Disclosure of Care Indicator Information to Third Parties Policy

NOTE What if pre-incapacity earnings are not available?

Locate the ACC003 employee earnings certificate or discuss with your Team Leader. If you are still unsure obtain guidance.

 **PROCESS** Seek Internal Guidance

g Consider the timing of the task. The tasks route to the Recovery Administration team with an 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 assessment referral.

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

6.0 Create Treating Provider Purchase Order Recovery Administrator

a Check the task provides the following information:

- GP Name and Vendor ID
- Advise how you verified the client was seen at this practice eg: ACC18
- PO code: MEDR
- Rehab action: Vocational rehabilitation and independence
- Frequency: 1 quarter from today's date
- Links to the PDF Recovery Plan and VIIS01 Vocational independence Factsheet
- Documents to send to the Treating Provider

NOTE What if there is information is missing?

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

Principles of Working in the Administration Team

b Create the Purchase Order using the information provided in the task.

Creating purchase orders using general + QE

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

c Approve the Purchase Order.

d Select 'Add documents' and generate the following:

- VIO1 ACC194 pack Vocational Independence Assessment GP questionnaire PO Vendor

e Create an email using the appropriate template, attach the required document(s) and send to Treating Provider.

f In Salesforce, close the task.

7.0 Review assessment referral task Recovery Administrator

a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.

b Check the task provides the following information:

- Geographic location
- Vendor preference
- Type of VIOA (standard/complex)
- Pre-incapacity earnings
- If the meeting with the client was face to face or phone meeting (Option 1) or; the client couldn't be contacted (Option 2)
- Purchase order code (Standard VIOS1/Complex VIOC1)
- Name of document group or advise no documents are to be sent - if there are documents missing from this group please contact the Recovery Team Member to advise. You cannot send what is not there.

NOTE What if there is information missing?

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

Principles of Working in the Administration Team

NOTE What if it is a NGCM - Admin Request task for a re-referral as the Provider is unable to accept a referral?

Go to Activity 8.0 (a) Create Assessment Purchase Order.

NOTE What if it is a NGCM - Admin Request task to create a Purchase Order for the Treating Provider?

Go to Activity 6.0 (a) Create Treating Provider Purchase Order.



8.0 Create Assessment Purchase Order

Recovery Administrator

- a** In Eos, generate a Purchase Order using referral type Vocational Independence Occupational Assessment.

NOTE What if this is for a re-referral?

Locate the original Purchase Order and continue with this process.

-  Creating purchase orders using general + QE
-  NG GUIDELINES Purchase Order Details - Vocational Independence Occupational Assessment

- b** Identify and select an appropriate contracted provider for the referral type and client's geographic area.



NOTE What if this is for a re-referral?

Update the original Purchase Order with the new Provider and continue with this process.

NOTE What if a preferred provider has been specified?

Use the provider identified

- c** Add the selected Provider as a participant on the claim.

-  Manage Participants (Eos Online Help)
-  Contracted Suppliers by Geographic Area of Coverage

- d** Approve the Purchase Order.

NOTE What if the purchase order requires a higher delegation?


Refer to system steps below.

-  Request Authorisation for a Purchase Order - System Steps



- e** Select 'Add documents' and generate the following:

- ACC6278 ACC referral for Occupational Assessment

- f** Add additional information received in the task to the referral. For guidance refer to the Admin Template - ACC6278 ACC referral for Occupational Assessment.

-  Admin Template - ACC6278 Initial Occupational Assessment

- g** Perform privacy checks of all the documents. These must not contain any injury or medical information. This is crucially important as failure to observe constitutes a privacy breach.

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

- h** Generate a Bulk Print of the "Vocational Independence Occupational Assessment - Assessor" Document Group by following the system steps below.

-  Create Bulk Print


- i** Generate the Bulk Print Index

NOTE How do you generate the Bulk Print Index?

- Click properties
- Click view contents less
- Right click convert to PDF
- Save to desktop
- Upload to Claim using document type VCF006
- Label as Bulk Print Index
- Delete file from desktop

- j** Open the bulk print and save to your desktop.

- k** Email the ACC6278 and the bulk print index to the vendor using 'Requests and referrals' template and add the bulk print. Ensure you delete the bulk print from your desktop.

-  Emailing from Eos using a template - System Steps

NOTE What if you identify the documents you're sending exceed 10MB?

Use Adobe Pro to Reduce file size:

- Select Optimize PDF
- Select Reduce File Size Or Split document
- Select organize page
- Select Split
- Select Split by File Size (up to 10MB)

The document will save in the same location and the original document and will be name PART1, PART2 (depending in the size of the file being split).

- l** Send the linked 'V102 Vocational Independence Assessment - client' letter and VIIS01 Vocational Independence Factsheet to the client enclosing the ACC691, ACC191, ACC193 and VIIS01 Vocational independence Factsheet - (IMPORTANT)

-  VIIS01 Vocational Independence Factsheet

NOTE Do not send if the task states that the V102 letter has already been sent to the client.

- m** In Salesforce, close the referral task.

NOTE What if you are advised by a Provider they are unable to accept a referral?

Go to Activity 8.0b and complete a re-referral.

9.0 Review VIOA report

Recovery Coordinator, Recovery Partner



- a** In Eos, open the VIOA report.

NOTE What if the Provider or client advised they failed to attend?


Go to Manage Non-Compliance.

-  **PROCESS** Manage Non-Compliance

- b** Perform Privacy checks on the report.


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


- c** Check the report contains the required information and meets our criteria and quality standards. The VIOA evaluation checklist (below) provides a list of these standards and should be used to confirm these have been met before accepting the VIOA report from the assessor.

-  VIOA Report evaluation checklist

NOTE What if you are unsure as to how to proceed?

Go to Seek Internal Guidance.

-  **PROCESS** Seek Internal Guidance

- d** Discuss with the assessor any questions you have and agree on a timeframe for completing an amended report, if required.
- e** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.
 -  Identity Check Policy
- f** Contact the client by their preferred method of communication. Inform the client we have received the VIOA assessors report which they will receive a copy of. Remind them of the upcoming VIMA appointment/referral (as applicable).
- g** Send a copy of the report to the client for comment by email.

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


Generate the VID09 letter and amend as appropriate. Create a NGCM - Send letter task and attach the VID09 and the ACC195 VIOA report to request these are sent to the client by post or courier.

NOTE What if the client provides comments?

Send these to the assessor for consideration.

NOTE What if the client advises there is information in the report which is factually incorrect?

Contact the Provider and request the incorrect is updated on the report and an amended report is provided. For further guidance refer to Managing a client's request to change personal information.

-  Managing a client's request to change personal information


NOTE What if the client advises they disagree with the opinion provided the assessor in the report?

The client can supply a 'statement of correction' to ACC which is then included with the report. This means any time the report is sent out, the statement of correction must be sent as well.


- h** Open the Agreed Intervention in the Recovery Plan and add the outcome.

NOTE What if you are unsure how to add the outcome?

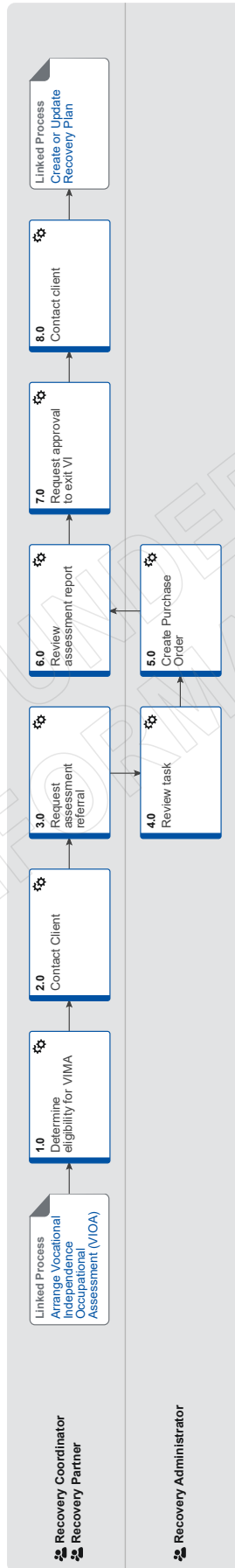
Go to Create or Update Recovery Plan.

-  **PROCESS** Create or Update Recovery Plan

- i** Initiate a VIMA referral. Go to Arrange Vocational Independence Medical Assessment (VIMA).

 **PROCESS** **Arrange Vocational Independence Medical Assessment (VIMA)**
Recovery Coordinator, Recovery Partner

Arrange Vocational Independence Medical Assessment (VIMA) v18.0



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Arrange Vocational Independence Medical Assessment (VIMA) v18.0



Summary

Objective

To arrange Vocational Independence Medical Assessment (VIMA) for considering whether a client's vocational rehabilitation is complete and whether a client can work in roles other than their pre-injury job for 30 hours or more a week.

Background

The VIMA is part of the Vocational Independence (VI) Assessment process. This assessment process determines whether a client can work in other roles for 30 hours or more a week. The VIMA is the final assessment and is used to consider:

- whether a client's Vocational Rehabilitation is complete and
- whether the work types identified in Vocational Independence Occupational Assessment (VIOA) are medically sustainable for at least 30 hours or more per week.

Owner

[Out of Scope]

Expert

Procedure


PROCESS Arrange Vocational Independence Occupational Assessment (VIOA) Recovery Coordinator, Recovery Partner

1.0 Determine eligibility for VIMA

Recovery Coordinator, Recovery Partner

NOTE Where do you find more information about Vocational Independence?

Refer to About Vocational Independence Policy and the Vocational Independence Journey pages below.

-  About Vocational Independence Policy
-  Vocational Independence Journey

- In Salesforce, go to the claim and open Te Kete.
- Check the client has completed a VIOA assessment and has been sent a copy of the report.

NOTE What if the client hasn't completed a VIOA assessment?

This is a pre-requisite to VIMA. Go to Arrange Vocational Independence Occupational Assessment (VIOA).



This process ends.

PROCESS Arrange Vocational Independence Occupational Assessment (VIOA)

- Review the client's current circumstances, medical information and other information on the claim and check that continuing with the VIMA remains appropriate.

NOTE Where do you find more information about the VIMA?

Refer to Vocational Independence Assessments [VIOA/VIMA] Policy or the VIMA Service Page.



-  Vocational Independence Assessments [VIOA/VIMA] Policy
-  Vocational Independence Medical Assessment (VIMA) Service Page

NOTE What are the keys steps required to progress a client through the VI assessment?

Refer to the Vocational Independence Journey page for support on the end to end view of Vocational Independence.

Use the Vocational Independence Assessment Checklist for a list of the key steps required in progressing a client through the VI assessment. This should be used as a reference only, to ensure key steps are completed.

Follow the correct Promapp process for details on how to undertake each step.


-  Vocational Independence Journey
-  Vocational Independence Assessment Checklist

2.0 Contact Client

Recovery Coordinator, Recovery Partner

NOTE What if you have already confirmed the VIMA appointment with the client?

Go to Activity 3.0 Request Assessment referral.

- Open Group VMS SharePoint site and identify potential VIMA Providers geographically close to the client.
 -  Group VMS SharePoint site
- Contact the client or Authority to Act (ATA) by their preferred method of communication.

NOTE What if you are unable to contact the client?

1) Attempt a maximum of two contacts over two full working days before leaving a voicemail or sending a notification to request client contact.

2) If you are unable to reach the client, extend the task for an additional two working days and note in the task description that this is the second attempt to contact the client.

3) On the task due date and if there has been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach them by phone letter. The CM04 letter will be populated with client injury details, however you need to update the letter as follows:

'We recently tried to contact you about your injury that happened on [date of accident auto]. I tried calling you to talk about how we may be able to help you recover from your injury/injuries, but haven't managed to get in touch. It would be good to hear from you on how you are progressing or discuss what other support we could offer, please give me a call or email me to arrange a convenient time for me to call you back.'

4) Extend the task date as appropriate to take into account postal delivery and note in the task description this is the third attempt to contact the client and the CM04 letter has been sent.

5) On the task due date and if there has been no contact from the client and they are continuing to receive support, seek internal guidance to determine next steps.

6) If you're in Partnered and no contact is made with the client after 3 attempts, you must contact the provider, GP or other verified contact on the claim.

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

 Identity Check Policy

- d** Confirm your client understands the purpose of the assessment and agrees to attend.

NOTE What if the client does not agree to participate?

Find out why the client does not want to participate, consider their reasoning and alternatives. Record this as a contact on the claim. If you are unsure how to proceed go to Seek Internal Guidance.


 **PROCESS** Seek Internal Guidance

- e** Using the VMS Sharepoint booking site identify and agree a suitable provider, date and time with the client and schedule the appointment.

 Group VMS SharePoint site

NOTE How do you book a VIMA appointment?

Refer to the Book an appointment through the Centralised booking system (CBS) process.


 **PROCESS** Book an appointment through the Centralised booking system (CBS)

NOTE What if there are no providers at the client's location?

Discuss suitable transport options with the client, including:

- Can the client attend an appointment out of town?
- Will the client need transport support ie taxi, flights?
- Will the client require a support person?
- Will the client require accommodation?

Refer to Arrange Ancillary Flight Services process or another Ancillary Service processes ie Accommodation, Taxi, Public Transport or Other travel.


 **PROCESS** Arrange Ancillary Flight Services

- f** In Salesforce, record the conversation as a Contact action.


- g** Add the Agreed Intervention to the Recovery Plan.

NOTE What if you are unsure how to add an Agreed Intervention?

Go to Create or Update Recovery Plan, then return to this process and continue.

 **PROCESS** Create or Update Recovery Plan

- h** Create a Reminder action to notify the client of the appointment details 2 days prior to the appointment. If you consider sending the RL01 Reminder – Assessment appointment letter, ensure you are aware of timeframes of sending letters to clients.

 RL01 Reminder - Assessment appointment - client

3.0 Request assessment referral


Recovery Coordinator, Recovery Partner

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

- ACC195 Vocational Independence Occupational Assessment report
- ACC197 Vocational Independence Assessment Recommendation form
- ACC191 Vocational Independence Assessment: Summary, review and quality check
- ACC691 Vocational Independence Assessment readiness check form (not mandatory, if returned)
- ACC193 Vocational Independence assessment client questionnaire (not mandatory, if returned)
- ACC194 Vocational Independence Assessment GP questionnaire (not mandatory, if returned)
- Vocational Independence (VI) review decisions (if applicable)
- Initial Occupational Assessment report (IOA)
- Initial Medical Assessment report/s (IMA) and any past VIMA report/s
- Curriculum Vitae
- All Vocational Rehabilitation reports
- All Medical reports
- Information on other claims including Mental Injury claims
- Recovery Plan/s (IRP)
- Schedule of Claimant Injuries.

NOTE What if there are clinical records missing?

Go to Request Clinical Records. Once received, return to this process.

 **PROCESS** Request Clinical Records

- b** Check if there are documents on other claims relevant to the assessment.

NOTE What if there are documents on other claims?



Create a copy and transfer to the other claim:

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

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg. Medical records and reports from claim: 100XXXXXXXXX

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

c Perform privacy checks on the documents.

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

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, before adding the document to the document group.

-  NGCM - Redact information from PDF documents

d In Eos, create two document groups titled: 'Vocational Independence documents (IOA/IMA/Recovery Plan/Vocational Reports); and 'Vocational Independence Medical documents'.

-  Manage document groups

e In Eos, generate a Medical Assessment referral task for an 'Vocational Independence Medical Assessment'. For further information refer to Referring Tasks to Recovery Administration - Principles.


-  Creating Manage Referral Tasks - System Steps
-  Referring Tasks to Recovery Administration - Principles


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

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

f Complete the mandatory fields in the e-form. Note the region in 'booking sheet' field of the e-form. Provide the following information in the task:

- date and time of the booking
- appointment address as per VMS booking sheet
- name of assessor
- vendor ID and email address
- purchase order code
- any referral information if referral is for reassessment (ie for VI deterioration purposes)
- factors that may impact the assessment, eg communication difficulties or interpreter, services.
- name of document group or advise no documents are to be sent
- letter option - 1 copy of VIOA sent previously, 2 copy VIOA enclosed
- 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.

-  NG GUIDELINES Purchase Order Details - Vocational Independence Medical Assessment

-  Disclosure of Care Indicator Information to Third Parties Policy

NOTE What are the complex VIMA criteria?

- A Serious Injury profile; or
- A covered Sensitive Claim; or
- The covered injury is a moderate to severe traumatic brain injury; or
- 2.5 years or more have passed since the date of accident.

If the client meets one or more of the criteria a complex VIMA needs to be requested, use service item code VMV02.

g Consider the timing of the task. The tasks route to the Recovery Administration team with an 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 action for the future date when the support will be required.

When the Reminder action is due return to Activity 3.0 Request assessment referral.

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

4.0 Review task

Recovery Administrator


a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.

b Check the task provides the following information:

- date and time of the booking
- appointment address as per VMS booking sheet
- name of assessor
- vendor ID and email address
- purchase order code
- any information to be included with referral
- factors that may impact the assessment, e.g. communication difficulties or interpreter, services
- name of document group or advise no documents are to be sent.














NOTE What if there is information missing?

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

 Principles of Working in the Administration Team

5.0 Create Purchase Order

Recovery Administrator


- a** In Eos, generate a Purchase Order using referral type Vocational Independence Medical Assessment.
-  Creating purchase orders using general + QE
 -  NG GUIDELINES Purchase Order Details - Vocational Independence Medical Assessment
 -  Purchase Order - Handy Hints on how to create and edit POs
 -  Service Contracts and Contracted Providers - MFP spreadsheet
- b** Access Group VMS SharePoint site to obtain the physical address of the vendor, date and time of the appointment. Add the referral date to the appointment.
-  Group VMS SharePoint site
- c** Add the Provider as a participant on the claim.
-  Manage Participants (Eos Online Help)
- d** Approve the Purchase Order.
- e** Select 'Add documents' and generate the following:
- VI05 Vocational Independence Medical Assessment appointment - PO - client
 - VI04 Vocational Independence Medical Assessment referral with appointment - PO - vendor
 - ACC192 Vocational Independence medical assessment referral document list.
- f** Complete the ACC192 VIMA referral documents list.
- g** Add additional information received in the task to the referral. For guidance refer to the Admin Template - Vocational Independence Medical Assessment.
-  Admin Template - Vocational Independence Medical Assessment
 -  VI04 Vocational Independence medical assessment referral with appointment
 -  VI05 Vocational Independence medical assessment appointment
 -  Admin Template - ACC192 Vocational Independence Medical Assessment Referral Documents List
- h** Perform privacy checks on the documents in the group.
-  Privacy Check Before Disclosing Information Policy
 -  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- i** Complete the documents and convert them into non-editable PDF's.
- j** Generate a Bulk Print of the two document groups: 'Vocational Independence documents (IOA/IMA/Recovery Plan/Vocational Reports) and; 'Vocational Independence Medical documents' by following the system steps below.
-  Create Bulk Print
- k** Create and send an email to the Vendor using 'Requests and referrals' template.


NOTE What if there is a document group?

Open the document group and link the VI04 letter to the group and email to the vendor.

NOTE What if the email is too large to send as a single email?






Contact the vendor and ask if the referral can be sent by courier. If yes, confirm correct physical address then go to Prepare and Send Client Information by Courier then return to this process. Otherwise, send by email.

 **PROCESS** Prepare and Send Client Information by Courier

- l** Send the VI05 Vocational Independence Medical Assessment appointment - PO - client letter and VIIS01 Vocational Independence Factsheet to the client by their preferred method of communication.
-  VIIS01 Vocational Independence Factsheet
- m** In Salesforce, close the referral task.


6.0 Review assessment report

Recovery Coordinator, Recovery Partner

- a** In Eos, open the VIMA report.
- NOTE What if the Provider or client advised they failed to attend?**
- Go to Manage Non-Compliance.
-  **PROCESS** Manage Non-Compliance
-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- b** Perform privacy checks on the report.
-  Privacy Check Before Disclosing Information Policy
 -  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- c** Check the report contains the required information and meets our criteria and quality standards. The VIMA Report evaluation checklist (below) provides a list of these standards and should be used to confirm these have been met before accepting the VIMA report from the assessor.
-  VIMA Report evaluation checklist
- NOTE What if you have queries in relation to the report or you are concerned about the clinical quality of the report?**
- Manage these directly with the assessor. If an amended report is required, this is expected to be received within 2 working days.
- NOTE What if no roles are considered suitable in the VIMA?**
- Do not complete an ACC198, please discuss with a peer, Team Leader, Practice Mentor on suitable next steps.
- d** Send a copy of the VIMA report to the client and their GP by their preferred method of communication. Inform the client that we have sent a copy of the report to their GP.
- e** In Salesforce, create a Contact action with a due date which allows sufficient time for the client to read the report and consult other parties if necessary.
- NOTE What if the client requests changes or advises there are inaccuracies in the report?**
- The client can supply a 'statement of correction' to ACC which is then included with the report. This means any time the report is sent out, the statement of correction must be sent as well.

NOTE What if the client advises there is information in the report which is factually incorrect?


Contact the Provider and request the incorrect is updated on the report and an amended report is provided. For further guidance refer to Managing a client's request to change personal information.

-  Managing a client's request to change personal information

7.0 Request approval to exit VI

Recovery Coordinator, Recovery Partner

- a** In Eos, generate and complete the ACC198 Vocational Independence Assessment - Final quality check and decision form.

-  ACC198 Vocational Independence Assessment - Final quality check and decision

- b** Request written guidance from a Technical Specialist to confirm whether or not the client has achieved vocational independence, linking the ACC198.

NOTE What if you are unsure how to request written guidance?

Go to Seek Internal Guidance. Once the completed and signed ACC198 has been received, return to this process.

-  **PROCESS** Seek Internal Guidance

NOTE What if Clinical Services comment is required?

Technical Services will decide if confirmation of vocational independence needs to be obtained from a Clinical Advisor.

- c** Open the NGCM - Written Guidance task from Recovery Support, review the guidance and action recommendations where appropriate.

NOTE What if the client has not achieved VI, but may achieve it with further vocational assistance?

- consider the recommendations of the VIMA assessor or Technical Specialist for further vocational rehabilitation
- update the client's Recovery Plan.

Continue with this process.

NOTE What if the client has not achieved VI but is working part-time and can't increase their work hours?


- check the Technical Specialist comments and discuss with them if needed
- reconsider the rehabilitation outcome(s)
- record this outcome in Eos
- update the client's Recovery Plan.

Continue with this process.

NOTE What if the client has not achieved VI but can work part-time and is not working?


- check the Technical Specialist comments and discuss with them if needed
- reconsider the rehabilitation outcome(s)
- record the outcome in Eos

Continue with this process.

-  **PROCESS** Create or Update Recovery Plan

NOTE What if the client has not achieved VI and is unlikely to achieve it with further vocational assistance?

A client may reach a point in their recovery when further rehabilitation won't result in a recovery outcome. To ensure that we continue to manage the client effectively and appropriately, have a discussion with your Team Leader/internal guidance and consider the Identify a Client for No Further Rehabilitation process.

-  **PROCESS** Identify a Client for No Further Rehabilitation

8.0 Contact client

Recovery Coordinator, Recovery Partner

- a** Consider if it is appropriate to meet the client face to face.

NOTE What if you are unsure how to determine if F2F is appropriate?

Go to Arrange Face to Face Client Meeting, then return to this process.

-  **PROCESS** Arrange Face to Face Client Meeting

- b** On the Contact action due date, contact the client by their preferred method of communication.

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

-  Identity Check Policy

- d** Explain to the client it has been decided by the assessors and ACC they have achieved Vocational Independence and as a result of this their weekly compensation (WC) will end three months from the day after we send a decision letter.

NOTE What if the client has not achieved Vocational Independence?

Review the guidance provided by the Assessor and Recovery Support, if appropriate, discuss any additional vocational rehabilitation options or barriers to rehabilitation.

- e** Discuss the VIOA and VIMA assessments and answer any questions.

- f** Advise the client they will receive a med cert expiry notification close to when their weekly compensation will cease. This is a reminder of when their final payment will be and as they have reached the end of their payment period there is no need to obtain further medical cover.

- g** Check if the client would like assistance to search for a job.

NOTE What if they would like assistance?


Complete this process, then go to Set Up Job Search Support.

-  **PROCESS** Set Up Job Search Support

NOTE What if the client would like counselling or budgeting advice?

Advise the client to the yellow pages of their local phone book or search the internet for free budget advice in their local area.

- h** Process Referring clients to Work and Income

-  Referring Client to Work and Income

- i** Check if client would like to be contacted within the next 3 months.

NOTE What if they do want to be contacted?

Add a 'Contact' task with a due date agreed with the client.

- j** In Salesforce, record the conversation as a Contact action.
- k** Generate and send the VI06 letter to the client by their preferred method of communication.
- l** Generate and send the VI08 letter to the GP (ensure the client is informed that this has been sent).
- m** In Eos, add and approve incapacity for 3 months from the day after the decision was issued.
- n** Tick the Vocational Independence indicator on the General tab of the ACC45 screen.
- o** Check if the client has active supports ie Social Rehabilitation and consider if reassessment of the support is required (a VI decision does not impact the client's access to treatment or other entitlements related to their injury).
- p** Cancel future dated Recovery Check Ins, if applicable.
- q** Add a reminder action to close the claim with a due date of when they achieve Vocational Independence if there are no further supports.



PROCESS

Create or Update Recovery Plan

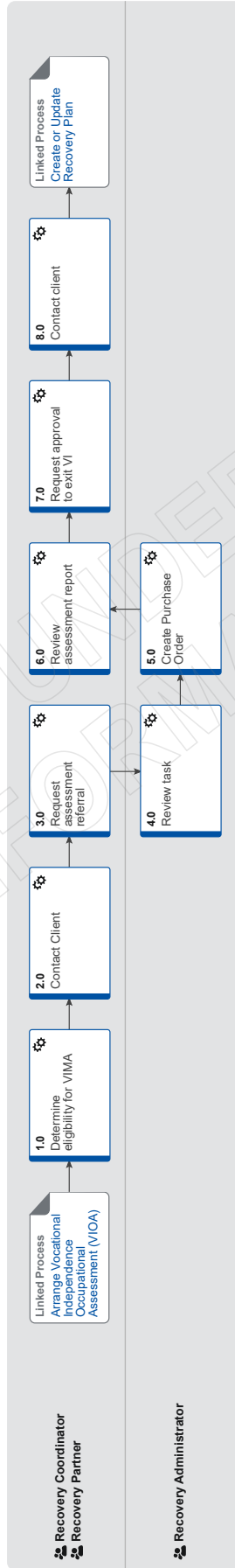
Recovery Coordinator, Recovery Partner

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Arrange Vocational Independence Medical Assessment (VIMA) v18.0



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To arrange Vocational Independence Medical Assessment (VIMA) for considering whether a client's vocational rehabilitation is complete and whether a client can work in roles other than their pre-injury job for 30 hours or more a week.

Background

The VIMA is part of the Vocational Independence (VI) Assessment process. This assessment process determines whether a client can work in other roles for 30 hours or more a week. The VIMA is the final assessment and is used to consider:

- whether a client's Vocational Rehabilitation is complete and
- whether the work types identified in Vocational Independence Occupational Assessment (VIOA) are medically sustainable for at least 30 hours or more per week.

Owner

[Out of Scope]

Expert

Procedure

PROCESS

Arrange Vocational Independence Occupational Assessment (VIOA) Recovery Coordinator, Recovery Partner

1.0 Determine eligibility for VIMA

Recovery Coordinator, Recovery Partner

NOTE Where do you find more information about Vocational Independence?

Refer to About Vocational Independence Policy and the Vocational Independence Journey pages below.

- About Vocational Independence Policy
- Vocational Independence Journey

- In Salesforce, go to the claim and open Te Kete.
- Check the client has completed a VIOA assessment and has been sent a copy of the report.

NOTE What if the client hasn't completed a VIOA assessment?

This is a pre-requisite to VIMA. Go to Arrange Vocational Independence Occupational Assessment (VIOA).

This process ends.

- PROCESS** Arrange Vocational Independence Occupational Assessment (VIOA)

- Review the client's current circumstances, medical information and other information on the claim and check that continuing with the VIMA remains appropriate.

NOTE Where do you find more information about the VIMA?

Refer to Vocational Independence Assessments [VIOA/VIMA] Policy or the VIMA Service Page.

- Vocational Independence Assessments [VIOA/VIMA] Policy
- Vocational Independence Medical Assessment (VIMA) Service Page

NOTE What are the keys steps required to progress a client through the VI assessment?

Refer to the Vocational Independence Journey page for support on the end to end view of Vocational Independence.

Use the Vocational Independence Assessment Checklist for a list of the key steps required in progressing a client through the VI assessment. This should be used as a reference only, to ensure key steps are completed.

Follow the correct Promapp process for details on how to undertake each step.

- Vocational Independence Journey
- Vocational Independence Assessment Checklist

2.0 Contact Client

Recovery Coordinator, Recovery Partner

NOTE What if you have already confirmed the VIMA appointment with the client?

Go to Activity 3.0 Request Assessment referral.

- Open Group VMS SharePoint site and identify potential VIMA Providers geographically close to the client.
 - Group VMS SharePoint site
- Contact the client or Authority to Act (ATA) by their preferred method of communication.

NOTE What if you are unable to contact the client?

1) Attempt a maximum of two contacts over two full working days before leaving a voicemail or sending a notification to request client contact.

2) If you are unable to reach the client, extend the task for an additional two working days and note in the task description that this is the second attempt to contact the client.

3) On the task due date and if there has been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach them by phone letter. The CM04 letter will be populated with client injury details, however you need to update the letter as follows:

'We recently tried to contact you about your injury that happened on [date of accident auto]. I tried calling you to talk about how we may be able to help you recover from your injury/injuries, but haven't managed to get in touch. It would be good to hear from you on how you are progressing or discuss what other support we could offer, please give me a call or email me to arrange a convenient time for me to call you back.'

4) Extend the task date as appropriate to take into account postal delivery and note in the task description this is the third attempt to contact the client and the CM04 letter has been sent.

5) On the task due date and if there has been no contact from the client and they are continuing to receive support, seek internal guidance to determine next steps.

6) If you're in Partnered and no contact is made with the client after 3 attempts, you must contact the provider, GP or other verified contact on the claim.

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

 Identity Check Policy

- d** Confirm your client understands the purpose of the assessment and agrees to attend.

NOTE What if the client does not agree to participate?

Find out why the client does not want to participate, consider their reasoning and alternatives. Record this as a contact on the claim. If you are unsure how to proceed go to Seek Internal Guidance.


 **PROCESS** Seek Internal Guidance

- e** Using the VMS Sharepoint booking site identify and agree a suitable provider, date and time with the client and schedule the appointment.

 Group VMS SharePoint site

NOTE How do you book a VIMA appointment?

Refer to the Book an appointment through the Centralised booking system (CBS) process.


 **PROCESS** Book an appointment through the Centralised booking system (CBS)

NOTE What if there are no providers at the client's location?

Discuss suitable transport options with the client, including:

- Can the client attend an appointment out of town?
- Will the client need transport support ie taxi, flights?
- Will the client require a support person?
- Will the client require accommodation?

Refer to Arrange Ancillary Flight Services process or another Ancillary Service processes ie Accommodation, Taxi, Public Transport or Other travel.


 **PROCESS** Arrange Ancillary Flight Services

- f** In Salesforce, record the conversation as a Contact action.


- g** Add the Agreed Intervention to the Recovery Plan.

NOTE What if you are unsure how to add an Agreed Intervention?

Go to Create or Update Recovery Plan, then return to this process and continue.

 **PROCESS** Create or Update Recovery Plan

- h** Create a Reminder action to notify the client of the appointment details 2 days prior to the appointment. If you consider sending the RL01 Reminder – Assessment appointment letter, ensure you are aware of timeframes of sending letters to clients.

 RL01 Reminder - Assessment appointment - client

3.0 Request assessment referral


Recovery Coordinator, Recovery Partner

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

- ACC195 Vocational Independence Occupational Assessment report
- ACC197 Vocational Independence Assessment Recommendation form
- ACC191 Vocational Independence Assessment: Summary, review and quality check
- ACC691 Vocational Independence Assessment readiness check form (not mandatory, if returned)
- ACC193 Vocational Independence assessment client questionnaire (not mandatory, if returned)
- ACC194 Vocational Independence Assessment GP questionnaire (not mandatory, if returned)
- Vocational Independence (VI) review decisions (if applicable)
- Initial Occupational Assessment report (IOA)
- Initial Medical Assessment report/s (IMA) and any past VIMA report/s
- Curriculum Vitae
- All Vocational Rehabilitation reports
- All Medical reports
- Information on other claims including Mental Injury claims
- Recovery Plan/s (IRP)
- Schedule of Claimant Injuries.

NOTE What if there are clinical records missing?

Go to Request Clinical Records. Once received, return to this process.

 **PROCESS** Request Clinical Records

- b** Check if there are documents on other claims relevant to the assessment.

NOTE What if there are documents on other claims?

Create a copy and transfer to the other claim:

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

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg. Medical records and reports from claim: 100XXXXXXXXX

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

c Perform privacy checks on the documents.

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

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, before adding the document to the document group.

- 📄 NGCM - Redact information from PDF documents

d In Eos, create two document groups titled: 'Vocational Independence documents (IOA/IMA/Recovery Plan/Vocational Reports); and 'Vocational Independence Medical documents'.

- 📄 Manage document groups

e In Eos, generate a Medical Assessment referral task for an 'Vocational Independence Medical Assessment'. For further information refer to Referring Tasks to Recovery Administration - Principles.

- 📄 Creating Manage Referral Tasks - System Steps
- 📄 Referring Tasks to Recovery Administration - Principles

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

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

f Complete the mandatory fields in the e-form. Note the region in 'booking sheet' field of the e-form. Provide the following information in the task:

- date and time of the booking
- appointment address as per VMS booking sheet
- name of assessor
- vendor ID and email address
- purchase order code
- any referral information if referral is for reassessment (ie for VI deterioration purposes)
- factors that may impact the assessment, eg communication difficulties or interpreter, services.
- name of document group or advise no documents are to be sent
- letter option - 1 copy of VIOA sent previously, 2 copy VIOA enclosed
- 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.

- 📄 NG GUIDELINES Purchase Order Details - Vocational Independence Medical Assessment

- 📄 Disclosure of Care Indicator Information to Third Parties Policy

NOTE What are the complex VIMA criteria?

- A Serious Injury profile; or
- A covered Sensitive Claim; or
- The covered injury is a moderate to severe traumatic brain injury; or
- 2.5 years or more have passed since the date of accident.

If the client meets one or more of the criteria a complex VIMA needs to be requested, use service item code VMV02.

g Consider the timing of the task. The tasks route to the Recovery Administration team with an 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 action for the future date when the support will be required.

When the Reminder action is due return to Activity 3.0 Request assessment referral.

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

4.0 Review task

Recovery Administrator


a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.

b Check the task provides the following information:

- date and time of the booking
- appointment address as per VMS booking sheet
- name of assessor
- vendor ID and email address
- purchase order code
- any information to be included with referral
- factors that may impact the assessment, e.g. communication difficulties or interpreter, services
- name of document group or advise no documents are to be sent.














NOTE What if there is information missing?

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

 Principles of Working in the Administration Team

5.0 Create Purchase Order

Recovery Administrator


- a** In Eos, generate a Purchase Order using referral type Vocational Independence Medical Assessment.
-  Creating purchase orders using general + QE
 -  NG GUIDELINES Purchase Order Details - Vocational Independence Medical Assessment
 -  Purchase Order - Handy Hints on how to create and edit POs
 -  Service Contracts and Contracted Providers - MFP spreadsheet
- b** Access Group VMS SharePoint site to obtain the physical address of the vendor, date and time of the appointment. Add the referral date to the appointment.
-  Group VMS SharePoint site
- c** Add the Provider as a participant on the claim.
-  Manage Participants (Eos Online Help)
- d** Approve the Purchase Order.
- e** Select 'Add documents' and generate the following:
- VI05 Vocational Independence Medical Assessment appointment - PO - client
 - VI04 Vocational Independence Medical Assessment referral with appointment - PO - vendor
 - ACC192 Vocational Independence medical assessment referral document list.
- f** Complete the ACC192 VIMA referral documents list.
- g** Add additional information received in the task to the referral. For guidance refer to the Admin Template - Vocational Independence Medical Assessment.
-  Admin Template - Vocational Independence Medical Assessment
 -  VI04 Vocational Independence medical assessment referral with appointment
 -  VI05 Vocational Independence medical assessment appointment
 -  Admin Template - ACC192 Vocational Independence Medical Assessment Referral Documents List
- h** Perform privacy checks on the documents in the group.
-  Privacy Check Before Disclosing Information Policy
 -  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- i** Complete the documents and convert them into non-editable PDF's.
- j** Generate a Bulk Print of the two document groups: 'Vocational Independence documents (IOA/IMA/Recovery Plan/Vocational Reports) and; 'Vocational Independence Medical documents' by following the system steps below.
-  Create Bulk Print
- k** Create and send an email to the Vendor using 'Requests and referrals' template.


NOTE What if there is a document group?

Open the document group and link the VI04 letter to the group and email to the vendor.

NOTE What if the email is too large to send as a single email?






Contact the vendor and ask if the referral can be sent by courier. If yes, confirm correct physical address then go to Prepare and Send Client Information by Courier then return to this process. Otherwise, send by email.

 **PROCESS** Prepare and Send Client Information by Courier

- l** Send the VI05 Vocational Independence Medical Assessment appointment - PO - client letter and VIIS01 Vocational Independence Factsheet to the client by their preferred method of communication.
-  VIIS01 Vocational Independence Factsheet
- m** In Salesforce, close the referral task.


6.0 Review assessment report

Recovery Coordinator, Recovery Partner

- a** In Eos, open the VIMA report.
- NOTE What if the Provider or client advised they failed to attend?**
- Go to Manage Non-Compliance.
-  **PROCESS** Manage Non-Compliance
-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- b** Perform privacy checks on the report.
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-  Managing a client's request to change personal information

7.0 Request approval to exit VI

Recovery Coordinator, Recovery Partner

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-  ACC198 Vocational Independence Assessment - Final quality check and decision

- b** Request written guidance from a Technical Specialist to confirm whether or not the client has achieved vocational independence, linking the ACC198.

NOTE What if you are unsure how to request written guidance?

Go to Seek Internal Guidance. Once the completed and signed ACC198 has been received, return to this process.

-  **PROCESS** Seek Internal Guidance

NOTE What if Clinical Services comment is required?

Technical Services will decide if confirmation of vocational independence needs to be obtained from a Clinical Advisor.

- c** Open the NGCM - Written Guidance task from Recovery Support, review the guidance and action recommendations where appropriate.

NOTE What if the client has not achieved VI, but may achieve it with further vocational assistance?

- consider the recommendations of the VIMA assessor or Technical Specialist for further vocational rehabilitation
- update the client's Recovery Plan.

Continue with this process.

NOTE What if the client has not achieved VI but is working part-time and can't increase their work hours?


- check the Technical Specialist comments and discuss with them if needed
- reconsider the rehabilitation outcome(s)
- record this outcome in Eos
- update the client's Recovery Plan.

Continue with this process.

NOTE What if the client has not achieved VI but can work part-time and is not working?


- check the Technical Specialist comments and discuss with them if needed
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Continue with this process.

-  **PROCESS** Create or Update Recovery Plan

NOTE What if the client has not achieved VI and is unlikely to achieve it with further vocational assistance?

A client may reach a point in their recovery when further rehabilitation won't result in a recovery outcome. To ensure that we continue to manage the client effectively and appropriately, have a discussion with your Team Leader/internal guidance and consider the Identify a Client for No Further Rehabilitation process.

-  **PROCESS** Identify a Client for No Further Rehabilitation

8.0 Contact client

Recovery Coordinator, Recovery Partner

- a** Consider if it is appropriate to meet the client face to face.

NOTE What if you are unsure how to determine if F2F is appropriate?

Go to Arrange Face to Face Client Meeting, then return to this process.

-  **PROCESS** Arrange Face to Face Client Meeting

- b** On the Contact action due date, contact the client by their preferred method of communication.

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

-  Identity Check Policy

- d** Explain to the client it has been decided by the assessors and ACC they have achieved Vocational Independence and as a result of this their weekly compensation (WC) will end three months from the day after we send a decision letter.

NOTE What if the client has not achieved Vocational Independence?

Review the guidance provided by the Assessor and Recovery Support, if appropriate, discuss any additional vocational rehabilitation options or barriers to rehabilitation.

- e** Discuss the VIOA and VIMA assessments and answer any questions.

- f** Advise the client they will receive a med cert expiry notification close to when their weekly compensation will cease. This is a reminder of when their final payment will be and as they have reached the end of their payment period there is no need to obtain further medical cover.

- g** Check if the client would like assistance to search for a job.

NOTE What if they would like assistance?


Complete this process, then go to Set Up Job Search Support.

-  **PROCESS** Set Up Job Search Support

NOTE What if the client would like counselling or budgeting advice?

Advise the client to the yellow pages of their local phone book or search the internet for free budget advice in their local area.

- h** Process Referring clients to Work and Income

-  Referring Client to Work and Income

- i** Check if client would like to be contacted within the next 3 months.

NOTE What if they do want to be contacted?

Add a 'Contact' task with a due date agreed with the client.

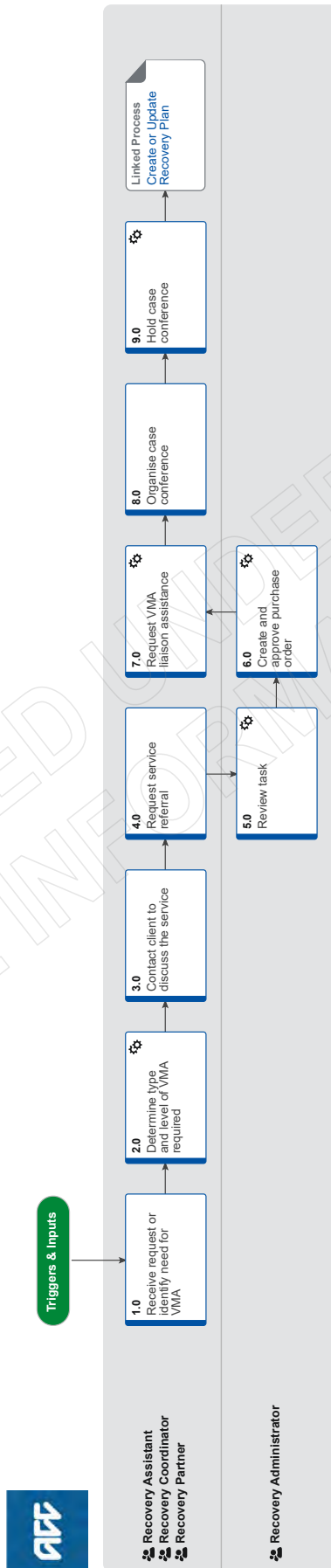
- j** In Salesforce, record the conversation as a Contact action.
- k** Generate and send the VI06 letter to the client by their preferred method of communication.
- l** Generate and send the VI08 letter to the GP (ensure the client is informed that this has been sent).
- m** In Eos, add and approve incapacity for 3 months from the day after the decision was issued.
- n** Tick the Vocational Independence indicator on the General tab of the ACC45 screen.
- o** Check if the client has active supports ie Social Rehabilitation and consider if reassessment of the support is required (a VI decision does not impact the client's access to treatment or other entitlements related to their injury).
- p** Cancel future dated Recovery Check Ins, if applicable.
- q** Add a reminder action to close the claim with a due date of when they achieve Vocational Independence if there are no further supports.

**PROCESS****Create or Update Recovery Plan**

Recovery Coordinator, Recovery Partner

RELEASED UNDER THE
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Summary

Objective

To request medical advice for clients receiving vocational rehabilitation and approve requests from GPs and Vocational Rehabilitation providers.

Background

Vocational Medical Assistance (VMA) is an advisory service that Recovery Team members, general practitioners (GPs) and Vocational Rehabilitation Service (VOC) providers can access. The service is available for clients receiving vocational rehabilitation (such as the Stay at Work (SAW) or Back to Work (BTW) service).

There are two components of VMA:

- Liaison Services (advice from an expert by phone or email)
- Case Conferencing (phone and/or face-to-face meeting with support team).

Owner [Out of Scope]

Expert

Procedure


1.0 Receive request or identify need for VMA

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the request.

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 Where do VMA requests come from?

Requests for VMA result from the Recovery Team member, GPs on their behalf or the Vocational Rehabilitation providers needing vocational medical advice.


- b** Confirm the type of VMA required.

NOTE What type of VMA service is available?

- VMA Liaison Service:
The Recovery Team member, GP or VOC provider should consider using this service when they require immediate expert occupational medicine advice by phone or email to answer general clinical questions about a client's vocational rehabilitation

- VMA Case Conference:
The Recovery Team member, GP or VOC provider should consider using this service when they need a phone or face-to-face meeting with members of the client's vocational rehabilitation team to discuss and reach a consensus on how to solve a vocational rehabilitation problem.

- c** Understand the VMA service, refer to Vocational Medical Assistance (VMA) Service Page.

 Vocational Medical Assistance (VMA) Service Page

2.0 Determine type and level of VMA required

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a** Confirm the client's eligibility for the VMA service.
b Consider the options available to the client.

NOTE What other options are available?

If the question you are trying to answer is complex, then consider referring for a Vocational Rehabilitation Review (VRR) or go to (NGCM) Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance

- c** Check if the service has been provided more than five times to the client.

 Gather Additional Information or Advice

NOTE What if the service has been used less than five times?

There is no purchase order or approval required.

- If the request is from a Recovery Team member:

- For Liaison VMA:
contact the client, the provider and request assistance (go to steps 3.0 Contact Client to discuss service and 7.0 Request VMA liaison assistance)

- For VMA case conference:
contact the client, the provider and relevant parties to organise the case conference (go to steps 8.0 Organise case conference and 9.0 Hold case conference)

- if the request comes from a GP and/or a Provider, they will use the service and inform the Recovery Team member that the service will be used.

- d** Approve or decline request for VMA service, using the NG Principles Decision Making guidelines.

 NG Principles Decision Making

NOTE What if the request is declined?

Phone the requestor and the client and let them know why VMA (liaison or conference) is not the most appropriate option and discuss the alternative option with them.

- e** In Salesforce, add a contact to record the conversation with the client and requestor.

- f** Identify the providers that can be used for this service.

 Contracted Suppliers by Geographic Area of Coverage

NOTE What if the client has an existing relationship with a previous provider who was involved in their rehabilitation?

- 1) Note the preference.
- 2) Load the 'vendor/provider' as a participant . This enables Recovery Admin to validate the email and then email the purchase order directly from Eos if required.


The Recovery Team Member must ensure all known participants are loaded on the file and then removed when no longer relevant.

 Manage Participants (Eos Online Help)


3.0 Contact client to discuss the service

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- b** Explain why they need to use this service, what the service will do, as well as what their responsibilities are.

 Client Legislative Rights and Responsibilities Policy

NOTE What do you need to explain the client?

Make sure:

- your client understands and agrees with the referral
- key stakeholders are aware of the referral.


Explain who the provider will talk to and why. This will help ensure the client provides authority to the provider to contact other parties (eg employer).

If a conference is requested, obtain approval to invite employers and other relevant parties as required.

- c** Check that the client has provided consent to collect and share information.

NOTE What if the client has not provided consent?

If the client has not provided consent to collect and share information, go to (NGCM) Obtain Client Authority to Collect Information process.

 **PROCESS** Obtain Client Authority to Collect Information

- d** Update the Recovery Plan with the agreed intervention.

NOTE How do you update the Recovery Plan?

Go to (NGCM) Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

- e** Confirm if the service has been used more than five times.


NOTE What if the service has been used less than five times?

Go to 7.0 Request VMA liaison assistance or 8.0 Organise case conference, depending on the service required.

4.0 Request service referral

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a** Generate a General task to Recovery Administration for 'Vocational Medical Assistance' service.


 Contracted Suppliers by Geographic Area of Coverage


NOTE What information is required for the approval?

Ensure you add to the General task all the information required for the approval:

- General template
- Service: (Liaison or Conference)
- Vendor:
- Code: VMA01 Liaison or VMA02 Case Conference State 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.

 Service Contracts and Contracted Providers - MFP spreadsheet

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

 Disclosure of Care Indicator Information to Third Parties Policy

5.0 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 information to ensure it has all the information you need to proceed.

NOTE What if the target date needs clarification?


Target date clarification may need to be sought in the following situations:

- Target date has passed
- Target date is in 0-6 weeks time
- You are unsure of the target date based on the information provided.

If this is the case, go to NG PRINCIPLES Working in the Administration Team in below Note.


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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to NG PRINCIPLES Working in the Administration Team.


 Principles of Working in the Administration Team

6.0 Create and approve purchase order

Recovery Administrator

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- a** In Eos, generate a purchase order for the specified service.

 Creating purchase orders using general + QE

NOTE What purchase order service code should you use?

Use purchase order service code = VMA01 Liaison or VMA02 Case Conference.

NOTE What if the Vendor hasn't been added as a participant?


Add the Vendor as a participant in Eos.

 Manage Participants (Eos Online Help)

- b** Approve the purchase order.

NOTE What if you do not have the delegation to approve the purchase order?

- 1) Save the Purchase order.
- 2) Create and send a Request Authorisation task to a Recovery Team Member for a purchase order approval.
- 3) Go to NGCM - FINAL Request Authorisation for a Purchase Order - System Steps.

 Request Authorisation for a Purchase Order - System Steps

- c** Inform the Recovery Team Member the Purchase Order number.

7.0 Request VMA liaison assistance

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Email or phone the provider to confirm required Vocational Medical Assistance.

NOTE What do you need to confirm?

- Client's name
- Claim number
- Purchase Order Number.

NOTE What if the provider fails to respond?

If the provider fails to respond within 48 hours, consider escalating as a performance issue.

- b** Provide the purchase order number as given by the Administration team.

- c** In Salesforce, record advice as a 'contact'.

NOTE What do you need to consider when recording advice?

Include VMS and the referral number (1,2,3,4,5) as this will inform the number of time the service has been used.

- d** Send GP a copy of the advice, if appropriate.

- e** This process ends here.

NOTE What if you're unsure if the information is correct?

If you're unsure the details are correct, check with the VMS and/or VOC provider to clarify and correct where appropriate.

- f** Provide a copy of the final record to all attendees, either by email or post, within 48 hours of the conference.

- g** Upload the minutes to Eos.

NOTE What should be recorded in Eos?

- 'VMA' and the referral number eg 1, 2, 3, 4, 5, in the Subject line so we can keep track of the number of VMA services provided.
- Names of everyone you sent a copy to.



PROCESS

Create or Update Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

8.0 Organise case conference

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Arrange to have the case conference within 10 working days of talking to the VMS provider, if possible.

- b** Contact the required attendees by phone or email and invite them to attend.

- c** Confirm conference type, date and time.

NOTE Should the meeting be held face to face?

Refer to NG GUIDELINES Client Face to Face Meetings.

- NG GUIDELINES Client Face to Face Meetings

NOTE What if attendees are not available within a reasonable timeframe?

Consider other options eg VMA Liaison or a VRR in the interim.

9.0 Hold case conference

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review claim information to check that Vocational Rehabilitation plans are in the Recovery Plan and the client's progress to date.

- b** Agree in advance with the provider if a Recovery Team member needs to attend the conference.

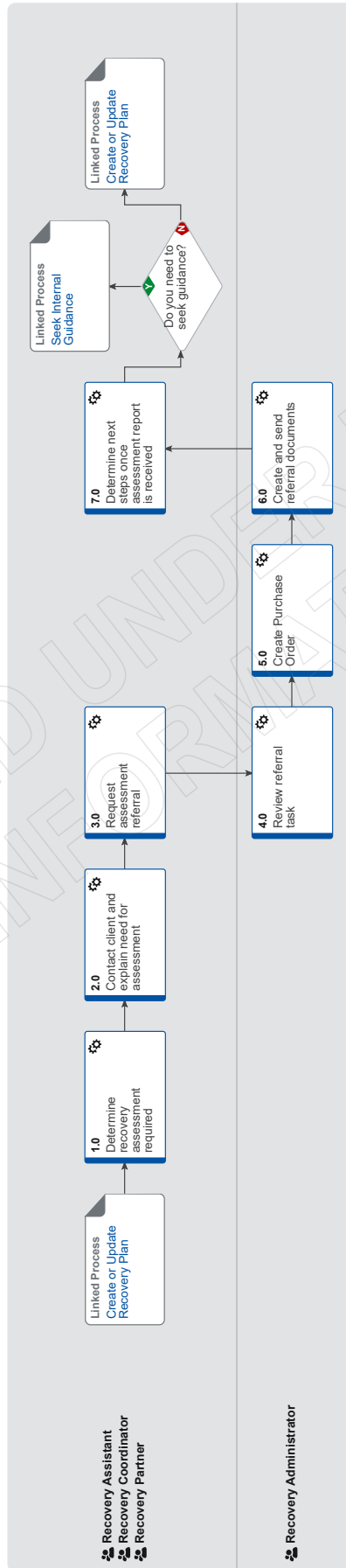
NOTE What if the Recovery Team member can't attend the conference?

The Recovery Team member needs to consider sending a representative.

- c** Coordinate with Provider who will facilitate conference and record minutes.

- d** Facilitate conference and record minutes, if required.

- e** Review the minutes to ensure only appropriate information is recorded.



RELEASED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

The purpose is to create and send a Vocational Rehabilitation Review referral in order to provide the most appropriate support for our clients throughout their recovery.

Background

A Vocational Rehabilitation Review (VRR) is a brief clinical assessment to assist people returning to work following an injury.

The VRR service is designed for anyone who is currently receiving a Stay at Work (SAW) or Back to Work (BTW) service and medical aspects of 'fitness for work' are unclear, or rehabilitation has stalled. It is designed to be readily available and easy to access for case owners, vocational rehabilitation providers and GPs.

Use this service when you need an expert clinical opinion and recommendations from a medical specialist on the client's fitness for work, medical certification and/or their ability to participate in a Vocational Rehabilitation Service (VOC) programme.

The VRR can be done at any point in the client's vocational rehabilitation (up until they begin Vocational Independence Assessments).

Owner

[Out of Scope]

Expert

Procedure



PROCESS

Create or Update Recovery Plan
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine recovery assessment required

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Confirm client's eligibility for the Vocational Rehabilitation Review (VRR) assessment.

NOTE When would you consider referring for a VRR?

If any of the following criteria are met:

- momentum and confidence in the rehabilitation process has been lost
- a difference in opinion between the Vocational Rehabilitation Services (VOC) provider and General Practitioner (GP) about a proposed return to work plan
- a clearly defined medical opinion on fitness for work is required
- a client doesn't have a GP and needs medical clearance to undertake a return to work programme with a VOC provider
- because the client fears re-injury or pain when undertaking extended duties
- a client is experiencing an increase in pain during a work trial and it is unsure if it is safe
- the employer is reluctant to extend the client's duties in case they aggravate their injury
- medical leadership is required to restore a team approach.

To confirm eligibility criteria seek internal guidance from an advisor from Recovery Support. Refer to (NGCM) Seek Internal Guidance.

PROCESS Seek Internal Guidance



NG Principles Decision Making

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 types of referral?

- standard
- complex

NOTE When would you refer for a complex VRR?

- a client who is unable to return to their pre-injury role
- a client whose case relates to a complex physical injury
- a client who has a covered complex mental injury
- where the covered injury is for a moderate to severe traumatic brain injury
- where the claim is older than 6 months at the time of the referral.

NOTE What if a Vocational Rehabilitation Service (VOC) provider is requesting prior approval for a VRR referral?

VRS providers can ask for up to, and including, three VRRs before seeking approval from ACC. Check Eos to confirm the number of previous VRR services the client has had.

If the request made is for VRR number:

1, 2 or 3: The VOC provider can make a direct referral to the VRR provider using the ACC6245 provider referral form. They do not need prior approval but they must let the client's Recovery Team/member and GP know. Let the VOC provider know that they can arrange the referral. Add the Agreed Intervention to the Recovery Plan. The provider will use the medical notes they hold for the referral; if further medical notes are required see Section 1.0 b. No further action is required by ACC until the report is received.

4 or greater: Recovery Team/member should consider the request:

If you approve the request:

- Continue with this process

If you decline the request:

- Generate and send the following decline letters:
- VR14 Additional vocational rehabilitation review - decline – client
- VR15 Additional Vocational rehabilitation review - decline – GP

NOTE How does a GP request a VRR?

- the client's GP can make the referral directly to a Service Provider on fitness for work certification and/or the ability of the Client to participate in a vocational rehabilitation programme at any point in the Client's rehabilitation.

NOTE Timeframes

If the service has been initiated during VR, then the VRR component must end before the client enters the Vocational Independence process. No further assistance can be offered past this point as this may be perceived as providing on-going rehabilitation.

NOTE What are alternative services to consider?

For clients with complex diagnostic issues, consider Medical Case Review (MCR) or Medical Single Discipline Assessment (MSDA). Go to (NGCM) Seek Internal Guidance, for the best option.

 **PROCESS** Seek Internal Guidance

- b** Ensure current medical notes are on file so they can be sent to the VRR provider.

NOTE What if the current medical notes are not on file?


You will need to obtain these before the referral is sent to the provider. Go to (NGCM) Request Clinical Records.

 **PROCESS** Request Clinical Records

 View Client Consent

NOTE What if the client has not granted ACC authority to collect medical and other records?

You will need to obtain the client's authority to collect medical and other records. Refer to (NGCM) Obtain Client Authority to Collect Information.

 **PROCESS** Obtain Client Authority to Collect Information

- b** Open Group VMS SharePoint site and identify potential providers that the client can use for this service. Suitable providers will be geographically close to the client and capable of providing the assessment. Take the client's cultural or other needs into consideration.


 Service Contracts and Contracted Providers - MFP spreadsheet

 Group VMS SharePoint site

NOTE What if want to seek a second opinion?

If you're looking for a second opinion regarding diagnosis or treatment, then the VRR is not the right service. Alternatively, a GP can refer to another doctor for a second opinion using the clinical services contract or other contracted services such as the MCR or SDA contracts, which may be more appropriate.


A doctor can also refer to another doctor for advice using the Clinical Services contract for a standard or complex second opinion assessment.


 Arranging an additional medical assessment referral


- c** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- d** Explain that you are referring them to this service and what the service will do, as well as what their responsibilities are. For more guidance on how to discuss the service with your client see note below.

 Vocational Rehabilitation Review (VRR) Service Page

 Client Legislative Rights and Responsibilities Policy

 Client choice of providers Policy

- e** Advise the client of potential providers you have identified in their location or in the area closest to them, in the VMS tool.

NOTE What else do you need to discuss with the client?

- the time, place and name of the assessor. Make sure that your client can attend, explain to them the benefits of attending the appointment and their responsibilities to participate in their rehabilitation.

- Explain that there is no cost, that we can contribute or arrange travel and that they can bring a support person with them.

- Let them know that the specialist will send us a report which we will send them a copy of.

- Ensure your client understands the purpose of the assessment and the possible outcomes.


2.0 Contact client and explain need for assessment

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Check that the client has granted ACC the authority to collect medical and other records.

NOTE What if there are no providers at the Client's location?

Send a request to the Recovery Administration Team to set up taxi or transport.


 **PROCESS** Arrange Ancillary Taxi Service

NOTE What if the client does not agree to participate?

Find out why the client does not want to participate and consider their reasoning and alternatives. Go to (NGCM) Seek Internal Guidance, if your unsure how to proceed.

 **PROCESS** Seek Internal Guidance

- f** Choose the next available appointment in the Group VMS SharePoint site . When you receive confirmation of the appointment from the Provider, record a contact. Go to Group VMS SharePoint site to confirm the VMS booking.

 Group VMS SharePoint site

NOTE Do ACC receive a confirmation of the booking?

For the Group VMS SharePoint site, you won't get any confirmation from the provider that the assessment is booked. However, of your client's name and claim number are recorded in the spreadsheet, then it is considered that you have that booking confirmed. When the referral documents are emailed to the provider, you will usually get an email back confirming receipt. If the provider cancels the clinic, ACC will be informed.

NOTE What if the provider does not appear as a current participant?

Load the "vendor/provider" as a participant. This enables the Recovery Administration Team to validate the email and then email the purchase order directly from Eos if required.

The Recovery Team Member must ensure all known participants are loaded on the file and then removed when no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

- g** Email or phone employer (if authority given) and let them know of the assessment.
Alternatively you can send the following letter:
• VR12 Vocational rehabilitation review notification – employer


- h** Create a reminder action to notify the client of appointment details the day prior to the appointment. Enter the date, time and location of the appointment in the description field.

- i** In Salesforce, add a contact note as a record of the conversation.

- j** Add the agreed intervention to the Recovery Plan.

NOTE How do you update the Recovery Plan?

Go to (NGCM) Create or Update Recovery Plan.


 **PROCESS** Create or Update Recovery Plan

NOTE What documents do you need to include?


- Current medical certificate
- Previous or most recent Stay at Work (SAW) report
- Previous or most recent Back to Work (BTW) report
- Previous or most recent WSA report
- ACC188 Job Task Analysis form if on file
- GP notes
- Specialist notes
- Imaging notes
- Physio notes
- DHB notes
- Signed ACC6300 or ACC6300D Authority to collect medical and other records. NOTE: If verbal consent was provided please note this in the task eform for Recovery Admin.

NOTE What do you do if you don't have all the information to complete the referral?

Once you have requested the additional information required, create a reminder action, set the target date for when you expect to receive the information. If you require further information, refer to Gather Additional Information or Advice.

 Gather Additional Information or Advice

- b** Perform privacy checks on documents.


 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

Check documents:

- are relevant to the referral
- do not contain any third party information
- do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 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, before adding the document to the document group.

 NGCM - Redact information from PDF documents

- c** Create a referral-specific document group and enter 'Vocational Rehabilitation Review' and today's date in the document group description field.

- d** Add the documents to the group.

3.0 Request assessment referral

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, find all the documents that need to be sent along with the referral.

NOTE What if there are documents from other claims that are relevant to the assessment?


When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files. E.g. Medical records and reports from claim: 100XXXXXXXX

Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

 Manage document groups

- e Generate a Vocational Rehabilitation referral task for Recovery Administration for a 'Vocational Rehabilitation Review'.

NOTE How do you refer a task to Recovery Administration?

Please see Referring Tasks to Recovery Administration - Principles for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

NOTE How do you generate and send a referral task to Recovery Administration?

Go to NGCM Create a Referral Task.


 Creating Manage Referral Tasks - System Steps

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

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


NOTE What information do you need to include in the referral task?

- VMS booking sheet region used (eg Southern folder>Dunedin>Dr ABC)
- Date and time of the booking
- Vendor preference, if applicable
- Type of assessment (standard/complex)
- Rehabilitation interventions and outcomes (past, present and planned)
- Any recommendations (medical) from Recovery Support
- Employment details (including, if relevant and known, any pre-injury jobs, work type and reasons for leaving pre-injury occupation)
- Relevant provider contact details
- Any known or potential barriers to rehabilitation (e.g. transportation, childcare etc.)
- Provide the correct service code. Refer to the Purchase Order guidelines.

 NG GUIDELINES Purchase Order Details - Vocational Rehabilitation Review

NOTE Will extra time be required?

Inform Recovery Administration that extra time is required and to add to the purchase order the VMR02 service code to cover the time taken for the VRR provider to communicate their recommendations with each party.

 Service Contracts and Contracted Providers - MFP spreadsheet

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

- Call Recovery Administration
- Give the Recovery Administrator who answers the call the claim number
- The Recovery Administrator will open the claim in Eos and find the task on the claim
- Transfer the task into the Recovery Administrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.

NOTE What if the request is required in the future?

If the request is required in the future, set a reminder task for the future date when the service will be required. When the reminder task comes up send a task to Recovery Administration to continue with the process. Consider the contract timeframes and SLAs as specified in the service page

NOTE What are the SLAs?


The referral tasks route to the Recovery Administration team with an SLA of 24 hours.

- f Complete all the mandatory fields and any additional information to be included in the referral form including questions received via written guidance or hotline advice from Recovery Support and the standard questions supporting reason for referral or assessment request. For guidance see the link below.

NOTE What if your client has a Care indicator?

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of Care Indicator Information to Third Parties Policy

- g Ensure you inform the GP of the referral, if required. Note task if a VR13 should be sent to GP to advise of the referral.

4.0 Review referral task Recovery Administrator

- a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.

NOTE What if you cannot open the task?

If you pull a task through that you cannot open, transfer it back into the relevant Recovery Administration queue to be allocated to an Administrator who has the Secured Action to complete the task.

Ensure all tasks related to sensitive claims are transferred back to the Recovery Administration Department for the Sensitive Claims Administrator, all other claim tasks should go to the Recovery Administration Department queue with the Recovery Administrator role.

You may also have pulled through a task with a claim that was managed in the Launch Pad Recovery Plan (LPRP) subcase before 12 August 2019.

Only certain Recovery Administrators have the Secured Action to complete these tasks.

- b** Review the task to ensure it has all the information you need to proceed.

NOTE What if the target date needs clarification?

Target date clarification may need to be sought in the following situations:

- Target date has passed
- Target date is in 0-6 weeks time
- You are unsure of the target date based on the information provided.

If this is the case, go to NG PRINCIPLES Working in the Administration Team in below Note.

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




If required information is missing from the task, or you need guidance on working within the Administration Team, go to NG PRINCIPLES Working in the Administration Team.

 Principles of Working in the Administration Team

5.0 Create Purchase Order

Recovery Administrator


- a** In Eos, generate a Purchase Order for the specified referral.

-  Creating purchase orders using general + QE
-  NG GUIDELINES Purchase Order Details - Vocational Rehabilitation Review
-  Purchase Order - Handy Hints on how to create and edit POs

- b** Identify and select the vendor as specified by the Recovery Team Member.
- c** Locate the contracted vendor via the Geographic Location search, once selected add the vendor as a 'Vendor - Contracted' participant in Eos.
- d** Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Refer to the 'Request Authorisation for a Purchase Order - System Steps'.

 Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.


- 1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2). Select 'OK'.
- 3). Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

6.0 Create and send referral documents

Recovery Administrator

- a** Create the referral document for the service.

 ACC98 ACC referral for Vocational Services

- b** Populate with extra information noted on the referral task.


- c** Confirm details of the appointment and location on VMS booking sheet

 <https://accnz.sharepoint.com/sites/Group-VMSBookings>

- d** Check the task to ensure all relevant information is captured before you exit the document.

NOTE What does a quality referral look like?


Refer to the Admin Template - Vocational Rehabilitation Review Referral.

 Admin Template - Vocational Rehabilitation Review Referral

- e** Ensure you have completed the document (to convert the document into a non-editable pdf).


- f** Link the referral to the document group 'Vocational Rehabilitation Review'.

- g** Perform privacy checks using NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- h** Update the VMS booking sheet with the date the referral is sent.


NOTE For information and instructions to open a Update the VMS booking sheet, go to Book an appointment through the Centralised booking system (CBS).


 **PROCESS** Book an appointment through the Centralised booking system (CBS)

- i** Create and send an email using 'Requests and referrals' template and attach the documents.

NOTE What if the document is too large to send in a single email?

Contact the vendor and ask if the referral can be sent by courier. If yes, confirm correct physical address, go to Prepare and Send Client Information by Courier then return to this process. Otherwise, send by email.


 **PROCESS** Prepare and Send Client Information by Courier

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


j Send the referral to the vendor.

NOTE **What if the Vendor requires the documents to be sent via courier?**

Go to Prepare and Send Client Information by Courier process.

 **PROCESS** Prepare and Send Client Information by Courier

k Send the VR11 Vocational rehabilitation review appointment - client letter to the client include a VOCIS131 Vocational rehabilitation review - client information sheet if required.

 VR11 Vocational rehabilitation review appointment - client

 VOCIS131 Vocational rehabilitation review - client

NOTE **Alternatively you can send the following letter.**

• VR13 Vocational rehabilitation review notification – GP with a VOCIS132 GP information sheet if needed.

l In Salesforce, close the assigned referral task.

7.0 Determine next steps once assessment report is received

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Receive notification that the ACC6245 and VRR report has been received and is attached to the claim.

NOTE **What should you expect from the VRR report?**

The medical assessor will conduct a brief clinical examination of the client and provide their opinion and recommendations, focusing on the client's fitness for work.

You should expect:

- brief face-to-face assessment with very rapid turn-around time
- determine restrictions and fitness for work relating to the covered injury and/or other conditions
- explain to the client their current condition, injury recovery process and fitness for work
- provide the next rehabilitation steps (the service should complement the VOC being provided)
- identifying any other factors affecting recovery
- the assessor will clarify the diagnosis.

However, the service is not designed for clients with complex diagnostic issues

Following the VRR, the provider will complete a short report.


The provider will also:

- communicate with GP - discussing the diagnosis, injury management, barriers to rehabilitation, and fitness for work recommendations
- communicate with other treatment providers and VOC provider to discuss and seek support for recommendations
- communicate with the Client's employer (where applicable) to discuss current restrictions, timelines for recovery, and to facilitate safe and durable vocational rehabilitation
- communicate with the Client's Case Owner


 NG GUIDELINES VMS Report Expectations

NOTE **What if the client fails to attend and/or participate in the VRR?**

If the client fails to attend or take part in the VRR you should find out why. In some cases you may need to consider implementing the non-compliance process, seek guidance from Recovery Support and refer to Decline Entitlement When Client is Non-compliant Policy.

 Decline Entitlement When Client is Non-compliant Policy

b Perform Privacy and Relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

c Obtain guidance from an advisor from Recovery Support to confirm next steps. This will ensure a robust decision is being made prior to issuing any formal decision.

NOTE **Go to (NGCM) Seek Internal Guidance.**

 **PROCESS** Seek Internal Guidance

d Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

e Discuss report and next steps with client. Consider if a face-to-face meeting is required, refer to NG GUIDELINES Client Face to Face Meetings.

 NG GUIDELINES Client Face to Face Meetings

NOTE **What else do I need to discuss?**


- remind them why the assessment was needed
- discuss the content of the report
- explain what will happen next, any entitlements that may be affected and the various options available.

f Provide copy of the report to client and key stakeholders as per their preferred contact method.

NOTE **What if the client requests that the report is changed or incorrect?**

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Go to Managing a client's request to change personal information (CHIPS).

 Managing a client's request to change personal information

g In Salesforce, add a contact note as a record of the conversation.

h Update the agreed intervention in the Recovery Plan.

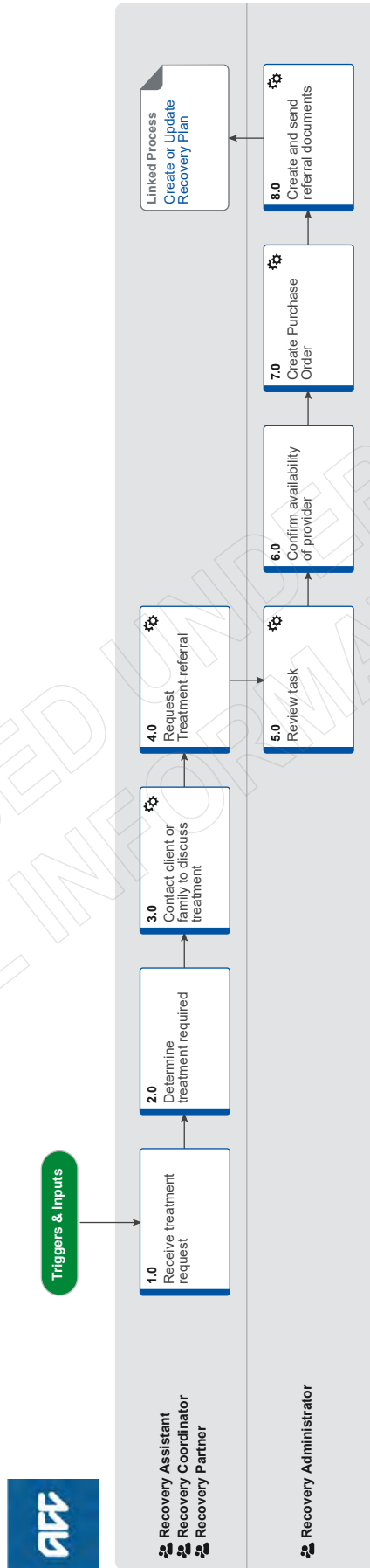
Do you need to seek guidance?

Recovery Assistant, Recovery Coordinator, Recovery Partner

YES....  **PROCESS** Seek Internal Guidance

NO.... Continue

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Summary

Objective

To put in place counselling that is provided under Accident Compensation Regulations (AC Regulations) for Clients with a Mental Injury.

Background

ACC is liable for the payment towards counselling costs under Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003: <http://www.legislation.govt.nz/regulation/public/2003/0388/latest/DLM235778.html/>

Owner

[Out of Scope]


Expert

Procedure

1.0 Receive treatment request


Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review the incoming request for counselling services. Refer to the physical injury counselling service page below for more information on the service.

 Physical Injury Counselling

NOTE What if the request involves a change or update in the client's diagnosis or covered injury?

Go to Assess cover for an additional injury or change in diagnosis process.

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

NOTE What if the request is for approving further physical injury counselling?

The treatment provider must complete and send an ACC090 Review of counselling report containing sufficient rationale as to why further sessions are required. Refer to the Approving further physical injury counselling link for more info.


 **PROCESS** Seek Internal Guidance


 About Physical Injury Counselling Service Page

 ACC090 Review of counselling report

NOTE What if the treatment request is for additional supports or if more than 10 sessions are likely to be needed?

The client will require an assessment to determine cover for Mental Injury Caused by Physical Injury (MICBPI). Determine the level of assessment needed based on the nature of the client's injury, mental health history, and medical history. Go to the processes below to arrange an assessment.

 Assess and Fund Mental Health Treatment: Psychiatric

 Assess and Fund Mental Health Treatment: Psychological

2.0 Determine treatment required

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Confirm the client's eligibility for the requested support.


NOTE What is the eligibility criteria for the requested support?

To be eligible for counselling:

- The claim cover status must be accepted
- The treating provider is an approved ACC registered counsellor
- The treatment request is considered necessary and appropriate for the client's recovery.

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

- b Approve or decline the request. Refer to NG Principles Decision Making.

 NG Principles Decision Making

NOTE What if you need guidance to determine if counselling sessions should be approved?


Talk to your Team Leader first, the if further guidance is needed refer to the Recovery Support Decision Tree to help work out next steps.

 Recovery Support Decision Tree

3.0 Contact client or family to discuss treatment


Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.


 Identity Check Policy

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

Go to Obtain Authority to Act (ATA) process.

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


- b Explain the treatment, if it is being approved/partially approved/declined, and what their rights and responsibilities are.

 Client Legislative Rights and Responsibilities Policy

NOTE What if the client has a preferred provider?

- If the client has no preference of a preferred provider, we will select a provider as discussed with the client (we need to show that we have kept our client fully engaged and informed).
- If the client has a preference, load the provider and their vendor as a participant. Ensure the vendor and provider are contracted for this service by using the Geographic Location search. This enables Recovery Administration to validate the email and then email the purchase order directly from Eos if required.
- The Recovery Team Member must ensure all known participants are loaded on the file and then removed when no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

 Client choice of providers Policy

- c** Check that 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.

 **PROCESS** Obtain Client Authority to Collect Information

- d** In Salesforce, record the details of the discussion with the client regarding the decision to approve/partially approve/decline the request.

NOTE What do you have to do to document your decision?

Refer to Issue Recovery Decision process.

 **PROCESS** Issue Recovery Decision

NOTE What if the request is declined?


Send the TMT999 Treatment decline decision - PO - client letter to the client.

 TMT999 Treatment decline decision - PO - client

- e** Add the treatment as an Action in the Recovery Plan.

NOTE How do you update the Recovery Plan?

Go to Create or Update Recovery Plan process.

 **PROCESS** Create or Update Recovery Plan

4.0 Request Treatment referral

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, create a referral-specific document group and name it 'Counselling treatment'. Refer to the system steps below for further guidance.


 Manage document groups

- b** Perform privacy checks to ensure that the documents are relevant to the referral, do not contain any third party information and do not contain any other information that needs to be withheld.

 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 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, before adding the document to the document group.

 NGCM - Redact information from PDF documents

- c** Add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?

When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims.

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files eg: Medical records and reports from claim: 100XXXXXXXX

Do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

 Manage document groups

NOTE What if you need to seek vendor availability?

Within the task, note if applicable:

- Preference for face to face sessions, telehealth or openness to both,
- How far can the client travel
- Provider gender preference
- Additional provider skills, specialties or experiences? (specific therapies such as EMDR/CBT, paediatrics, experience with prisoners etc)

Advise in task if you require Admin to advise of positive Vendor responses, prior to sending referral to next best available Vendor.

5.0 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?

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below

 Principles of Working in the Administration Team

6.0 Confirm availability of provider



Recovery Administrator

- a** Identify and select the vendor as specified in the task.

NOTE What if no vendor is specified is specified in the task?




Refer to Client Admin - Finding Providers System Steps

 Client Admin - Finding Providers System Steps

-  Service Contracts and Contracted Providers - MFP spreadsheet
-  Contracted Suppliers by Geographic Area of Coverage

7.0 Create Purchase Order Recovery Administrator

- a** In Eos, generate a purchase order for the referral. Refer to the Creating purchase orders using general + QE system steps below for how to create a purchase order.


-  Purchase Order - Handy Hints on how to create and edit POs
-  Creating purchase orders using general + QE
-  Counselling Purchase order details

- b** Locate contracted vendors via the Geographic Location search, this must be done even if the vendor details are provided in the task. Once selected add the vendor as a 'Vendor - Contracted' participant in EOS. When supplied with a non-contracted vendor, add as a 'Vendor - Non-Contracted'.

-  Manage Participants (Eos Online Help)

NOTE **How can you search for a non-contracted vendor?**

Refer to the system steps below.

-  Search for a Party

- c** Approve the Purchase Order.

NOTE **What if the purchase order requires a higher delegation?**

Save the purchase order. Create a Request Authorisation task. Refer to the system steps below for guidance.

-  Request Authorisation for a Purchase Order - System Steps

NOTE **What if you get a limited payment error message when authorising the purchase order?**

If you have received a request to amend a purchase order or create a purchase order for client reimbursements change the limited payment indicator.

- 1) In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2) Select 'OK'
- 3) Go back to the purchase order to authorise

Once you have authorised the purchase order and notified the vendor, remember to change the Limited Payment List Indicator to 'Yes'.

8.0 Create and send referral documents Recovery Administrator


- a** Create the referral document: ACC265 Referral for Psychological Services.

-  Admin Template - Initial Counselling Sessions


- b** Create the purchase order approval letter: COU10 - Initial Counselling Sessions Approve for the Vendor and the client.

NOTE **Are there additional documents to be generated and sent to the Vendor?**

Generate the ACC095 - Full Assessment Treatment & Rehabilitation Plan, ACC090 Review of Counselling Report and the ACC097 Completion Report and attach to the Vendor letter

-  COU10 - Initial Counselling Sessions Approve - Vendor

- c** Populate the letter with the information noted on the referral task. Check all the information within the task has been captured.

-  Admin Template - Initial Counselling Sessions

- d** Complete the documents (to convert the document into a non-editable pdf).

- e** Link the referral documents to the document group already created.


- f** Perform privacy checks using Inbound and Outbound Document Checks.


-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE **What if the document group contains an old e-form?**

Convert the e-form to PDF so it can be emailed by Eos.


Refer to Convert an Internal Referral e-form to a PDF document.


-  Convert an Internal Referral e-form to a PDF document.

-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks


NOTE **What if the referral contains sensitive personal information?**

If the referral contains unnecessary sensitive personal information, refer to NG PRINCIPLES Working in the Administration Team, for information and guidance on redactions, password protecting documents and sending passwords to providers.

-  Principles of Working in the Administration Team


-  Sending docs to providers.docx

- g** Create an email using the Requests and referrals template, attach the referral and document group and select the most appropriate email address (commonly listed under General Purchasing).

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


NOTE **What if the provider requires the documents to be sent via courier?**

Go to Prepare and Send Client Information by Courier process.

-  **PROCESS** Prepare and Send Client Information by Courier


- h** Send the COU10 or COU30 letter together with the 'Working Together' fact sheet to the client by their preferred communication channel and check if the client has a safe contact (if this has not been included in the referral task):


- For initial approval use COU10 - Initial Counselling Sessions Approve - Claimant.
- For additional approval use COU30 - Additional Counselling Sessions Approve - Claimant.

-  ACC255 Kōrero mai - Working together

NOTE How do you confirm if the client has a safe contact?

Refer to the system steps below.

 View a safe contact (Eos Online Help)

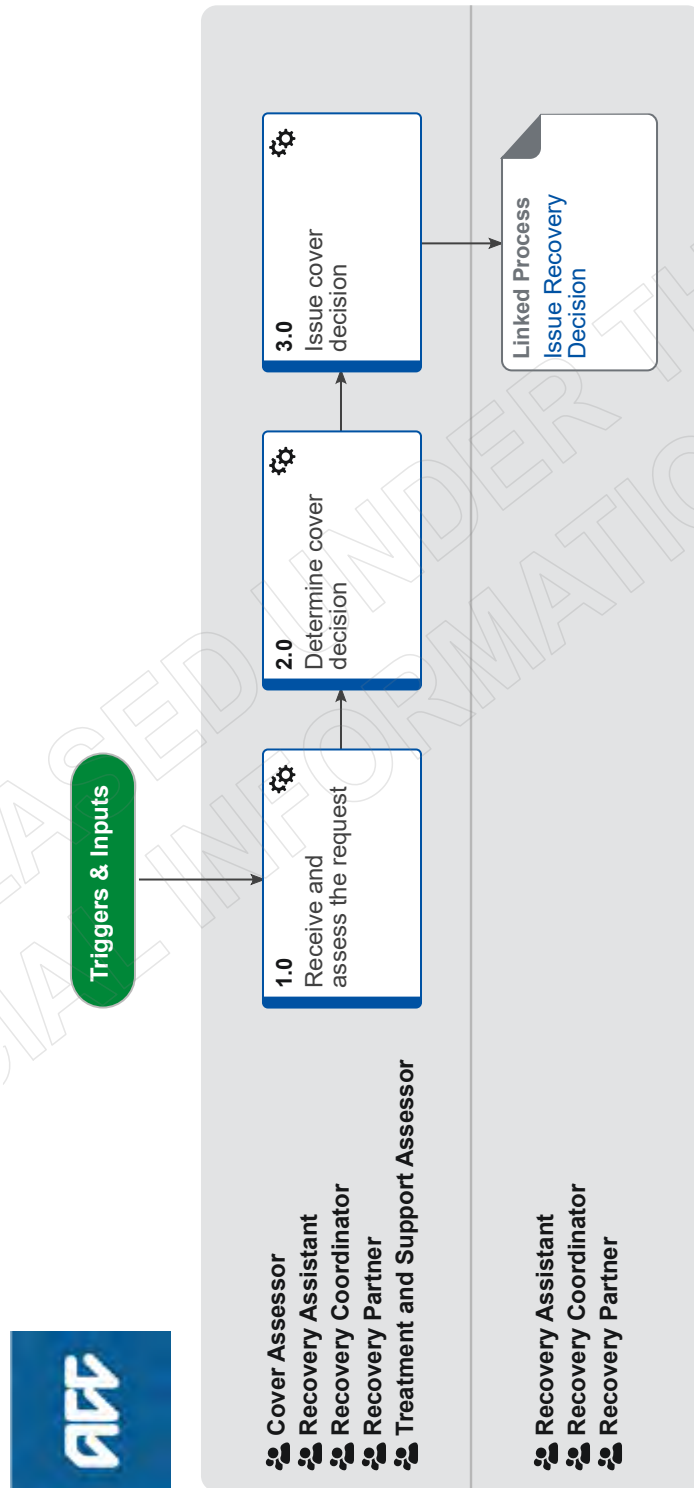
 In Salesforce, close the assigned referral task.

 **PROCESS**

Create or Update Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

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Summary

Objective

The objectives of the process are:

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

Background

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

If the 'new injury' is different comparing to the 'original injury', we will assess cover for the 'new injury'. This is because clients might want to request entitlement(s) and support(s) to help recover from their injury, but ACC can only approve entitlements and supports for the injuries that have been granted cover.

The Accident Compensation Act 2001 allows providers (on behalf of clients) and clients to submit:

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

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

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

Owner

[Out of Scope]

Expert

Procedure

1.0 Receive and assess the request

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

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

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

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

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

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

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

PROCESS Seek Internal Guidance

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

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

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

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 if the client, provider, or advocate has called and advised ACC verbally of the request?

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

b Check you have all of the minimum required information on the request:


- the injury diagnosis (code and description).
- the body site of the injury (if applicable).
- the date of accident or event (in which the person was injured).
- short description of why adding or changing a diagnosis.

NOTE What if information is missing?

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

c Confirm the client has an accepted claim.

NOTE What if the request is for a new event?


- A new claim must be lodged.
 - ensure it's appropriate to lodge a new claim without the client seeing an ACC registered provider
 - call the client and get verbal authority to register a new claim.
 - complete the Referral for New Claim Lodgement form. In the section 'Transfer Claim To', write your name and team details. If this claim is a WRGP injury, write - Work related Gradual Process Queue
 - email the completed form to Hamilton.Registration@acc.co.nz
-  **PROCESS** Consequential Injury Claims Policy

 Referral for New Claim Lodgement

NOTE What if the request is for a possible Work Related Gradual Process injury?

Contact the Work Related Gradual Process team on huntline 87815 to discuss and ensure it is appropriate to lodge a new claim and to help manage expectations

NOTE What if the claim is for a physical injury and has cover status of 'held'?

- Refer to Assess Claim for Cover :: with variations process.
-  **PROCESS** Assess Claim for Cover :: Simple PICBA claim

NOTE What if this is for a Treatment Injury?

All Treatment Injury claims are assessed via a Treatment Injury Cover assessor. In Eos, create a General Task with the additional diagnosis, set the priority to 'High' and transfer the task to the TIC Administration queue.


NOTE What if the request for additional cover is for hearing loss on a claim in actioned cases.

Transfer the claim to the hearing loss queue.


NOTE What if the request for additional cover is for hearing loss and the claim is with a recovery team.

If the request is for an additional diagnosis relating to hearing loss it needs to be tasked to 'Hearing loss claims'


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

- Refer to Make Cover Decisions for Mental Injury Caused by Physical Injury process.
-  **PROCESS** Make Cover Decisions for Mental Injury Caused by Physical Injury


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

- Refer to Make Cover Decision for Work-Related Mental Injury Claims process.
-  **PROCESS** Make Cover Decisions for Work-Related Mental Injury Claims


NOTE What if the request is for a sensitive claim and is in Assisted Recovery?

- Transition the claim to Partnered Recovery, refer to Transition Claim process.
-  **PROCESS** Transition Claim

NOTE What if the request is for a sensitive claim and is in Partnered Recovery?

- Refer to Make Cover Decision for Mental Injury Caused by Sexual Abuse process.
-  **PROCESS** Make Cover Decision for Mental Injury Caused by Sexual Abuse

NOTE What if the request is for an imminently terminal condition?

- Refer to Escalate Permanent Injury Compensation application for a rapidly deteriorating client process.
-  **PROCESS** Escalate Permanent Injury Compensation application for a rapidly deteriorating client

NOTE What if this is for a Maternal Birth Injury that is actively managed by the MBI Supported Recovery team?

Transfer the claim to the MBI Supported Recovery Team.

NOTE What if this is for a Maternal Birth Injury claim in Actioned cases or any other Recovery Teams?





Transfer the claim to the MBI queue.

NOTE What if the request is for cover for a hernia and you are a Treatment and Support Assessor?

- Add a general task with the description: Assess additional diagnosis - 'Insert hernia type'
- Change the task priority to 'high'.
- Transfer the task to the Registration - Low Complex Dunedin queue.

d Ensure that you've read and understood the Timeframes to Determine Cover Policy below.


We must issue an extension decision advising the client of this before the current time frame expires. For more information please refer to the Complicated claim and Non-complicated claim Business Rules.

-  Timeframes to determine cover Policy
-  Complicated claim definition
-  Non-complicated claim definition
-  Identify Claims for Rapidly Deteriorating Clients

2.0 Determine cover decision


Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

- a** Determine if an additional injury or change of diagnosis can be covered based on the information available by using the Add or change diagnosis decision traffic light tool.

 **TOOL** - Add or change diagnosis decision traffic light

NOTE What if there is enough information available to make a decision?


In Eos add the additional diagnosis into the Medical tab and set the Outcome Status to 'Accept or Decline', refer to the Add an Injury Code system steps below.
Go to step 3.0a Issue Recovery Decision and continue with the process.


 Add an Injury Code


NOTE What if there is not enough information available to make a decision?

In Eos add the additional diagnosis into the Medical tab and set Outcome Status to 'Investigating'.

Go to step 2.0c in Extend Cover Decision Timeframe process to create and send the CVR30 Time Extension – advise – claimant decision letter, and once completed return to this process and continue.

 **PROCESS** Extend Cover Decision Timeframe

 CVR30 Time Extension - advise - claimant

 Add an Injury Code

NOTE What if you are outside the 21 day timeframe to determine a cover decision and requires ongoing assessing?

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

Ensure you take the following steps :

1. contact the client to advise them that they have deemed cover for the diagnosis
2. in Salesforce add a contact to document your rationale for the decision (in Eos if you are a Cover Assessor or Lodgment Administrator)
3. generate CVR75 Deemed cover - client letter
4. send the letter via the client's preferred method of communication
5. in Salesforce, in the Recovery Plan, update Life Area: Health: Diagnosis [name] - accepted
6. continue with the process.

 **PROCESS** Deemed Cover Decisions When Timeframes Not Met Policy

 CVR75 Deemed Cover - client letter

b In Eos, create the 'NGCM - Cover decision required' task.

NOTE What if you are a recovery team member?

1. edit the description of the task with the diagnosis (name of diagnosis) and the date the cover decision is due.
2. change the target date of the task to one month before the due date.
3. change the priority to 'High'.


NOTE What if you are a Cover Assessor?

- Edit the task that you received with the following:
1. additional diagnosis name.
 2. decision due on date.
 3. set the priority to 'High'.
 4. set the target date to 3 working days before the decision due date.

c Determine if you need to request medical notes. Refer to the Request Clinical Records process for guidance.

NOTE What are examples of additional medical notes?

Lodgment notes, imaging, specialist records, etc.

 **PROCESS** Request Clinical Records

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

You have to make a decision with the information available, you can continue to assess or investigate as more information is received.

NOTE How to request information from NZ immigration (Customs/PAX)

When requesting information around a client's international movements from NZ immigration - movementchecks@customs.govt.nz - Also referred to as Customs or PAX movements - Please include a copy of the ACC45 with the request and wording request:

"I am currently considering a request for ACC cover and I need to confirm (x travel dates) for the following person: (client's details).

I've attached a copy of the ACC45 form for this claim, in which the client authorises ACC to collect information to determine what support ACC can provide.

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

NOTE What if the claim is in Enabled Recovery?

Transition the claim to Assisted Recovery, refer to Transition Claim process below.

 **PROCESS** Transition Claim


d In Salesforce, in the Recovery Plan update Life Area: Health: Request for new diagnosis [name of diagnosis] received through [source] on [the date received]. Cover decision is due on [date].

NOTE What if you are a Cover Assessor?

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

e Review the clinical notes once received for any additional information needed to make a decision.

f Determine if cover for the additional diagnosis can be accepted or declined using the Add or change diagnosis decision traffic light tool.


 TOOL - Add or change diagnosis decision traffic light


 Complex Regional Pain Syndrome

 Guideline for accepting cover for concussion

NOTE What if the additional diagnosis 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 – Questionnaire to client - Hernia

NOTE What if you are unsure whether you can accept or decline the additional diagnosis or change in diagnosis?

Seek guidance via the Seek Internal Guidance process

 **PROCESS** Seek Internal Guidance

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

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


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


- You must issue a decision with the information you have.


For complicated claims - if approaching the 4 month timeframe:

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

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

 **PROCESS** Extend Cover Decision Timeframe

 Deemed cover decisions when timeframes not met Policy

 CVR31 Time Extension - request - claimant

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

 **PROCESS**

Issue Recovery Decision

Recovery Assistant, Recovery Coordinator, Recovery Partner

3.0 Issue cover decision

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

- a In Eos, in the Medical tab update the diagnosis status to 'Approve or Decline' and then generate the appropriate decision letter.

 CVR70 Cover approve - add injury - claimant

 CVR999 Cover decline decision - client

NOTE What if the claim is for a complex mental injury?

Generate the appropriate decision letter.

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

 MIS12 Approve mental injury claim - client

 CVR999 Cover decline decision - client

 SCU999 SCU Cover decision - PO - client

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

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

 CVR48 Claim approve - work injury - employer

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

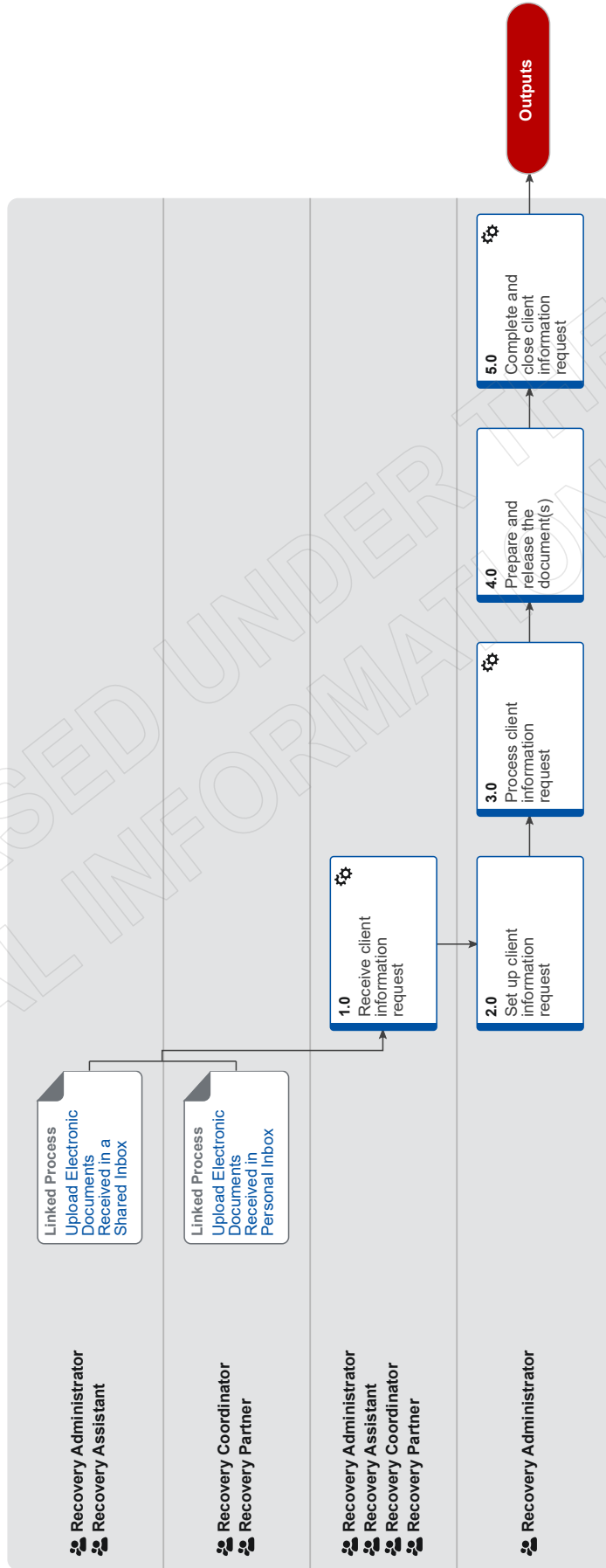
NOTE What if you are a Cover Assessor?

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

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

NOTE What if you are a Cover Assessor?

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



Summary

Objective

The purpose of this process is to manage requests for client information so that the information is provided to the requestor.

Background

A request for client information can come from the client, client advocate or an external party. A request can be received in a variety of ways such as shared email/fax, personal email, phone call or in person at an ACC office. A request can be for personal information (such as client files, client related emails and call recordings) or for other information we hold (such as official information).

Owner

[Out of Scope]

Expert

Procedure

PROCESS

Upload Electronic Documents Received in a Shared Inbox

Recovery Administrator, Recovery Assistant

PROCESS

Upload Electronic Documents Received in Personal Inbox

Recovery Coordinator, Recovery Partner

1.0 Receive client information request

Recovery Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

- Acknowledge receipt of the request with the requestor.
- Determine if the request for information is simple or complex.

NOTE What is considered a simple request?

Simple requests will be actioned by the recovery team members.

A simple request for information is a request made by the client for a single non-sensitive document to be sent via Email (this may include a non-sensitive document on a sensitive claim e.g. a payslip) or post (not courier). If sending a simple request, ensure that the client's email address is verified and privacy checks are complete before sending the requested document.

Any other requests, including sensitive documents, couriered documents, and pre-employment checks are considered complex. Complex requests are sent to the administration team for action. See steps below.

- Check that there is sufficient information from the request to proceed. This includes ensuring that all delivery methods are verified, including mobile numbers if passwords are being sent by etxt.

NOTE What if the request does not contain sufficient information?

Refer to the guidelines for 'Confirming requirements for client information requests' and obtain the additional information required.

- Confirming requirements for client information requests

- In Eos, from the Party File (individual claim if for only one claim, or sensitive claim if one of the claims requested is sensitive), create a 'Complete Request for Copy of Clients Information' task, copy the request template into the task.

NOTE This is not a NGCM task and must be added through the main Party / Claim screens.

NOTE What request template do you use?

(Remove all irrelevant information and delivery methods.)

[NAME] called for: [All claims/ All information / Full copy of this claim only/ full copy of (list claim numbers)/List particular documents if partial request]

Request received on:

Delivery Method:

- Email to verified address, etext password
- CD to branch/delivery address, etext password
- USB to branch/delivery address, etext password
- Paper to branch/delivery address, ACC6181 read and risk accepted.
- Please confirm branch for pick up if applicable:

Best contact phone number if needed is:

[Number]

Preferred contact for password: (alternate email/text/call)

NOTE What if more than one claim is requested?

List the claims in one template as per the above, do not create multiple tasks.

2.0 Set up client information request

Recovery Administrator

- In the Client Information Requests queue, review the task.
- If required, contact the requestor to confirm the detailed information requirements.

NOTE Why would you need to contact the requestor?

Whilst the recipient of the request will verify the initial information requirements with the requestor in Activity 1.0, the CIT Set Up team member may contact the requestor to confirm more detailed information requirements before the task proceeds further. An example might be to clarify the date range for the information that is required.

- Record the requests in the CIR work register for your location.

NOTE Where is the register located?

Dunedin: \\DUNWMG0001\TempCIT
 \DunedinRegional\register

- Setup up the file by following the CIR Map.


CIR Map

<https://accnz.sharepoint.com/:x:/r/sites/Group-ClientA>

- e If required, gather any information that is needed from relevant business units.
- f Update the 'Complete Request for Copy of Clients Information' task with further information at this point (such as file size, due date for the request to be closed).
- g Determine if the client information request meets the criteria for a 'small', 'large' or 'complex' file.
- h Allocate the task to the small or large/complex file queue.

NOTE What if you are sending the document(s) via courier using Pre-alert?

Go to the 'Send Confidential Information by Courier using Pre-Alert' process before continuing to Activity 5.0.

 **PROCESS** Send Confidential Information by Courier using Pre-alert

3.0 Process client information request

Recovery Administrator

- a Follow the CIR Map to process the information request from the relevant file queue.

NOTE What if the request is for a client managed by the Remote Claims Unit (RCU)?

Refer to CIT RCU Dispatch Process below.

 CIT RCU Dispatch Process

- b Conduct a privacy check.

 Privacy Check Before Disclosing Information Policy

- c Assess the redactions that are required to the documents under sections 49 to 53 of the Privacy Act and complete any deletions and redactions.

 Privacy Act 2020
<https://www.legislation.govt.nz/act/public/2020/0031/l/>

- d Replace the original document(s) in Eos with the redacted version to ensure that this is the only version that is sent out in the future.

NOTE Why do you need to replace the original document(s) in Eos?

This ensures the redactions and deletions to the document(s) are reflected on the claim file and prevents the original document from being sent out in future without the redactions and deletions.

4.0 Prepare and release the document(s)

Recovery Administrator

- a Check whether the release method is by email, internal release, paper, CD or USB.
- b Follow the CIT Map to prepare and release the document(s).
- c Complete the ACC6173 Information Disclosure Checklist and upload it to the client's claim.


 ACC6173 Information Disclosure Checklist

- d Complete a final dispatch check to ensure the documents are ready for release. This includes checking the client address is correct, any labelling is correct and the release method is correctly prepared.

- e Release the document(s) using the identified release method in task a.

NOTE What if you are sending the document(s) via courier package?

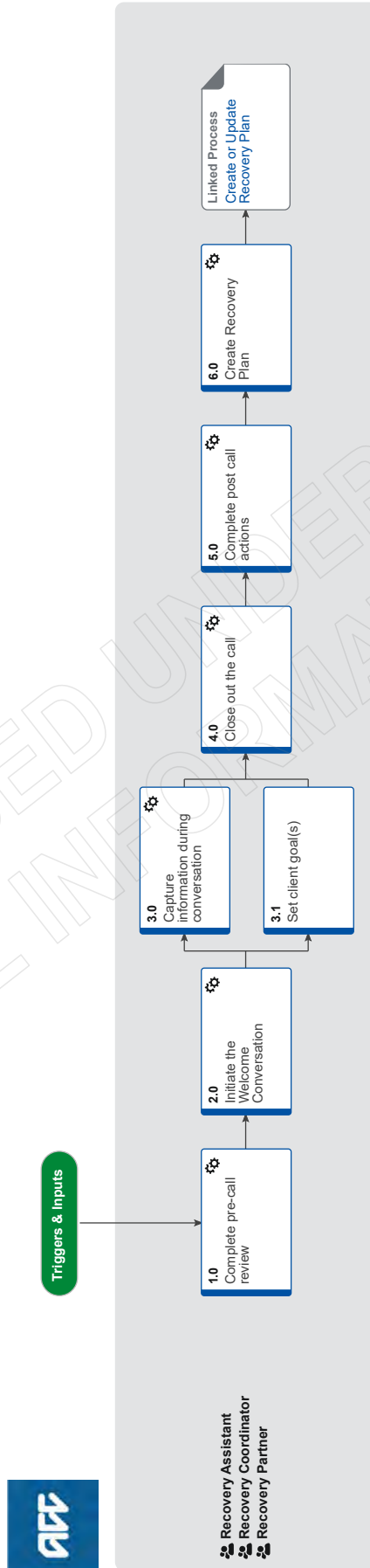
Go to Prepare and Send Client Information by Courier process before continuing to Activity 5.0.

 **PROCESS** Prepare and Send Client Information by Courier

5.0 Complete and close client information request

Recovery Administrator

- a Follow the CIT Map to complete final administration including saving relevant emails.
- b If used, complete the redaction spreadsheet so that there is a record of the redactions that have been made to the documents against the claim.
- c In Eos, close the 'Complete Request for Copy of Clients Information' task.





Summary

Objective

To help ACC understand what is important to our clients, and ensure they understand our role in their recovery so that our clients will feel listened to, involved, supported, and empowered.

By the close of the call, the client should understand:

- The purpose of the call
- ACC's role in their recovery
- How ACC will use their information
- What entitlements and supports are available to them.

Background

The Welcome Conversation is the first interaction we have with clients in the Assisted, Supported and Partnered teams following their injury event. After a claim is registered and has been matched to a team and allocated, we conduct a Welcome Conversation as part of the client on-boarding process.

A Welcome Conversation can also be conducted when we re-open a previously closed (Actioned) claim due to a new request for support. In these cases, due to the passing of time, the information in the original Welcome Conversation doesn't reflect the client's current situation.

Owner

[Out of Scope]

Expert

Procedure

1.0 Complete pre-call review

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Check for other open claims.

New claims received for clients with other open claims are grouped with other claims and automatically assigned to the team that provides the highest level of management.

For additional information refer to the Client Welcome Conversation - Pre-call Review guidelines and the Having Recovery Team Transition Conversations guidelines and Hāpai Welcome Conversation Guide.

- Hāpai Welcome Conversation Guide
- ACC705 Knowledge resource
- NG GUIDELINES Client Welcome Conversation - Pre-call Review
- NG SUPPORTING INFORMATION Having Recovery Team Transition Conversations

b Before conducting the Welcome Conversation, consider if the client is being supported by the right team.

NOTE What if you are unsure why a client may be considered to be in the wrong team?

Go to Transition Claim.

PROCESS Transition Claim

NOTE What if the claim is for a Complex Mental Injury?

Go to Conduct CMI Welcome Conversation.

PROCESS Conduct CMI Welcome Conversation

NOTE What if the client is a resident of the Chatham Islands?

Ensure the claim has been allocated to one of the dedicated Chatham Islands Recovery Partners (currently [Out of Scope] and [Out of Scope]). Refer to the "Assess and Fund Treatment and Rehabilitation for Residents of the Chatham Islands" process for reasons why this is important.

PROCESS Assess and Fund Treatment and Rehabilitation for Residents of the Chatham Islands

c Check if there is a delayed request for weekly compensation.

NOTE What if there is a delayed request for weekly compensation?

- A delayed request for weekly compensation (DRWC) is
DOFI = A request for weekly compensation received 28 days + ECO max (days) or more, after the date of the accident
DOSI = A request for weekly compensation received 28 days, or more, after the end date of the last period of incapacity

Go to Assess Delayed Request for Weekly Compensation.

PROCESS Assess Delayed Request for Weekly Compensation (DRWC)

d Check is there is a backdated weekly compensation request.

NOTE What if the request is backdated?

Go to Preparing and confirming a backdated weekly compensation request.

PROCESS Assess a Backdated Weekly Compensation Request

e Check if the client is receiving Weekly Compensation on an existing open claim.

NOTE What if the client is receiving Weekly Compensation on an existing open claim?

Determine whether the covered injury on this claim is resolved, as weekly compensation will need to be transferred if it has resolved. If it's not clear confirm with a Clinical Advisor which claim the weekly compensation should be associated with. Go to the Seek Internal Guidance process, Activity 3.1 Request Written Guidance. Based on the guidance provided you may need to transfer the weekly compensation to a different claim.

PROCESS Seek Internal Guidance

f Check if the claim was previously managed.

NOTE What if the claim was previously managed in Launchpad?

Consider if it is relevant to have a Welcome Conversation or Recovery Check-in depending on how long the claim has been closed. From NGCM roll out - all claims previously managed in the Launchpad will have a read only LPRP sub-case in Eos. Review the LPRP to understand the client and claim information. The claim must now be managed from the Recovery Plan in Salesforce. Go to Create or Update Recovery Plan process.

PROCESS Create or Update Recovery Plan

NOTE What if the claim was previously managed in Business as Usual?

If the claim has been transitioned from BAU you need to Create a Recovery Plan sub-case in Eos:

- From the ACC45 Claim, select the Activity tab
- Select Transfer to NGCM
- Select the Recovery Team your claim is in
- Select OK.

For more information regarding claims migration from BAU to NGCM refer to link below:

NOTE What if the client has another open claim with Escalated Care Pathways?

If the claim is not a musculoskeletal injury then the claim should continue to be managed by a Recovery Team Member. If it is for a musculoskeletal injury, contact the ECP Team on 77097 to discuss.

The ECP Team may contact the ECP Provider managing the other claim to see if they also need to manage the additional claim. If they are going to do this, they will create a general task in EOS to track the progress and outcome. While you are waiting for an outcome, you can partially complete the welcome conversation and arrange any urgent supports required e.g. home help. You should refrain from arranging rehab services, as the ECP Provider may be able to offer this as part of their services to the client.

If the ECP Provider needs to manage the additional claim, the ECP Team will update and transfer the claim to the ECP queue in EOS. If the Provider does not need to manage the additional claim, the ECP Team will update the task description to reflect this and close the general task.

Claims Transition (Sharepoint)

g Check if there's a note in the Description field of the task advising the Welcome Conversation was paused.

To view information captured during a paused Welcome Conversation;

- go to the Close Out section of the Welcome Conversation
- Recovery Status Life Areas, or
- the Paused Welcome Conversation Transcript in Eos.

h Review Te Kete.

NOTE What do you need to consider if you're a Recovery Assistant?

Consider these key factors:

- Approved injuries
- There is no delayed request for weekly compensation
- Check the accident description and injury
- Check medical certificates injuries match approved diagnoses.

NOTE What if you are in the Partnered team?

Review the Customer Engagement for Partnered Recovery guidelines and consider:

- whether if it is possible to speak with the client in the first instance. Identify the most appropriate person to contact from the client's party record. It may be family/whanau or a safe contact.
- if your client is in hospital and you're unsure who to contact, speak with a clinical staff member in the first instance. Confirm the most appropriate contact person for the client.
- the best approach to the client conversation. The client's the situation and impact of the injury on the contact person.

- if it is appropriate to arrange weekly compensation without speaking to the client.

Customer Engagement for Partnered Recovery

NOTE What if a face to face Welcome Conversation has been requested?

Assess the suitability of having a face to face meeting. Go to the process below, and refer to Client Face to Face Meetings guidelines to determine if a meeting is required.

PROCESS Arrange Face to Face Client Meeting

i In the Claim Summary panel in Salesforce, check if the client has registered with MyACC.

NOTE What if the client has registered with MyACC?

Check if the client has requested Weekly Compensation and/or any supports post registration.

NOTE What if the client hasn't registered with MyACC?

When you contact the client, ask if they would like to register and manually resend an invite.

PROCESS Invite Client to MyACC

j Review Te Kete or the Recovery Plan consent tab to confirm the client has provided consent to collect medical and other records.

NOTE What if the client hasn't provided consent?

Refer to the NG GUIDELINES Obtain Verbal or Written Authority to determine the type of consent required. Request this when you contact the client.





ACC Guidelines to obtain verbal or written authority


k Confirm who you need to contact. There may be an Authority to Act (ATA) who is acting on the client's behalf.

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

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

To find resources to support a client with language and cultural needs, refer to the following documents.

-  NG GUIDELINES Supporting the Diverse Needs of our Clients
-  When to use an Interpreter Policy
-  Working with an interpreter process
-  Connecting Now - phone interpreting service for ACC

- m** Open the Welcome Conversation in Salesforce and select the relevant conversation.
- n** To prepare for the conversation, read the Client Welcome Conversation - During a call guidelines prior to contacting the client.
 -  Client Welcome Conversation - During a call

2.0 Initiate the Welcome Conversation

Recovery Assistant, Recovery Coordinator, Recovery Partner

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

NOTE What if you are unable to contact the client, ATA or alternative contact person?

Refer to the Welcome Conversation Call Attempts document.

-  Welcome Conversation Call Attempts

- b** From Te Kete, confirm you are speaking with the right person by asking ACC's identity check questions. Record that you have performed the identity check as a contact on the claim.

-  Identity Check Policy

- c** Verify and update the client's contact details.

NOTE What if you are provided updated or new information?

Update the client's Party Record

-  **PROCESS** Update Client Party Records

- d** Confirm with the client or ATA it is a suitable time to complete the conversation.

NOTE What if the client advises they do not require any support?

Do not complete the Welcome Conversation and CLOSE the complete welcome conversation task. Closing the task instead of cancelling the task ensures the client receives a heartbeat request to provide feedback on their experience with ACC following this interaction.

NOTE What if client or ATA advises they are unable to have the conversation now?

- 1) Send the client our contact details via e-text for them to call us when appropriate.
 - 2) Cancel the welcome conversation
 - 3) Move the claim into actioned cases
- When the client or the ATA calls back the claim can be reopened.

NOTE What if client or ATA advises during the conversation they are unable to continue?

- 1) Agree with the client or ATA a preferred date to call back.
- 2) Select Pause.
- 3) In the Schedule Callback popup window, enter the preferred Callback Date, the reason for the callback and information requirements for the next call.
- 4) Select Save.
- 4) Complete To Do List actions that can be done now.

A new Welcome Conversation task will be created for the callback, a 'Paused Welcome Conversation' transcript document will be generated on the ACC45 and a contact will be created on the Recovery Plan.

NOTE What if the client requests to continue the conversation face to face?


Assess and determine the suitability of a face to face meeting. G to Arrange Face to Face Client Meeting.

-  **PROCESS** Arrange Face to Face Client Meeting

- e** Start with the 'Intro' tab of the Welcome Conversation to progress the client led conversation.

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

Refer to NG GUIDELINES Managing Threat of Self-harm Calls for guidance.


-  NG GUIDELINES Managing Threat of Self-harm Calls

- f** Determine and obtain verbal authority to collect medical records about the client if needed.

NOTE How do you determine if you need to obtain authority to collect medical and other records?

In Salesforce, the Introduction section of the Welcome Conversation will display the Consent section. This indicates that you need to obtain consent.

You can obtain consent verbally, for more information regarding consent refer to the process below:

-  **PROCESS** Obtain Client Authority to Collect Information

- g** Discuss Client's Rights and Responsibilities and confirm that the client understands these'.

NOTE How do you determine if you need to discuss sending the ACC165 Client Rights and Responsibilities?

In Salesforce, the Introduction section of the Welcome Conversation will display the Clients Rights and Responsibilities section if the client does not have an active Client's Rights and Responsibilities Indicator.


If the client is only needing one off support and will be closing the claim after the conversation, we do not need to send the ACC165 Client Rights and Responsibilities.

If the client is having ongoing supports, advise the client that you need to share with them information about their rights and responsibilities and confirm they understand these. Check how the client would like to receive this information (eg, email, post) and note this in the Rights and Responsibilities section of the Welcome Conversation.

These tasks need to be manually created see 5.0 Complete post call actions'

- Post or email the ACC165
- Follow up reminder set for 10 working days to follow up with the client if not received

What if the client doesn't return the ACC165? It's important the client acknowledges their rights and responsibilities, so it's important you record this as a contact on the clients claim, and it's been recorded the form has been sent to the client.

 ACC165 Declaration of rights and responsibilities

3.0 Capture information during conversation

Recovery Assistant, Recovery Coordinator, Recovery Partner


a Capture information collected at each stage as you work through the Welcome Conversation. You must only add in information that is discussed with the client.

 Identify Claims for Rapidly Deteriorating Clients

NOTE Where is key information captured?

Key information from the Welcome Conversation will be captured automatically in the appropriate life area note.

The fields in the Welcome Conversation that will be automatically captured are denoted by a paired asterisk (**).

 Medical Certification for non-Serious Injury claims Policy

b Add actions to be completed after the conversation has ended to the To do List:

- Select New on the To Do List
- Complete the Subject field or select an option from the Standard Subjects field
- Record information which will enable you to complete the post call action

c Capture the client's employment and income status.

 Add an employer participant

NOTE What if the client is self-employed?

There are rules and criteria required to confirm your client's employment status and eligibility for weekly compensation. For more information refer to the policy below:

 Confirm Self-Employed Person is an Earner Policy

NOTE What if your client is unable to provide all their payment information during the call?

- Let your client know that we won't be able to proceed with setting up payments until we have all the information. Ask that they either call/email in the missing information or submit it via MyACC.
- Continue the Welcome Conversation and override the warning message during the close out to complete the Welcome Conversation.
- Complete all appropriate actions on your To-Do list and create the Recovery Plan.
- Set a Reminder task (linked to the 'Other' life area) for a week later explaining that the Weekly Compensation Setup Task needs to be sent to Payments once missing information is received (task should also clearly state which information is needed).


NOTE What if the Client advises you they have resigned, been terminated or received redundancy?

Refer to information link below for guidance.

NOTE What if an employer has made payment of holiday and/or sick pay during a period the client is unable to work?


Refer to Manage Abatement in EOS section 2.0 for guidance.


 **PROCESS** Manage Abatement in Eos

 Client resigns, loses job / termination, is made redundant

d Check if the Employer is an AEP participant to determine if the claim needs to be managed by a TPA or employer. Refer to the following lists:

- Accredited Employer list for work related claims
- Participating Accredited Employers for non-work related claims

 Participating Accredited Employers (Non-work claims only)

 Accredited Employer list for work related claims

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


Check if the client has a MyACC account. If yes, this will need to be deactivated. Go to 'MyACC for Client' Activity 5.0 (c) for instructions on how to do this.

Advise the client their claim will be managed by their employer's Third Party Administrator and someone will be in touch with them soon. If required, let the client know their MyACC account will be deactivated due to their account being managed by their employer.

Follow the process link to 'Transition Claim to an Accredited Employer'.

NB: Clients are not able to opt out of AEP for work related claims, only for non-work related claims.

This process ends.


 **PROCESS** Identify and Transfer Non-Work-Related Injury Claim to Third-Party Administrator (TPA)

 Transfer a claim

e Check if the client is eligible for Weekly Compensation. Refer to:

- Eligibility criteria for weekly compensation policy, and
- Client Welcome Conversation Weekly Compensation and Employment guidelines.

 Eligibility Criteria for Weekly Compensation Policy

 NG GUIDELINES Client Welcome Conversation - Weekly Compensation and Employment

NOTE What if the client is not entitled to Weekly Compensation?

Advise the client, and send the SPD999 Decline Entitlement letter with the ACC255 Working Together factsheet. Record the decision as a contact in Salesforce. Go to the Recovery Plan and update the vocational life area with a note of the decision and the rationale.

NOTE What payment information will be visible in the Welcome Conversation?

If the client already has an IRD number and bank account number, this will display in the financial details section. You can override the IRD or bank account number if these have changed.

On completion of the Welcome Conversation, the IRD number, bank account number, and tax code will be automatically updated in Eos.

NOTE What if the client has requested Weekly Compensation via MyACC?

Check the 'MyACC Weekly Compensation Request' task to confirm that you have the correct contact details for their Direct Manager and Payroll contact.

If not, then collect this information as part of the Work and Work Planning section. You can also add a


To-Do List item to update the employer contact details following the call.

NOTE What if you receive a request for a Lump sum payment or Independence Allowance (LSIA)?

- Advise the client they are eligible to apply, and an application pack will be sent to them.
- Create a 'Send LSIA application pack task'.

This will automatically route to the Treatment & Support team to generate and send to the client.

For further information refer to send a permanent injury process below


 **PROCESS** Send a Permanent Injury Compensation application pack

f Advise the client that it's likely we will contact their employer so we can all work together to prepare their recovery plan, to return them to work at the right time in the right way. Confirm that the client is OK with this and that they are comfortable with us discussing their claim with their employer.

Once you have informed the client about ACC contacting their employer advise them that the employer does not need to see a copy of their Recovery Plan. Also, the employer does not have the right to review the Recovery Plan.

Check all auto-populated fields and remove data as necessary.

 Individual Rehabilitation Plan Policy


 AC Act 2001, Schedule 1, Clause 7 - Preparation of individual rehabilitation plan


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

NOTE What if the client is uncomfortable to include the employer in the development of their Recovery Plan?

You will need to discuss further with the client to explore their hesitance and negotiate a solution. Take a common sense approach for dealing with this situation considering the client's right for privacy (section(7)1 of the Privacy Act).

g Advise client that we want to ensure we have the right health professionals involved in the preparation of their recovery plan. Therefore, we need from the client the contact details (if known) of their Lead Health Practitioner and any other Health Practitioner they want us to invite to participate in the preparation of their Recovery Plan. Advise the client the health professionals do not need to see a copy of their Recovery Plan and they also do not have the right to review.

 Individual Rehabilitation Plan Policy

 AC Act 2001, Schedule 1, Clause 7 - Preparation of individual rehabilitation plan
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

3.1 Set client goal(s)

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Set a recovery goal and agreed target date with the client.

NOTE What target date should you set?

Target dates should be agreed with the client during your conversation with the client and based on the Expected Claim Outcome (ECO) or the treatment providers recommendation eg a medical certificate, surgery notes, General Practitioner (GP) notes or an intervention completion report (ie housing modifications, transport for independence).

The client should be reassured that this is an estimated date based on the information we have about their injury.


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

Check the following criteria is met:

- If the client has had a non-work injury (Fund code: Earners, Motor Vehicle, Treatment Injury and Residual - if client was an earner at DOI)
- Cover has been accepted
- The client has more than 7 days incapacity
- The client was an Earner at DOI
- The client is currently employed by a Participating Accredited Employer


If the criteria is met then go to Transfer Claim to Accredited Employer (AE) or Third-Party Administrator (TPA) Service. This process ends.

If the criteria is not met then continue with the Welcome Conversation.

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

NOTE What do you do if you are a Recovery Partner?

It may not be suitable to set a recovery goal with your client at this time. When the time is right, refer to Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

4.0 Close out the call

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine the next key milestone and stage in the client's recovery journey. Then schedule the first Recovery Check-in conversation.

NOTE What is a Milestone?

Milestones are significant changes and achievements in the client's recovery pathway.


When considering an appropriate milestone, consider the wider context of the client's recovery eg their work type – a sedentary worker's Recovery Check-in may be at a different stage when compared with that of someone in a heavy work-type occupation.

- When is the next significant change in the client's recovery likely to occur (eg increased independence, noticeable strengthening, a phased return to work duties).

- When is it likely that the client's needs will change significantly?

NOTE What should you consider?

When considering an appropriate milestone think about the wider context of the client's recovery, eg regarding work type - a sedentary worker's Recovery Check-in may be at a different stage when compared with someone in a very heavy work type. An example could be going from non-weight bearing to weight bearing.

 **PROCESS** Conduct Recovery Check-in Conversation

Milestone Timing Examples:

WHEN	WHY
Client was using crutches and a moonboot can now weight bear	Client is now able to start strengthening
Client should be ready to get back into work, based on a specialist report	Begin planning on what a return to work would look like for this client
At completion of a programme (e.g. Concussion Services) and the report suggests further needs	Understand progress and plan for the next recovery period
Client's injury-state dramatically changes (e.g. injury complicated with infection, bone not healing)	Impacts on what we have previously planned, it is likely that we will need to understand the new recovery pathway and plan accordingly
(Report has unexpected recommendations (e.g. report advises longer recovery timeframe based on new information impacting recovery))	

What isn't a milestone?

A new medical certificate within the expected recovery period which we were anticipating	We'd like to know how a recent appointment went (i.e. how was their physiotherapy appointment this morning)
We need to check on some details (i.e. whether a client still needs taxis)	Compliance discussions – these can be treated as actions to ensure compliance in recovery.



Milestone Timing Examples.PNG

NOTE What is a stage?

Injury recovery can proceed through four key stages, acute, rehab, adaptation and stable. Healing can progress backward or forward depending on internal and external factors.

- Rehab – The period of treatment that is needed to enhance and restore functional ability and quality of life after an injury. This tends to be the longest of the stages and includes a client's gradual return to work — a critical component of rehabilitation and recovery.

- Adaptation – We support our clients to adapt to changes that will help them with their recovery. For some clients, we might be enhancing existing skills and knowledge to adapt to a new vocation after an injury, and supporting them towards Vocational Independence.

- Stable – We continue to support our client when their injury is stable, and we expect little further change in their recovery status. We consider if they need ongoing management or if we should close their claim.

- b Make sure you have gathered all the information you need in the Welcome Conversation.

- c Ask the client if they would like a copy of the printed Recovery Plan before they agree to the actions discussed. Check the client has verbally agreed to the recovery plan goals and actions that you've put in place. Note their agreement to the actions in the close out text box.

NOTE What if the client doesn't provide verbal agreement to an intervention or the plan we have identified as being reasonably required?

Confirm with the client:

- how they want to receive a copy of their Recovery Plan so they can review it
- a suitable timeframe for them to review their Recovery Plan
- a date to finalise the Recovery Plan.

We must give the client a reasonable timeframe to review and agree to a Recovery Plan. It's expected that a client is given 10 working days but a longer timeframe may be appropriate in some cases. They can also seek support from their Lead Health Practitioner, other Health Practitioner, other support person(s), or employer to participate in the development of their Recovery Plan

Once the client has received the Recovery Plan, they can:

- phone us to discuss their Recovery Plan and/or provide verbal agreement
- send their Recovery Plan back via email or post with feedback and/or agreement.

If you haven't heard from the client, phone them to finalise the plan. If you don't reach agreement during this conversation, advise the client that you will send them a decision finalising the plan.

- d End the call with the client.

- e Once all responses in the Welcome Conversation have been captured, click Save from the Close Out tab.

NOTE What happens automatically in Eos when you've completed the Welcome Conversation?

A Welcome Conversation transcript is created and a contact is added to the Recovery Plan. If applicable, the following is updated in the relevant Eos fields:

- Bank account, IRD number and Tax code
- verbal consent.

5.0 Complete post call actions

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a** Work through the actions in the To Do List. Complete the actions that must be done at that time. In Salesforce, click Launch Eos Claim on the Welcome Conversation task to open the Eos claim. Check you have the correct claim number.

NOTE What if you can't complete an action in the To Do List now?

To Do List actions that remain open will be automatically transferred to the Recovery Plan as an 'Action to be followed up' on the specified Target Date. Salesforce will create the relevant task in Eos.

NOTE What if you need clinical information to help complete the client's recovery plan?






Go to Request Clinical Records.

 **PROCESS** Request Clinical Records

NOTE What if you need to set up supports for the client?


If you need to set up:

- social supports for the client, go to Manage Social Interventions / Supports web link.
- vocational supports for the client, go to Manage Vocational Interventions / Supports web link.

-  Supporting clients with Social Needs
-  ACC705 Knowledge resource
-  Manage Social Interventions / Supports
-  Vocational Services Roadmap
-  Manage Vocational Interventions / Supports

NOTE What if you need to Assess and Fund treatment?

Go to the Manage Treatment Interventions processes.

 Manage Treatment Interventions / Supports

NOTE What if you need internal advice to determine next steps of the client's recovery?

Go to Seek Internal Guidance process.


 **PROCESS** Seek Internal Guidance


- b** Email the client their ACC165 Declaration of rights and responsibilities form. Use the Client Legislative Rights and Responsibilities guidelines for templates.

NOTE What if the client wants the form to be posted?

Arrange for a Recovery Administrator to post the form to the client.

- Make sure the client has a valid postal address.
- Send a 'Send Letter' task to the Recovery Administration department queue.

 ACC165 Declaration of rights and responsibilities

 NG GUIDELINES Client Legislative Rights and Responsibilities

- c** Check and update the fund code, if applicable.

NOTE How do you update the fund code?

Go to the Review and Update a Fund Code process for instructions on how to update a fund code. Once you have updated the fund code, return to this process and continue with the below tasks.

- d** In Eos Recovery Plan subcase, send the Contact Details Notification to the client.

NOTE What if there is no Recovery Plan subcase in Eos?

If there is no Recovery Plan subcase in Eos, you need to create one.

- From the ACC45 Claim, select the Activity tab
- Select Transfer to NGCM
- Select the Recovery Team your claim is in
- Select OK.

Also note that , you need to update the consent information in Eos.

Refer to document below:

 Create a Notification - System Steps

- e** In Eos, add consent if you have obtained verbal consent during the welcome conversation.

NOTE How do you add add consent in Eos?

Refer to system steps below.

 Add Client Consent

NOTE What if you need to update the client's preferred payment notification?

Refer to system steps below.

 Update the payment notification method

6.0 Create Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Click Create Recovery Plan.

NOTE What is automatically populated in the Recovery Plan?


The Recovery Plan will be automatically populated with the following, if applicable:

- Key information from the Welcome Conversation will be captured automatically in the appropriate life area note. The fields in the Welcome Conversation that will be automatically captured are denoted by a paired asterisk (**).
- Any open To Do List actions
- Recovery Goal
- Recovery Check-in action

- b** From Te Kete, navigate to the Recovery Plan. You may need to add some actions manually, eg agreed interventions.

NOTE What if you are unsure how to manually add actions?

Go to Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

- c** In Salesforce, enter information into the appropriate life area.

NOTE What information is important to capture in the Recovery Status Life Areas?

Refer to the Life Areas section of the Recovery Management Guideline.

NOTE What if you need to edit or delete a life area note?

You can edit or delete life area notes that you create, as long as this is done on the same day that you have created the note.
Team leaders can still edit or delete notes at any time.

 NG GUIDELINES Recovery Management

NOTE What if you add notes relating to another client by mistake?

Email your Recovery Leader:

- ask them to remove the incorrect information from the Life Area notes in Salesforce
- identify what information needs to be removed
- refer to the claim number.

- d** Add a note in the Recovery Check-in to check that the client has completed the ACC165, and to send an ad-hoc notification if they have not returned the completed form.

NOTE What if the client doesn't return the ACC165?

It's important the client acknowledges their rights and responsibilities, so it's important you record this as a contact on the client's claim, and it's been recorded the form has been sent to the client.

- e** Invite the client's Lead Practitioner and/or other Health Practitioner identified by the client to participate in the planning of the client's Recovery Plan.


NOTE How do you contact the Lead Practitioner and/or other Health Practitioners?

You can contact them by phone, email or by generating the RPL02 Invitation to participate in rehab plan - Vendor letter in Eos and send to the practitioner(s).

- f** In Salesforce, review the Employer Welcome Conversation action located on the Recovery Plan before making contact with the employer. Once you are ready and the client has agreed that you can speak with their employer, conduct an initial conversation with the client's employer. Ensure you do not discuss any sensitive client information to the employer.

NOTE What if you need to add the client's employer as a participant?

Refer to NG Guidelines Employer Conversation.

 NG Guidelines Employer Conversation

NOTE What if you're unable to contact the employer?

Assisted only - Before attempting the Initial Employer Welcome Conversation, please utilise the text message below, to make the employer aware of the pending phone call you will be making shortly.

Kia ora. ACC team member will be ringing you within the next 5-10 minutes to discuss your employee who sustained an injury. If you are unable to answer at this time, please call us back on 0800 222 435. Quote: (**ADD ACC45 number**) Please do not reply via text.

If you are unable to reach the employer on your first attempt, leave voicemail message if appropriate.

Edit the Initial Employer Welcome Conversation task with your attempts and any further details that would assist the next Recovery Assistant with this conversation regarding the client

Move the claim into the selected cohort (the Initial Employer Welcome Conversation will then pull into this cohort's department) for them to manage the claim and complete the second Employer Welcome Conversation attempt.

Supported and Partnered only - If you are unable to reach the employer on your first attempt, leave voicemail message if appropriate. Extend the Employer Welcome Conversation task out for three additional days (unless urgent). Note in the task description that this is the first attempt to contact the employer.

Second attempt in three days: Confirm Employer contact details are correct with the client or by checking the Employer Party Record and attempting other work contacts where possible. If there is a mobile number, send the following text 'Please contact us about your employee [ACC45 No]'. DO NOT disclose other client information in the text. In the task description note you have attempted to contact the employer on [mobile number] and sent an etxt. Push out the task for another 5 days.

Third attempt in five days: leave voicemail message and cancel the Employer Welcome Conversation Action with an outcome to note the unsuccessful attempts. Contact the client to advise you have not been able to make contact with their employer and ask them to liaise with them.

NOTE How to send an email to the employer when contact has not been made - Assisted Recovery only

Generate an email to the employer from EOS using the EOS email function and then copy and paste below template into the email - this will include the claim number and client name. Please ensure you have updated the bracketed areas to match the employer and the client.

Kia ora (employer's name)

We are keen to chat with you about your employee, who has recently had an (work) injury. We attempted to call (employer contact) on (phone number) on (date), but haven't had any luck making contact, so we are following up with this email.

ACC's role is to support your employee during their recovery from injury. You also have an important role to play as the injured person's employer, in supporting them to recover at work, where possible.

We would be pleased if you could confirm for us the following:

The employee worked for you at the time of the accident and still works for you currently.

- Who is the right person in your business to talk with about (injured employee's name) recovery at work opportunities?
- Is there anything you think would be beneficial for ACC to know about (injured employee's name) (or your business) that might impact on their recovery?
- Have you had a conversation with (injured employee) about the injury and how you might support them with recovery at work? (i.e. alternative or suitable duties; modifying tasks/environment/ hours to allow the person to work safely within any functional restrictions as they recover)

There are a number of ways ACC can help you to support your employee as they recover from their injury. Please reply to this email, or give us a call on 0800 101 996, so we can explore this further.

You can also find useful conversation guides and information about how to support your employee to recover at work on our website here Supporting your employee back to work (acc.co.nz). Now also might be a good time to register for MyACC for Business – where you can keep track of your levies, payments and work injury claims from your own device. Register here <https://business.acc.co.nz/login/register>.

NOTE What if the employer's email address is unverified?

You can still send the template email (see note above) to the employer even if the email address is not verified as long as the client has given that email address to us. If the email address is wrong, then it is considered a third party data loss, and not a privacy risk for recovery teams.

If you do not have an email address from the client and are attempting to use a non verified email address from the party level of the employer this will need to be verified before sending the email.

NOTE How do you create the Employer Welcome Conversation?

From the Salesforce Recovery Plan:
Actions > Create New Action? > Employer Welcome Conversation > Next > Conduct Employer Welcome Conversation OR Schedule Future Employer Welcome Conversation.

Additionally, the Employer Welcome Conversation will automatically create on the Recovery Plan if the Client/Representative has given permission for ACC to make contact with their Employer. Ensure the 'Contact Employer' item is open in the To-do list from the Welcome Conversation when you use [Create Recovery Plan].

NOTE What do you need to consider as you complete the Employer Welcome Conversation?

- Capture information collected and agreed as you work through the conversation.
- Save the conversation once all required information is recorded.
- Add To Do List items to capture post call actions, then complete these actions following the call.
- Any To Do List actions that remain open will be automatically transferred to the Recovery Plan when click Transfer To Do List.

NOTE How do you complete the Employer Welcome Conversation?

- 1) Review your notes and tidy as needed so that the record of the conversation is clear and accurate as to what was discussed.
- 2) Ensure the mandatory fields (these will be bolded) have information entered into them before pressing the 'Save Conversation' button.


- g** Arrange to send your client a copy of their Recovery Plan if required.

NOTE How do you generate a copy of the Recovery Plan for the client?

Click Send PDF to Eos on the Salesforce Recovery Plan.
Result: This will generate ACC7979 form.

NOTE What if the client wants the Recovery Plan sent to them by email?


Follow the Emailing from Eos – System Steps.

-  NGCM - FINAL Emailing from Eos - System Steps

NOTE What if the client wants the Recovery Plan sent to them by mail?

Refer to the NG GUIDELINES Sending Letters in NGCM.

- h** Close the NGCM Client Welcome Conversation task.

-  Send letters from Client Recovery and Claims Assessment

- i** Transition the claim to the correct Recovery Team or Assisted Recovery cohort.

NOTE What if the claim needs to be transitioned to another Recovery Team?


-  **PROCESS** Transition Claim

NOTE What if the claim needs to be transitioned to another Assisted Recovery cohort?

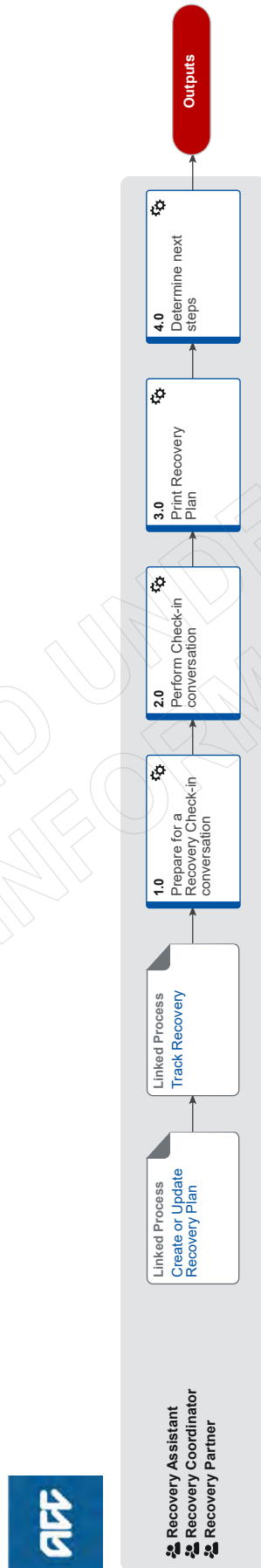
 Assisted Transitions Criteria

NOTE What if the claim needs to be closed?

 **PROCESS** Close claim

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

RELEASED UNDER THE
OFFICIAL INFORMATION ACT



RELEASED UNDER THE
OFFICIAL INFORMATION ACT



Summary

Objective

To identify when key recovery milestones have been achieved, and to gather information to ensure the client has the right level of support from us to reach the next milestone toward their recovery goal during the Recovery Check-in conversation.

Background

The Recovery Check-in conversation framework has been created to support our new ways of working, ensuring we have quality conversations and are contacting our clients at the right time, for the right reasons, and in the right way – every time.

During Recovery Check-in conversations, we identify any outcomes to current goals and actions since the previous Recovery Check-in, and add new goals and actions. We then update the Recovery Plan and check the client is still being supported by the best team for their needs, and finally set up the next Recovery Check-in (unless the client has reached their final Recovery Check-in point).

It also helps us identify when a client's recovery is not tracking as planned and to proactively remind clients of agreed key target dates within their recovery plan.

Recovery Check-ins provide a conversational framework to ensure our clients' needs are met and that they have a consistent experience with ACC. When successfully conducted and accurately recorded, ACC will have additional information for a particular client including:


- how they are feeling about progress towards their recovery and their level of confidence towards reaching their goals
- at what point they see themselves on their recovery path in terms of next steps, rehabilitation, treatment and progress towards their goals
- what support the client needs from ACC.


Owner

[Out of Scope]

Expert

Procedure

-  **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

-  **PROCESS** **Track Recovery**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Prepare for a Recovery Check-in conversation

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, check the timing of the Recovery Check-in conversation.


NOTE When should a Recovery Check-in conversation be scheduled?

- The timing of any Recovery Check-in conversation should align to a key milestone in the client's recovery.

This is primarily based on whether we think we can add value to the client's recovery – we'll contact them when they reach a recovery milestone to determine what level of support they need to reach their next milestone.

- If it's not the right time to have a Recovery Check-in task:
 - For claims in Assisted team, change the target date for the Recovery Check-in task and transfer the task back into the Assisted Recovery Department queue.
 - For claims in the Supported or Partnered team, change the target date for the Recovery Check-in task.

EXCEPTION : For claims where we are not providing any entitlement or intervention as there is no cover or claims that are open to complete a review process a Contact Action Task should be on the claim to ensure the client is kept updated about the progress and next steps are monitored .

 Examples of key milestones for Recovery Check-ins

NOTE What factors can determine the number and frequency of Recovery Check-in conversations?

The timing for each Recovery Check-in is unique for each client, based on an assessment of all currently available key information, which means that some clients may need more or less Recovery Check-in conversations than others.


For example, if a client's recovery is steadily on track, and there is no evidence of any obstacle to their recovery and they seem to be progressing well – then only a minimal number of Recovery Check-in conversations may be needed. Conversely, a client who has multiple or more complex injuries will likely require more Recovery Check-in conversations.

NOTE What if the client initiates contact before a scheduled Recovery Check-in?

If it is appropriate to have the Recovery Check-in now, go to 2.0 Perform Check-in conversation.

- b** Determine the purpose of the conversation.

When planning a Recovery Check-in conversation, be very clear on which milestone you plan to discuss and the stage of the client's recovery.

 Recovery Check-in - Supporting Information

NOTE What if you have received new or additional diagnosis before conducting a recovery check-in?

- 1) Check if the lodgment notes are on file such as medical certificates in Eos Incapacity tab.
- 2) Have a robust conversation with the client to clearly determine the mechanism of the injury if additional information is received.
- 3) Issue a decision promptly. If unable, contact medical hotline following Seek Internal Guidance process if needed.
- 4) Send a CVR30 Time extension Advise – Claimant letter if you need more time to assess the claim.

 **PROCESS** Seek Internal Guidance


NOTE What if you need to discuss a recent medical certificate relating to subsequent incapacity?

Perform a subsequent Welcome Conversation.

If the client requires Weekly Compensation and they are eligible, complete the Weekly Compensation section of the subsequent Welcome Conversation in Salesforce. You will only need to complete the Weekly Compensation section, and override the other mandatory questions once you have selected "Save" in the close-out section. The Welcome Conversation transcript will be automatically sent to Eos.

Once you have all the information for weekly compensation, Go to 'Request Set Up of Weekly Compensation Payments'.

For more information about subsequent incapacity, refer to the policy below.

 **PROCESS** Request Set Up of Weekly Compensation Payments

 Subsequent Inability to Work (Subsequent Incapacity)

NOTE What other key factors should you consider before conducting a Recovery Check-in conversation?

- Does any new information (reports, action updates, or other conversations), mean that the timing is no longer appropriate for this Recovery Check-in?
- Is the client's recovery still underway as planned?
- Is there anything you can do at this point to improve the client's journey?


NOTE What if the client has been transitioned from another team or recovery team member?

- Please conduct a claim review using the Transitioned Client Claim Review Te Whariki page

 Transitioned Client Claim Review


NOTE What if the client has been transitioned from Enabled?

You will need to discuss and agree with the client an overall Recovery Goal, actions and set up their Recovery Plan. Go to Create or Update Recovery Plan process.

 **PROCESS** Create or Update Recovery Plan

NOTE What if you need to prepare for a CMI Recovery Check-in conversation?

Refer to the CMI Recovery Check-in Conversation guidelines to help you have a Recovery Check-in conversation with a provider and/or an Assisted Complex Mental Injury (CMI) client.

 CMI Recovery Check-in Conversation guideline

NOTE What if you need to prepare for a CPI or a Long term stable Recovery Check-in conversation?

Refer to the CPI and Long term stable Recovery Check-in Conversation guidelines. These guidelines are for Complex Physical Injury (CPI) clients who are in:

- the Partnered Recovery team, or
- those clients who have transitioned from Partnered Recovery to the Assisted Recovery team.

Review the claim so you have the knowledge of the client's circumstances before making the call. The language we use when talking with clients who have sustained a lifelong injury should reflect that.

For example, it is not appropriate to ask someone with a permanent disability how their recovery is progressing. If in doubt or unsure, talk to the Team Leader or Practice Mentor.

 NG GUIDELINES: CPI Recovery and Long Term stable Check-in Conversation

- C** Determine the correct (or best) person to have the conversation with.

NOTE How do you determine the correct or best person?

When planning a Recovery Check-in conversation, it is important to first identify the most appropriate person to conduct the conversation with (and check if there is a safe contact and their relationship they have to the client) and also to be very clear on which milestone you plan to discuss.

Recovery team members need to determine who should be involved and which conversation guide to use.

The preferred option may be a case conference with the provider and the client.

NOTE What factors should you consider when planning your approach on the type of conversation to pursue in the Recovery Check-in conversation?

- Complex Physical Injury claims – many conversation variations are available for these injury types, including situations where the client has returned to work on a part-time basis, (which is a significant achievement and milestone point)
- Sensitive claims – which may require manual set up along with pre and post cover workaround options.
- The early planning of stages linking to ISSC engagement or the most recent documentation. Review cover status (ie is there an assessment pending)
- If you're in Partnered, consider the following aspects of their lives – where they live, the support needed to live independently, their confidence in living an every day life, support in their community and the support people around them, and if anything has changed.

NOTE What if the client is only able to communicate via email?

It is always best practice to conduct a recovery check in via phone so that we are able to gather as much information as possible to confirm the recovery is on track or to consider what additional services we may need to discuss. However, in exceptional circumstances, there will be some clients who are only able to communicate via email. This could be due to a range of factors such as:


- A client who lives overseas
- A client who has a hearing impairment
- An already established management plan which means they are unable to call ACC, or
- Because this has been identified as the only appropriate method to communicate with the client.

If you are considering recovery check ins via email for a client and they do not match this exceptional criteria, consult your team leader in conjunction with a practice mentor prior to using this method. Once confirmed, record the rationale in the Engagement life area.

2.0 Perform Check-in conversation

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Open the relevant guidelines to refer to during the Recovery Check-in conversation.

 Recovery Check-in - Supporting Information

NOTE What are the guidelines for a CMI Recovery Check-in Conversation?

Refer to NG GUIDELINES CMI Recovery Check In Conversation guidelines to help you have a Recovery Check-in Conversation with:

- a provider, and/or
- an Assisted Complex Mental Injury (CMI) client.

NOTE What if the purpose of the conversation is due to an assessment on a re-opened claim?

Tailor the Recovery Check In conversation to the clients current circumstances.

The purpose of this conversation is not to agree Recovery Goals or agree further Recovery Check Ins. These are not required while the request is being assessed. Advise the client what the next steps are and agree a date for your next contact.

In Salesforce, create a Reminder or Contact action on the claim, ensure the target date is the date agreed with the client. Go to Activity 4.0 Determine next steps.

 CMI Recovery Check-in Conversation guideline

- b** In Salesforce, establish contact with the client or relevant stakeholder, the provider or the participant and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

NOTE What if you can't establish contact?

1) Attempt a maximum of two contacts over two full working days before leaving a voicemail or sending a notification to request client contact.

2) If you are unable to reach the client, extend the task for an additional two working days and note in the task description that this is the second attempt to contact the client.

3) On the task due date and if there has been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach them by phone letter. The CM04 letter will be populated with client injury details, however you need to update the letter as follows:

'We recently tried to contact you about your injury that happened on [date of accident auto]. I tried calling you to talk about how we may be able to help you recover from your injury/injuries, but haven't managed to get in touch.

It would be good to hear from you on how you are progressing or discuss what other support we could offer, please give me a call or email me to arrange a convenient time for me to call you back.'

4) Extend the task date as appropriate to take into account postal delivery and note in the task description this is the third attempt to contact the client and the CM04 letter has been sent.

5) On the task due date and if there has been no contact from the client and they are continuing to receive support, seek internal guidance to determine next steps.


6) If you're in Partnered and no contact is made with the client after 3 attempts, you must contact the provider, GP or other verified contact on the claim.


 **PROCESS** Seek Internal Guidance


NOTE What if you're unable to contact a CPI client?

Follow the instructions as detailed in the [What if you can't establish contact?] note above. In the CM04 letter, update with the following:

We recently tried to contact you to see how you are managing your injury and if you need any additional assistance from ACC. If you would like to discuss your ongoing needs to assist your recovery, please call us on the number below.

 What to say in a voicemail message

 Decline Entitlement When Client is Non-compliant Policy

 CM04 Advise claimant that you were unable to reach them by phone

NOTE How can you confirm client contact details?

Consider the following:

- details on the ACC45
- latest ACC18
- contact the client's treating provider
- contact the client's employer.

NOTE What if they are reluctant or not comfortable to directly participate in a Recovery Check-in conversation?

In some cases, providers such as Social Workers can be nominated as a representative in situations where the client doesn't want to talk to ACC directly - for example, a complex physical injury case.

NOTE What if the client advises they are unable to have the conversation now or during the conversation they are unable to continue?


1) If possible, agree the next actions with the client and an alternative time to call back that suits them.

2) Update the target date in the task with this date.

3) Add a note in the description field of the task advising the conversation was paused, noting the components that weren't completed.

NOTE What do you need to consider before arranging a face-to-face conversation?

Go to Arrange Face to Face Client Meeting process.

 **PROCESS** Arrange Face to Face Client Meeting

NOTE What if the description in the task advises the recovery check in is to be conducted over email?

Confirm the following before creating the email:

- Check that the clients situation has been identified as being suitable to recovery check ins via email (see Activity 1.0c and the Engagement life area).
- Check that the clients email address has been verified.
- Consider what the milestone is and whether the timing is still correct. Review Te Kete, the Recovery Plan actions and life area notes along with recent contacts and documents before proceeding.


The description field should indicate if there are specific questions that need to be asked during this recovery check in. If not, consider the questions that are in the salesforces guided conversation (by double clicking the action) and tailor these to the clients current circumstances. Ie:

- Do we need to review progress towards the recovery goal? (With Partnered Physical Injury clients or Long Term Service Clients this may not be appropriate)
- Do we need to review progress of treatment?
- Do we need to review progress of social supports?
- Do we need to review progress of vocational supports?
- Are there any agreed interventions that have now been completed and have they achieved the intended outcome?
- Is there anything else we can do to help progress the recovery path for this client?

Once the email has been sent, edit the recovery check in action in Salesforce and note in the change reason that an email has been sent then move the due date out a week to allow the client to reply before we follow up.

NOTE What if the Client advises you they have resigned, been terminated or received redundancy?

Refer to information link below for guidance.

 Client resigns, loses job / termination, is made redundant

- C** From the Recovery Plan, open and complete the Recovery Check-in Conversation. Use the To Do List to record post call actions.

NOTE What if the recovery check in was conducted via email?

Consider whether we need further information/ agreement from the client prior to completing the recovery check in action in Salesforce. If we need more information, request this from the client by replying to their email and then edit the recovery check in action in Salesforce that a reply email has been sent then move the due date out a further week to allow the client to reply before we follow up.

If all actions have been completed/agreed to and we have advised the client of their next recovery check in date, complete the next steps

- 1) Ensure all emails are filed away and the properties have been updated accordingly.
- 2) Set up/edit any supports or requests that were requested/agreed to.
- 3) Update the recovery plan in salesforce with key information from this interaction.

NOTE What if you receive a request for a Lump sum payment or Independence Allowance (LSIA)?

- 1) Advise the client they are eligible to apply, and an application pack will be sent to them.
- 2) Create a 'Send LSIA application pack task'. This will automatically route to the Treatment & Support team to generate and send to the client.

For further information refer to the link below.

 Identify Claims for Rapidly Deteriorating Clients

 Independence allowance & lump sum (IALS)

- d** Discuss Client's Rights and Responsibilities if needed.

NOTE How do you determine if you need to discuss sending the ACC165 Client Rights and Responsibilities?

In Salesforce, the Recovery Check-in Conversation will display the Clients Rights and Responsibilities section if the client does not have an active Client's Rights and Responsibilities Indicator.

Advise the client that you need to share with them information about their rights and responsibilities and confirm they understand these. Check how the client would like to receive this information (eg, email, post) and note this in the Rights and Responsibilities section of the Welcome Conversation.

To-Do List items will be automatically created for the following:


- Post or email the ACC165
- Follow up reminder set for 10 working days to follow up with the client if not received

NOTE Where can you find more information about Recovery Check-in?

Refer to the Recovery Check-ins section of the Recovery Management Guide.

NOTE Where can you find more information about scheduling a Recovery Check-in?

Go to Create or Update Recovery Plan process, then refer to Activity 2.3 Add or update a Recovery Check-in.

 **PROCESS** Create or Update Recovery Plan

 NG GUIDELINES Recovery Management

NOTE What if this is the final Recovery Check-in?

Refer to Close Claim process.

 **PROCESS** Close claim

- e Finish the call with the client, ensuring you've gathered all the information you need and the client verbally agrees to the updated information for their Recovery Plan.

NOTE What if the client doesn't provide verbal agreement to an intervention or the plan we have identified as being reasonably required?

Confirm with the client:

- how they want to receive a copy of their Recovery Plan so they can review it
- a suitable time for them to review their Recovery Plan. We must give them a reasonable time to review and agree to a Recovery Plan. It's expected that a client is given 10 working days but a longer timeframe may be appropriate in some cases. They can also seek support from their Lead Health Practitioner, other Health Practitioner, other support person(s), or employer to participate in the development of their Recovery Plan
- a date to finalise the Recovery Plan
- they can seek advice from their Lead Health Practitioner, other Health Practitioner, other support person(s), or employer to help with the preparation of their Recovery Plan
- they can phone us to discuss their Recovery Plan and/or provide verbal agreement of their Recovery Plan
- they can send their Recovery Plan back via email or post with feedback and/or agreement
- we'll follow up with them before the finalisation date agreed if we've not heard from them
- if we don't reach an agreement at the finalisation date, we'll send them copy of the Recovery Plan again with a decision advising the client the Recovery Plan has been finalised as 'agreed'.

- f In Salesforce, work through the actions in the To Do List. Complete the actions that must be done at that time.

NOTE What if you are unable to complete an action?

Click the 'Transfer To Do Items' button. This will automatically transfer the open item to the Recovery Plan as an 'Action to be followed up' on the specified Target Date.

- g If you are unable to complete an action, click the 'Transfer To Do Items' button. This will automatically transfer the open item to the Recovery Plan as an 'Action to be followed up' on the specified Target Date.

NOTE What happens automatically in Eos when you've completed the Recovery Check-in Conversation?

A Recovery Check-in Conversation transcript is created and a contact is added to the Recovery Plan. Note that due to a system error it is currently saved as a 'decision letter' with the description as 'mailhouse letter'. A fix for this is pending, in the meantime the contact must be manually amended.

3.0 Print Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a If the client has requested a copy of their Recovery Plan, confirm how they want to receive this.

Ensure that the client has agreed to each specific intervention in the Recovery Plan. Agreement to interventions must be evidenced in contact notes either following discussions with the client/ATA or email. This means that the client's signature is not required on the printed Plan.

An employer must be given an opportunity to participate in the preparation of the Recovery Plan, however it does not mean they need to see a copy of the plan. Ensure you do not show any sensitive client information to the employer. Check all auto-populated fields and remove data as necessary. Where there is a sensitive claim we must follow directions by the client and not involve the employer.

- b Generate a copy of the Recovery Plan for the client.


NOTE How do you generate a copy of the Recovery Plan?

Click Send PDF to Eos on the Salesforce Recovery Plan.
Result: This will generate ACC7979 form.

- c Arrange to send the client a copy of their Recovery Plan.


NOTE What if the client wants the Recovery Plan sent to them by email?

Follow the Emailing from Eos – System Steps.

 NGCM - FINAL Emailing from Eos - System Steps

NOTE What if the client wants the Recovery Plan sent to them by mail?

Refer to Send letters from Client Recovery and Claims Assessment.

 Send letters from Client Recovery and Claims Assessment


4.0 Determine next steps

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a In Salesforce, create or update the plan with the new information or outcome of the conversation.

NOTE How do you create or update the Recovery Plan?

Go to Create or Update Recovery Plan process.

 **PROCESS** Create or Update Recovery Plan

- b Assess the information in the Recovery Plan and determine if the next step is clear and obvious.

NOTE What if you need internal advice to determine next steps of the client's recovery?

Go to Seek Internal Guidance process.

PROCESS Seek Internal Guidance

NOTE What if you need clinical information to help complete the client's recovery plan?

Go to Request Clinical Records process.

PROCESS Request Clinical Records

- c** Consider if your client needs to be transitioned to another team as your client is either tracking ahead or behind their Recovery Plan.

NOTE What if your client needs to be Transitioned to another team?

Remember to align the due date for Recovery Check-in conversations with key milestones. Go to Transition Claim process.

PROCESS Transition Claim

- d** Arrange an assessment to gather more information about the client's injury or recovery needs.

NOTE How do you arrange the assessment?

Go to the relevant web link below, then select the assessment process.

- Manage Social Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/fde996>
- Manage Vocational Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/ff8eb01>
- Manage Treatment Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/1bbffb1>
- Manage Ancillary Services
<https://go.promapp.com/accnz/Process/Group/0846c1>

- e** Determine the type of support required to help your client to achieve their recovery goal(s) and confirm their eligibility. Consider our Decision-making principles in the Recovery Management Guide.

To find details about how to create tasks for other types of financial supports, search for the support type in Promapp (eg lump sum, independence allowance, HCSS payments).

NG GUIDELINES Recovery Management

NOTE What if you need to set up supports for the client?

If you need to:

- set up social supports for the client, go to Manage Social Interventions / Supports web link.
- set up vocational supports for the client, go to Manage Vocational Interventions / Supports web link.
- respond to a treatment request, go to Manage Treatment Interventions / Supports web link.

- Manage Social Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/fde996>
- Manage Vocational Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/ff8eb01>
- Manage Treatment Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/1bbffb1>

NOTE What if you need to set up Weekly Compensation?

Go to the process below.

PROCESS Request Set Up of Weekly Compensation Payments

NOTE What if you need to reinstate Weekly Compensation?

In Eos, at ACC45 level, complete the reinstatement information in the Non Standard WC Setup Eform (documents tab, stand alone eform category). Then create a Setup weekly comp Entitlement task (the eform is linked automatically). The task auto routes to the Centralised Weekly Compensation queue.

Add a Non standard WC set up Eform

- f** Depending on where your client is at, consider the following.

NOTE What if your client is unlikely to be able to return to their pre-injury occupation due to their injury?

Go to Arrange Vocational Assessment web link, and then select these processes:

- Arrange Initial Occupational Assessment process, and
- Arrange Initial Medical Assessment process.

NOTE What if your client is undertaking IOA/IMA, VIOA/VIMA (Voc independence pathway)?

If your client is undertaking Initial Occupational Assessment/Initial Medical Assessment (IOA/IMA), Vocational Independence Occupational Assessment/Vocational Independence Medical Assessment (VIOA/VIMA), then arrange to send your client a copy of their Recovery Plan, requesting their signature to confirm the agreed interventions. Go to Activity 3.0 Print Recovery Plan.

NOTE If the client will need ongoing and extensive support please consider if they are suitable for Serious Injury profiling

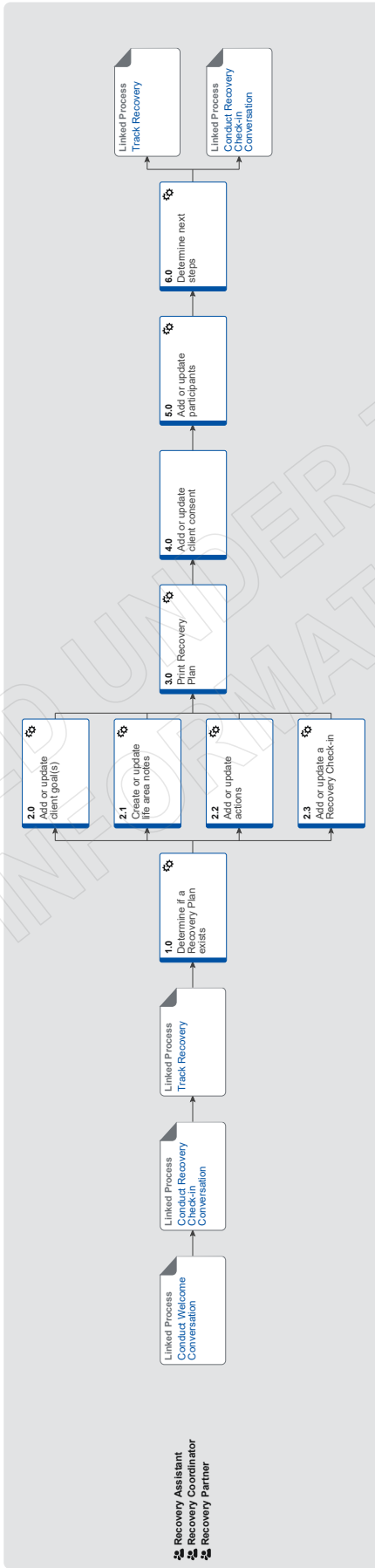
PROCESS Refer for an Injury Profile

- g** Determine if your client no longer needs support.

NOTE What if the client has confirmed they don't require any supports?

Go to Stop Supports.

PROCESS Stop Supports





Summary

Objective

To capture information in the client's Recovery Plan gathered during the Welcome Conversation, Recovery Check-in, or at any time new key information is received. The actions we add to the Recovery Plan are agreed with the client.

Background

Recovery Plans are fundamental to the effective and proactive end-to-end management of claims. Having a Recovery Plan ensures consistency in the set up and support of a client and their recovery.

It provides a clear and concise snapshot of what has / is currently happening on the claim, ensures the client receives the right support from ACC at the right time and in the right way, and enables us to have client interactions that are proactive, and outcome focused.

A Recovery Plan must also identify any obstacles and how to address these.

The benefits of a Recovery Plan are:

- Consistency in claim set-up and management
- Provides a clear and concise snapshot of what has and is currently happening on the claim
- Ability to understand the client's situation quickly, and build rapport easily
- Allows ACC to develop a relationship with the client
- Client receives the right support from ACC at the right time and in the right way
- Clients have a fit for purpose level of service
- Client interactions are pro-active and outcome focussed, not process driven
- Claim outcomes guided by Expected Claim Outcome (ECO) with agreed expectation and date


Owner


[Out of Scope]

Expert

Procedure

 **PROCESS** **Conduct Welcome Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Conduct Recovery Check-in Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Track Recovery**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine if a Recovery Plan exists

Recovery Assistant, Recovery Coordinator, Recovery Partner

- From Te Kete in Salesforce, navigate to the client's Recovery Plan.
If the Recovery Plan is in Salesforce, go to Activity 2.0 Review Recovery Plan.
If you receive an error message that the Recovery Plan does not exist in Eos, go to next step.
- Create a Recovery Plan sub-case in Eos:
 - From the ACC45 Claim, select the Add Activity tab
 - Select Transfer to NGCM
 - Select the Recovery Team your claim is in
 - Select OK.


NOTE What if you are a Recovery Coordinator or Recovery Partner?

If the claim is in your name and you transfer to NGCM, you will need to then transfer the claim back into your name.

NOTE What if a duplicate claim exists?

In Eos, label the claim as duplicate and any relevant data they hold, such as contacts, tasks or documents must be transferred to the master claim.

Go to Identify and Link Duplicate Claims: Standard process.

 **PROCESS** Identify and Link Duplicate Claims :: Not triggered by information requirement


NOTE What if a Launch Pad Recovery Plan (LPRP) subcase exists?

From NGCM roll out, all claims previously managed in the Launchpad will have a read only LPRP and must be managed from the Recovery Plan in Salesforce. Review the information on the LPRP to understand the client and claim information.

When a closed claim previously managed in the Launch Pad is reopened, a Recovery Plan sub-case should be automatically created when it is transferred from NGCM-Actioned Cases to one of the Recovery Teams.

2.0 Add or update client goal(s)

Recovery Assistant, Recovery Coordinator, Recovery Partner

- Read the guidelines below for further information about Recovery Management and completing a Recovery Plan.
 -  NG GUIDELINES Recovery Management
- In Salesforce, add a Recovery Goal by Selecting 'Goals' > 'Create New Goal?' > 'Recovery Goal' > 'Next'.

NOTE What are the Recovery Goal options?

All client's in Assisted, Supported and Partnered must have a Recovery Goal. Either:

- Be able to look after myself
- Be independent with some help
- Get back to school
- Manage my life
- Regain my independence
- Return to an alternative work type
- To live my best life
- Return to my pre-injury role
- Work and manage my life

c Set the Target Date and record a Rationale for the Recovery Goal.

NOTE What target date should you set?

Target dates should be agreed with the client during your conversation with the client and based on the Expected Claim Outcome (ECO) or the treatment providers recommendation eg a medical certificate, surgery notes, General Practitioner (GP) notes or an intervention completion report (ie housing modifications, transport for independence).

For clients who are engaged in ACC funded treatment for mental injury, target dates should align to available information or reports submitted by treating providers e.g. in Wellbeing Plan, an indication is given about how long treatment will be needed for and this should be the overall target date for recovery. Recovery goals are only set once a cover decision has been made therefore it may not be suitable to set a recovery goal with your client at this time.

NOTE What should you include in the rationale?

What the Recovery Goal target date is based on.

d Personal Goal(s) are optional and are used to personalise the Recovery Plan for the client.

NOTE What are examples of a Personal Goal?

- Be able to walk the dog
- Be able to run 5 kms.

NOTE How do you add a Personal Goal?

Select 'Goals' > 'Create New Goal?' > 'Personal Goal' > 'Next'.


e Update a Recovery Goal when the target date is reached or the goal has been achieved as agreed with the client.

NOTE What if the Recovery Goal is only partially achieved by the target date?

Confirm the Recovery goal is still relevant and set new target date as agreed with the client.

NOTE What if the Recovery Goal is no longer relevant?

Update outcome to indicate that the Recovery Goal is no longer relevant. Add a new Recovery Goal. For example, the client can no longer return to their pre-injury role, however they may be able to return to a job with lighter duties. If you are unsure about the creating new Recovery Goal(s) go to Seek Internal Guidance process.

 **PROCESS** Seek Internal Guidance

NOTE What information is important to capture in the Life Areas?

Refer to the Life Areas section of the Recovery Management Guideline.

NOTE What information is important to capture in the Life Areas for Hāpai clients?

Refer to the Life Areas section of the Recovery Management Guideline, however, use the below information to complete the following life areas sections in Salesforce.

Cultural

- Is karakia requested (upload copy if appropriate)
- Iwi affiliation if appropriate
- Kawa if specific is requested – detail
- Cultural support required? M&CC Team or Kāiwhiri – details
- Rongoā details (PO) and expiry

 NG GUIDELINES Recovery Plan Baseline

 NG GUIDELINES Recovery Management

NOTE What if you add notes relating to another client by mistake?

You can edit or delete any life areas that you create as long as you do so on the same day it was created.

If you are wanting to change any life area notes at a later date you will need to email your Recovery Leader:

- ask them to remove the incorrect information from the Life Area notes in Salesforce
- identify what information needs to be removed
- refer to the claim number.

2.2 Add or update actions

Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Salesforce, assess information captured and consider the actions required to help the client achieve their next milestone and overall Recovery Goal.

b Click Action to add or update actions to the relevant life area.

NOTE What are agreed actions?

- reminders
- contacts
- agreed Interventions.

For more information, refer to the Actions section of the Recovery Management Guide.

 NG GUIDELINES Recovery Management

c Add or update an Agreed Intervention on the Recovery Plan.

 Identify Claims for Rapidly Deteriorating Clients

2.1 Create or update life area notes

Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Salesforce, enter information into the appropriate life area.

NOTE How do you add or update an agreed intervention?

To add an Agreed Intervention:

- 1) On the Recovery Plan, in Salesforce, select 'Actions' > 'Create New Action?' > 'Agreed Intervention'.
- 2) Select the appropriate agreed intervention based on the life area it aligns with and the specific name before selecting 'Next'.
- 3) Complete the required fields before selecting 'Next'.

To edit an Agreed Intervention:

- 1) On the Recovery Plan, in Salesforce, click on the agreed intervention once to open the 'View / Edit Agreed Intervention' window.
- 2) Update appropriately then select 'Next'.

NOTE What date should you set the 'Expected Outcome Date' to?

This should be set to the date that we anticipate receiving the completion/assessment report related to the agreed intervention.

NOTE What could you include in the 'Next Action / Referral Details' field?

Include information in this field that will provide context to the referral:

- The purpose of the assessment
 - Name of the provider or vendor
 - Date, time and location of assessments
 - Purchase order number, end dates and updates
 - Expected outcome / Next steps - i.e. expecting a reduction in home help needs
- Understanding next steps when the agreed intervention is completed

To automatically copy the information from this field to the Life Area select the 'Copy to Life Area' tick box. You will be able to edit this life area note as long as you do so on the same day you created it.

NOTE What if the client is receiving ISSC support?

Upon receipt of the Early Planning Report, consideration needs to be given to the recovery stage the client is proceeding with:

- If the client is proceeding with Supported Assessment, a 'Mental Injury Assessment' or 'Psychiatric Services' Agreed Intervention should be added to the Recovery Plan.
- What date should you set this 'Expected Outcome' to?

An agreed intervention of 'mental injury assessment' or 'Psychiatric Services' should be added which goes 5 months from the last face to face session indicated within the early planning report, or the date in which ACC should expect the report to be completed and have been sent to ACC (often this is identified within the early planning report as well).

- If the client is proceeding with Support to Well-being (short-term), no Agreed Intervention is required until receipt of the Completion Report, at which point the Agreed Intervention of 'Therapy' should be added. This should include the date the service concluded and the outcome that has been achieved.

NOTE What if a client has agreed to participate in an Agreed Intervention during the phone call?

If your client has verbally agreed to participate in treatment, support and assessments, you must record this as a contact in Salesforce.

Be specific about each intervention and the client's agreement to that specific intervention; this helps to marry the discussion to the intervention and the client's agreement to engage in it.

For example: Work ready programme: Cath agreed to attend from 4/7/19 to improve her fitness for work and on completion commence GRTW early August.

NOTE What if the client wants to agree to the Agreed Intervention in writing rather than verbally?

- 1) Add Agreed Intervention in Salesforce, ticking the Sent for Agreement box.
- 2) Once you have finished filling out Recovery plan, generate copy of Recovery Plan and send to client as per section 3.0 below.

NOTE What should you do when you're assigned a 'Follow-up Recovery Plan Action: Agreed Intervention' task?

- 1) In Eos or Salesforce, check the tasks and documents on the claim to see if we have received the report about the Agreed Intervention.
- 2) In Outlook, check your personal or shared inbox to see if we have received the report about the Agreed Intervention.

If report has been received, go to the 'What if you need to record an outcome for an agreed intervention?' note below or 'How do you add or update the agreed intervention to the Recovery Plan?' note.

If report has not been received:

- 1) Check if there has been any correspondence from the provider.
 - 2) Contact the provider to follow-up if appropriate.
- If you have spoken to the provider or received correspondence advising there needs to be a new date for the Agreed Intervention (for example, extension required, time to send the report required), set the new due date as per request.
 - If you have attempted to speak to the provider and there is no correspondence or updates, set a new expected outcome date for when you expect to hear back from the provider with an update.

NOTE What if you need to record an outcome for an agreed intervention?

If the agreed intervention is completed, open the agreed intervention by clicking the action once from the Recovery Plan in Salesforce. Select 'Complete' then set an appropriate 'Outcome Date'. The Outcome Summary will be automatically populated and will be editable to make any necessary adjustments.

If the agreed intervention can no longer be achieved (ensure a record of the conversation has been saved noting who you spoke with and the reason(s) for this change) then you can select 'No Longer Relevant' on the agreed intervention then 'Next'. This will remove the agreed intervention from the clients Recovery Plan in Salesforce and however it will still appear on the printable Recovery Plan.

If the agreed intervention has been added in error, you can select 'Cancel' on the agreed intervention then 'Next'. This will remove the agreed intervention from the clients Recovery Plan in Salesforce and from the printable Recovery Plan.

 NG GUIDELINES Agreed Interventions

- d Add or update a Reminder Action on the Recovery Plan.

NOTE What are reminders used for?

Reminders are used as a prompt for a Recovery team member do something e.g. send notifications to clients, set up some supports in the future or extend a support when it is due to expire. When a Medical Certificate is about to expire there is an automatic notification set 7 days before expiry. However, if your client has requested to stop notifications, it may be appropriate to use a contact action to discuss this with them.

NOTE What notifications can you send to a client?

Refer to the Client Notifications section in the Recovery Management guide.
Refer also to the Manual Notification Types list in the Create a Notification system steps.

 NG GUIDELINES Recovery Management

 Create a Notification - System Steps

NOTE How do you update a reminder?

From the Recovery Plan, in Salesforce, click the reminder action once and update appropriate before selecting 'Next'.

- e Add or update a Contact Action on the Recovery Plan. When you add a contact, this creates a task to contact a key participant. We must add an outcome summary to the contact action when we have completed a conversation with a key participant.

NOTE What if the participant you were trying to contact is not available?

If a contact action already exists for this call, click the action once then update the description to include the date of this contact attempt and reschedule to an appropriate date to attempt the call again.

If a contact action doesn't exist for this call, create a new contact action by selecting 'Actions' > 'Create New Action?' > 'Contact' > 'Next' > 'Schedule Future Dated Contact'. Select a 'Contact With' option, add who needs to be contacted and why into the 'Description' field then choose a due date before selecting 'Next'.

NOTE What if the client calls and asks for their Recovery Coordinator to call them back?

Create a new contact action by selecting 'Actions' > 'Create New Action?' > 'Contact' > 'Next' > 'Schedule Future Dated Contact'. Select a 'Contact With' option, note the reason for call back and who and how to contact them in the 'Description' field then choose a due date before selecting 'Next'.

NOTE What if you entered a contact in error?

You will be able to edit a completed contact as long as you do so on the same day that you created it. From the Recovery Plan, in Salesforce, select the 'Completed' Toggle to view completed items on the Recovery Plan timeline. Locate the contact action that you need to edit and click it once to open the 'View / Edit Contact' window. The Outcome Summary field will now be editable and when updated and 'Next' is selected, the associated contact in Eos will reflect the changes.

If the contact was identified as incorrect after 24 hours then a ticket needs to be lodged with the Service Desk to have the contact removed in salesforce.

NOTE What if you capture additional information about the client during conversations with participants?

Add the new information to the appropriate Life Area on the Recovery Plan.

 NG GUIDELINES Recovery Management

NOTE Do Supports appear on the Recovery Plan?

Supports such as ancillary are not entered as actions on the Recovery Plan, they are tasks which go to Admin. Supports can be viewed from Te Kete or the Recovery Plan screen.

NOTE What if you need to set up Supports for your client?

Go to Activity 6.0 Determine next steps.


2.3 Add or update a Recovery Check-in

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a In Salesforce, determine the milestone. Schedule Recovery Check-ins at key milestones and stages in the client's recovery journey.

NOTE What should you consider?

When considering an appropriate milestone think about the wider context of the client's recovery, eg regarding work type - a sedentary worker's Recovery Check-in may be at a different stage when compared with someone in a very heavy work type. An example could be going from non-weight bearing to weight bearing.

 **PROCESS** Conduct Recovery Check-in Conversation

NOTE What is a Milestone?

Milestones are significant changes and achievements in the client's recovery pathway.

When considering an appropriate milestone, consider the wider context of the client's recovery eg their work type – a sedentary worker's Recovery Check-in may be at a different stage when compared with that of someone in a heavy work-type occupation.

- When is the next significant change in the client's recovery likely to occur (eg increased independence, noticeable strengthening, a phased return to work duties).

- When is it likely that the client's needs will change significantly?

Milestone Timing Examples:

WHEN	WHY
Client was using crutches and a moonroof can now weight bear	Client is now able to start strengthening
Client should be ready to get back into work, based on a specialist report	Begin planning on what a return to work would look like for this client
At completion of a programme (e.g. Concussion Services) and the report suggests further needs	Understand progress, and plan for the next recovery period
Client's injury-state dramatically changes (e.g. injury complicated with infection, bone not healing)	Impacts on what we have previously planned, it is likely that we will need to understand the new recovery pathway and plan accordingly
(report has unexpected recommendations (e.g. report advises longer recovery timeframe based on new information impacting recovery))	

What isn't a milestone?

A new medical certificate within the expected recovery period which we were anticipating	We'd like to know how a recent appointment went (i.e. how was their physiotherapy appointment this morning)
We need to check on some details (i.e. whether a client still needs taxis)	Compliance discussions - these can be treated as Actions to ensure compliance in recovery.

 Milestone Timing Examples.PNG

NOTE What is a stage?

Injury recovery can proceed through four key stages, acute, rehab, adaptation and stable. Healing can progress backward or forward depending on internal and external factors.


- Acute – This is the initial response stage following an accident, in which activity focuses on stabilising the injury and treating any inflammation (irritation, swelling or pain).

- Rehab – The period of treatment that is needed to enhance and restore functional ability and quality of life after an injury. This tends to be the longest of the stages and includes a client's gradual return to work — a critical component of rehabilitation and recovery.

- Adaptation – We support our clients to adapt to changes that will help them with their recovery. For some clients, we might be enhancing existing skills and knowledge to adapt to a new vocation after an injury, and supporting them towards Vocational Independence.

- Stable – We continue to support our client when their injury is stable, and we expect little further change in their recovery status. We consider if they need ongoing management or if we should close their claim.

- Close Claim; we have now considered it is ok to close the claim from active management and are closing the claim (refer to the closed claim page for criteria)

 Close Claim - Promapp Page
<https://au.promapp.com/accnz/Process/ac14995c-28>

b From the Recovery Plan, in Salesforce, click the Recovery Check in action once and update the description and date as required before selecting 'Next'. When the Recovery Plan is created from the Welcome Conversation, a Recovery Check-in will automatically be added to the Recovery Plan timeline.

NOTE What relevant information do you need to include?

When completing a Recovery Check-in with the client/ATA, enter:

- your next Recovery Check-in
- things to consider during the next Recovery Check-in (ie, the key milestone, etc which you will add into the conversation).

NOTE What if the claim is of a serious or sensitive nature?

Usually Partnered Recovery clients sustain life changing injuries. These clients and their support networks (family, whanau and others) require intensive support while they remain in rehabilitation facilities and when they have returned to their communities.

The Recovery Partner will cover the client's transition from acute care to active rehabilitation, part of which includes gathering information from multiple parties including employers, social workers and other entities.

3.0 Print Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, generate a copy of the Recovery Plan for the client if required.

NOTE How do you generate a copy of the Recovery Plan?

Click Send PDF to Eos on the Salesforce Recovery Plan.
Result: This will generate ACC7979 form

- b** Arrange to send your client a copy of their Recovery Plan.


NOTE What if the client wants the Recovery Plan sent to them by email?

Follow the Emailing from Eos – System Steps.

 NGCM - FINAL Emailing from Eos - System Steps

NOTE What if the client wants the Recovery Plan sent to them by mail?

1) Create a RPL04 letter and Working Together - Kōrero mai (ACC255) to accompany the Recovery Plan.
2) Follow the Send Confidential Information by Courier using Pre-alert process.

 **PROCESS** Send Confidential Information by Courier using Pre-alert

NOTE What if you need to send a copy of the finalised Recovery Plan to the client as the client has not agreed their Recovery Plan at finalisation date?

- In Salesforce, add a note that the Recovery Plan is regarded as 'agreed under Clause 8 of Schedule 1 Agreement to plan without the client's actual agreement'.
- Create a copy of the Recovery Plan.
- Create a copy of the RPL08 Deemed plan after mediation – client letter to the client explaining that the IRP is regarded as agreed. Include a clear rationale for why that measure has been taken.
- Note on the Recovery Plan being sent to client 'Regarded as finalised'.
- Send the Recovery Plan to the client using the method the client agreed to have the initial Recovery Plan sent to them - post or email.

 RPL08 Document Template

4.0 Add or update client consent

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Add the client's verbal authority to collect information to the Recovery Plan tab if obtained during the conversation.


NOTE How do you add the client's verbal authority to collect information?

Follow the Add, Edit, or View Client Consent system steps.

 Add Edit or View Client Consent


NOTE What if the client does not provide verbal authority to collect information?

Go to the process below.

 **PROCESS** Obtain Client Authority to Collect Information

NOTE What if the client withdraws their authority to collect information?

At any stage a client can decline or withdraw their authority. Go to the process below for further information.

 **PROCESS** Decline or Withdraw Client Authority to Collect Information

5.0 Add or update participants

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, add participants to the ACC45 level, including contact details for the main contact person/people for the client's recovery.

 Manage Participants

- b** Ensure you remove participants that are no longer involved in the client's rehabilitation.

6.0 Determine next steps

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Assess the information in the Recovery Plan and determine if the next step is clear and obvious.

NOTE Who are the key participants a contact could be with?

- Contact with Advocate
- Contact with Claimant
- Contact with Employer
- Contact with Family/Whanau
- Contact with Provider


NOTE What if you need internal advice to determine next steps of the client's recovery?

Go to the process below.

 **PROCESS** Seek Internal Guidance


NOTE What if you need clinical information to help complete the client's recovery plan?

Go to the process below.

 **PROCESS** Request Clinical Records

NOTE What if you need diagnosis(es) and the cause of a client's injury or current condition clarification as well as recommendations for further investigations, treatment or rehabilitation?

Go to Arrange Medical Case Review (MCR) Assessment process.

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

- b** Consider if your client needs to be transitioned to another team as your client is either tracking ahead or behind their Recovery Plan.

NOTE What if your client needs to be transitioned to another team?


Go to Transition Claim process.

 **PROCESS** Transition Claim




- c** Consider if an assessment to gather more information about the client's injury or recovery needs is required.

NOTE How do you arrange the assessment?


Go to the relevant web link below, then select the assessment process.

 Manage Social Interventions / Supports

<https://go.promapp.com/accnz/Process/Group/fde99c>

-  Manage Vocational Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/ff8eb01>
-  Manage Treatment Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/1bbffb;>
-  Manage Ancillary Services
<https://go.promapp.com/accnz/Process/Group/0846c>



d Determine the type of support required for your client and confirm their eligibility. Consider our Decision-making principles in the Recovery Management Guide. To find details about how to create tasks for other types of financial supports, search for the support type in Promapp (eg lump sum independence allowance, HCSS payments).

-  NG GUIDELINES Recovery Management

NOTE What if you need to set up supports for the client?


If you need to set up:

- social supports for the client, go to Manage Social Interventions / Supports web link.
- vocational supports for the client, go to Manage Vocational Interventions / Supports web link.

-  Manage Social Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/fde996>
-  Manage Vocational Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/ff8eb01>

NOTE What if an assessment to fund treatment is required?

Go to Manage Treatment Interventions / Supports web link.

-  Manage Treatment Interventions / Supports
<https://go.promapp.com/accnz/Process/Group/1bbffb;>

NOTE What if you need to set up weekly compensation for the client?

Go to the process below.

-  **PROCESS** Request Set Up of Weekly Compensation Payments

NOTE What if you need to maintain an existing weekly payment for the client?

If you're updating existing weekly compensation, go to the process below.

-  **PROCESS** Maintain Weekly Compensation


NOTE What if you need to reinstate Weekly Compensation?

In Eos, at ACC45 level, complete the reinstatement information in the Non Standard WC Setup Eform, (documents tab, stand alone eform category). Then create a Setup weekly comp Entitlement task (the eform is linked automatically). The task auto routes to the Centralised Weekly Compensation queue.

e Determine if your client is unlikely to be able to return to their pre-injury occupation due to their injury, or if they are vocationally independent.

NOTE How do you arrange an IOA to identify the types of work that may be appropriate for the client?

Go to Arrange Initial Occupational Assessment process.

-  **PROCESS** Arrange Initial Occupational Assessment (IOA)

f Determine if you are waiting on information from the client's Lead Health Practitioner and/or other Health practitioners in the planning of the client's Recovery Plan.

g Determine if you are waiting on information from the client's employer to help with the planning of the client's Recovery Plan.


-  Recovery Plan Policy


h Determine if your client no longer needs support.

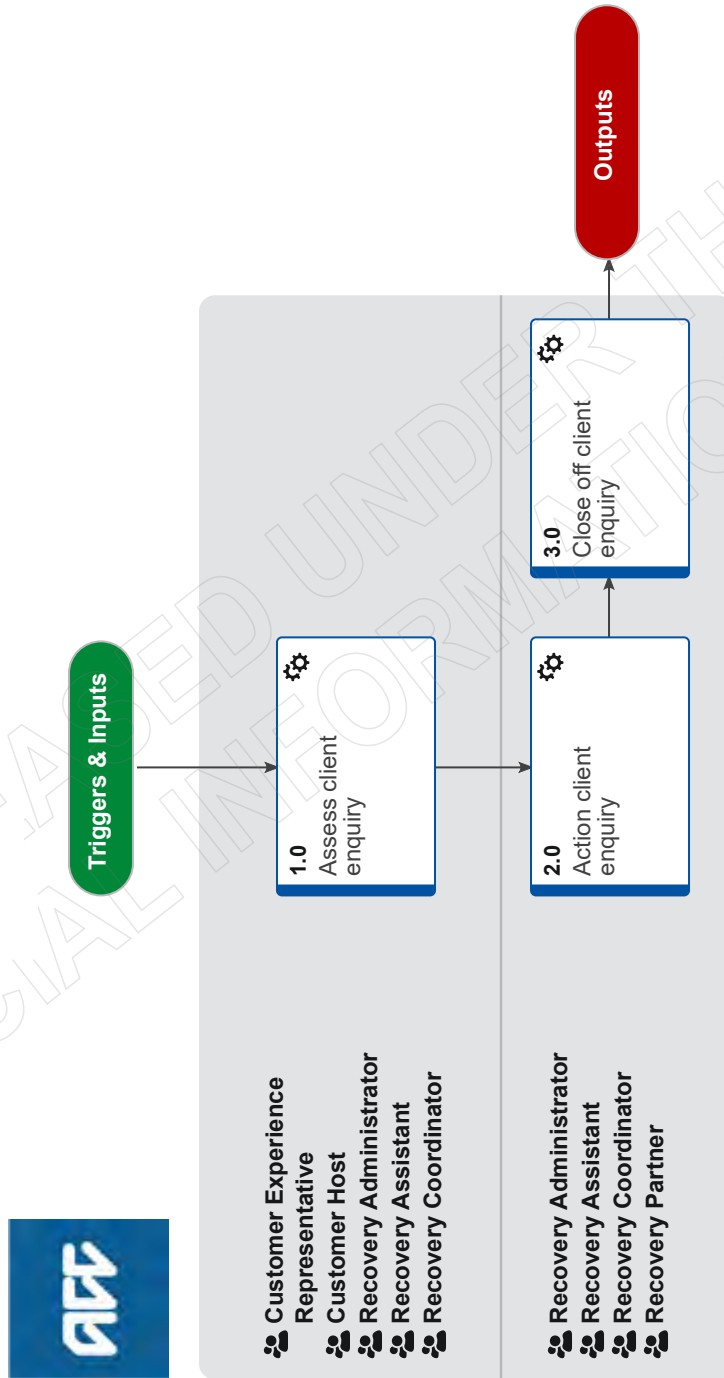
NOTE What if the client has confirmed they don't require any supports?

Go to Stop Supports process.

-  **PROCESS** Stop Supports

 **PROCESS** **Track Recovery**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Conduct Recovery Check-in Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner



Summary

Objective

The objective of this process is to direct client enquiries to the necessary teams in order for the enquiry to be resolved.

Background

Client enquiries are received through various channels - by phone, email, postal correspondence, in person at an ACC site or customer feedback forms.

Enquiries may be from the client themselves or another party such as the client representative or advocate, or insurer.

This process covers enquiries that are not covered by other processes. Enquiries received by the Client Contact Centre are out of scope because they will follow their own processes and knowledge base through the Vault.

Owner

[Out of Scope]

Expert

Procedure

1.0 Assess client enquiry

Customer Experience Representative, Customer Host, Recovery Administrator, Recovery Assistant, Recovery Coordinator

- a Confirm the type of client enquiry received.

NOTE What if you receive the client enquiry from another staff member or team?

Go to 2.0 Action client enquiry.

NOTE What if the client or their representative phones or emails a Recovery Team member directly?

Go to the Identity check Policy to confirm you are dealing with the correct person by asking ACC's identity check questions.

Complete the identity check and go to 2.0 Action client enquiry.

PROCESS Identity Check Policy

NOTE What if a client or their representative visits a site or hub to speak with someone directly?

Ask for details about their enquiry. If the enquiry relates to a claim, ask for information such as the claim number or injury date.

Advise a Team Leader there is someone wanting to discuss an issue. The Team Leader can arrange for someone to speak with the client or representative.

While the Team Leader is arranging this, advise the client someone will be with them shortly.

Go to 2.0 Action client enquiry.

NOTE What if the enquiry is from another party, such as the client's representative, advocate or insurer?

In Eos, look up the Recovery Team member assigned to the client's claim and forward the enquiry to them.

Go to 2.0 Action client enquiry.

NOTE What if the client or their representative is requesting the client's claim information?

Go to the Complete Client Information Requests process.

PROCESS Complete Client Information Requests

NOTE What if the client or their representative wants to update the client's personal details?

Go to the Update Client Details on Party Record process.

PROCESS Update Client Party Records

NOTE What if the Contact Centre is able to resolve the query at the first point of contact?

Add a Contact to the relevant record.

This process ends.

NOTE What if the client or their representative has a business or levy enquiry?

Forward the enquiry to business@acc.co.nz and inform the client or their representative that this has been done and that someone will be in contact.

Go to 2.0 Action client enquiry.

NOTE What if the client or their representative sends a written enquiry via postal services?

Go to the Upload Physical Documents Received via Postal Services.

PROCESS Upload Physical Documents Received via Postal Services

NOTE What if the client or their representative sends Heartbeat feedback?

Follow the Heartbeat Listening to our customers process.

PROCESS Acting on Heartbeat Feedback

NOTE What if the enquiry could relate to a review application?

- If the enquiry is an email, forward it to accreviewapplication@acc.co.nz
- Reply to the client advising them that the query has been forwarded to the appropriate team and they will be in contact.
- If the enquiry is over the phone, advise the client that a review application must be in writing. This can be an email asking for a review and should be sent to accreviewapplication@acc.co.nz.

Go to 2.0 Action client enquiry.

NOTE What if you need in-house legal advice to help with a client enquiry?

Email legal.services@acc.co.nz and provide as much background information as you can. For example:

- a description of the issue
- a summary of the key facts
- attach any background information or key documents
- your desired outcome and timeframes.

Go to 2.0 Action client enquiry.

NOTE What if you need privacy advice to help with a client enquiry?

Email privacy.officer@acc.co.nz or call them on

[s 9(2)(a)] You can contact them:

- when you identify, or are advised of, a privacy breach
- if you need advice about any privacy-related matters.

Go to 2.0 Action client enquiry.

NOTE What if you need assistance from a Clinical Advisor or Technical Specialist to help with a client enquiry?

Go to the Seek Internal Guidance process.

 **PROCESS** Seek Internal Guidance

NOTE What if you need assistance from another ACC team to help with a client enquiry?

Contact the relevant team or speak with your Recovery Leader if you are not sure who to contact.

Go to 2.0 Action client enquiry.

- d** Save any email correspondence against the client's claim record or Party record once it has been forwarded to the appropriate team.

NOTE What is the difference between these records?

- If the enquiry relates to a specific claim, add a Contact to the client's claim record.
- If the enquiry does not relate to a specific claim, or the claim hasn't been received yet, add a Contact to the client's Party claim record.

- e** Add details of the enquiry, the action taken and any relevant notes.

- f** Delete any emails from the inbox.

2.0 Action client enquiry

Recovery Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, open the client's Claim record.
- b** Review the enquiry and the client's claim information.
- c** Respond to the client or their representative with an answer to their enquiry.


NOTE What if you need to do identity checks?

Go to the Identity Check Policy to confirm you are dealing with the correct person by asking ACC's identity check questions.

 **PROCESS** Identity Check Policy

NOTE What checks are required before you disclose any information?

Go to the Privacy check before disclosing information Policy.

 **PROCESS** Privacy check before disclosing information Policy

NOTE What if you can't answer the enquiry?

- Find out more information, or identify a relevant role and escalate the enquiry, as applicable.
- When you are able, respond to the client or their representative with an answer to their enquiry, using the appropriate channel.
- If the enquiry may take some time to resolve, let the client know, and keep them informed.

3.0 Close off client enquiry

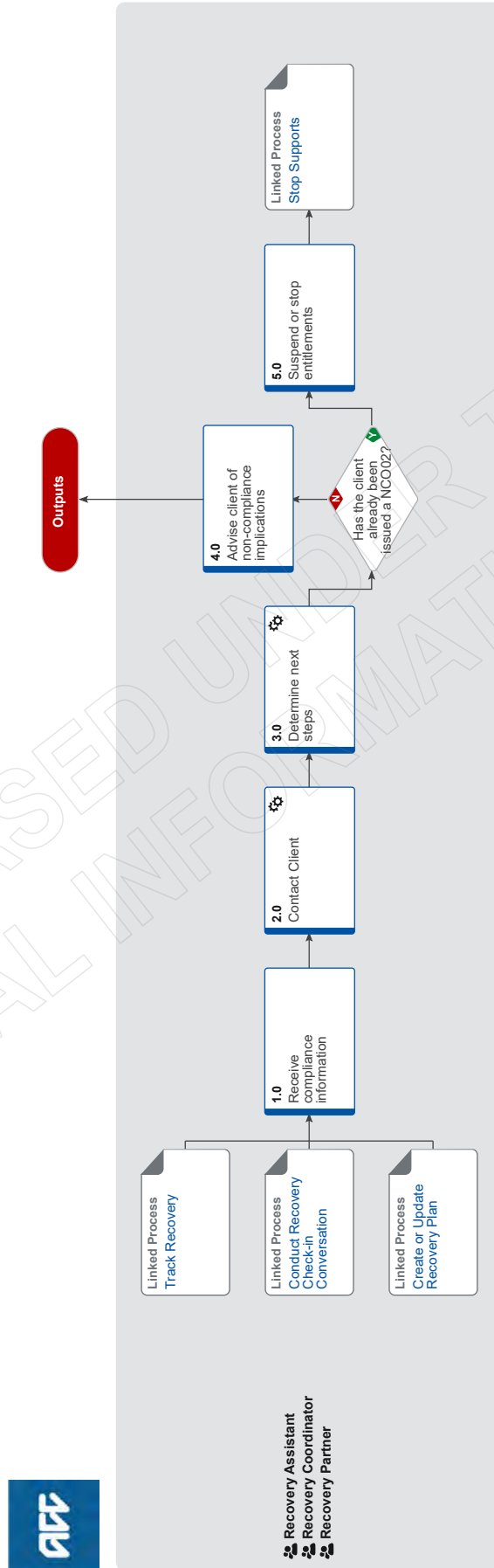
Recovery Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Ensure the enquiry has been resolved to the client's satisfaction.

NOTE What if you have been unable to resolve the enquiry?

Find out more information, or identify a relevant role and escalate the enquiry, as applicable.

- b** Close any outstanding tasks or activities when you are satisfied that the enquiry has been resolved.
- c** In Eos, record a Contact in the client Party record or Claim record and, if applicable, file away the enquiry email.





Summary

Objective

To detail the steps involved for when a client unreasonably fails or refuses to comply with a reasonable request from ACC. Requests may include, but are not limited to:

- attending appointments arranged by us
- participating in rehabilitation
- providing information.

NOTE:

We must refer to ACC's obligations under the Code of ACC Claimants' Rights (the ACC Code) Specifically Right 1, Right 2, Right 3, Right 4, Right 5 & Right 6.

In addition - ensure that you have a signed and agreed ACC165 Your rights and responsibilities form on file prior to proceeding to confirm any non-compliance to ensure the client is aware of their responsibilities whilst receiving ACC support.

Our requests must be reasonable, communicated in client's preferred method (email, phone, letter), understood by the client and able to be achieved by the client.

ACC must advise clearly of any consequence of unreasonably failing or refusing to comply with the reasonable request.

Background

We must warn clients about the impacts on their entitlements of not complying. If the failure or non-compliance continues, we can stop entitlement payments and send the client a decision letter.

We can reinstate entitlements after the client has complied with our request, e.g. they attend a rescheduled appointment.

Owner

[Out of Scope]

Expert

Procedure

- PROCESS** **Track Recovery**
Recovery Assistant, Recovery Coordinator, Recovery Partner

- PROCESS** **Conduct Recovery Check-in Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

- PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Receive compliance information

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive information related to the client's compliance.

NOTE What information you might have received?

- Client is responding to a NCO01 letter
- Reminder Action or Contact Action to contact client
- DNA (Did Not Attend) from provider
- Client has refused to provide information
- Client complied with NCO02 requirements
- Client did not comply with NCO02 requirements
- Client was non-compliant but has since become compliant

NOTE What if the client has missed an appointment?

Consider the information from the provider to see if it fits non-compliance.

Contact the client asking for an explanation to the non-attendance and consider if this constitutes non-compliance.

- b** Review the claim history.

NOTE What information should you look for?

Check whether we have already engaged with the client over non-compliance, including sending the client a NCO01 or NCO02, or marking the claim with a Non-Compliant indicator.

Look at the timeline of events and the process before the appointment or information request. Check that we engaged the client in discussion about reasonably required interventions and have captured these and the clients agreement in their Recovery Plan.

Check that we gave clear notice of the client's rehabilitation obligations, rights and responsibilities and whether there is a language or some other barrier to their attendance.

- Client Legislative Rights and Responsibilities Policy

NOTE What if you are unsure whether to proceed?

Discuss with your Team Leader or a Practice Mentor. Refer to the (NGCM) Seek Internal Guidance process below for further information and assistance.

- PROCESS** Seek Internal Guidance

- c** Confirm that the client has provided consent to collect and share information.

- View Client Consent

NOTE What if the client has not provided consent?

Go to the (NGCM) Obtain Client Authority to Collect Information process below.

If a client refuses to provide an authority to collect medical and other records and ACC is subsequently unable to obtain information to make a cover or initial entitlement decision, do not issue a decline decision on the basis of non-compliance.

The basis for the decline decision in those circumstances is ACC's inability to obtain the required information.

- PROCESS** Obtain Client Authority to Collect Information

2.0 Contact Client

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

NOTE What if you are unable to contact the client?

Attempt contact via as many means as are possible. For example via phone including leaving messages, sending a letter, sending an eTXT and emailing. Check the party case roles to see if they can be contacted through any of these, such as their employer or treatment provider. If they have any upcoming appointments or regular contact with a treatment provider, request that a message is passed on to contact you.

Failing to stay in contact with ACC is not a basis to suspend entitlements. You can only suspend entitlement if, for example, necessary and planned appointments are jeopardised. For instance, deciding to require a client attend a Medical Case Review, without previously discussing it with them and then using their lack of contact to suspend entitlements is not appropriate. If we have previously provided written advice that an appointment (such as a Medical Case review or Vocational Rehabilitation Service) is required and non-contact jeopardises organising this, non-compliance can be considered upon discussion with a technical specialist.

If a client has missed an appointment and you are unable to contact them:

1) Generate and send the NCO01 'Missed Appointment - unable to contact - claimant' letter, with clear expectations as to what the client needs to do next.

2) Create a Contact action for 7 consecutive days (14 consecutive days if letter is sent via post) from today, with a description of what needs to happen next.
For example: "NCO01 sent because (type of appointment) was missed. If no response will need to attempt contact and consider next steps"


3) Activate the Non-Compliant Indicator on the claim with "Investigating"
Enter attempts to contact into the "Add Non Compliance Indicator / Details" with the date and method of attempted contact.

 NCO01 Missed Appointment Letter


- b Discuss the situation with the client and record details of the conversation.


NOTE What if the client wants you to talk to another person on their behalf?

Refer to the 'NGCM) Obtain Authority to Act (ATA) process below for further information and guidance.

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

- c Explain to the client their rights and responsibilities whilst in receipt of ACC entitlements, ensuring that the client is able to clearly understand the communication that you are providing them.
Resend the Rights and Responsibilities form (ACC165) to the client and create a Contact on the claim to record that you have sent this and how.

 Accident Compensation Act 2001, Section 72: Responsibilities of claimant who receives entitlement
<https://legislation.govt.nz/act/public/2001/0049/latest/>

 ACC165 Declaration of rights and responsibilities

- d Confirm the clients preferred method of receiving the communication.
- e Create a Contact to document the client's explanation for their non-compliance and update the Engagement life area in Salesforce

3.0 Determine next steps

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine the next steps based on the claim and the reasons provided for the client's non-compliance. If necessary, ask a Practice Mentor for advice.

NOTE What if the Provider has advised of a DNA (Did Not Attend)?

You must check the Service Page for the relevant service before sending a task to Admin to update the Purchase Order with the correct DNA code as each DNA service allows for a different amount of DNA per service.

NOTE What if the client has missed an appointment but provided a reasonable excuse?

Arrange another appointment, or make sure the provider has scheduled a further appointment.

This process ends.

NOTE What if the client has missed an appointment, but has not been able to provide a reasonable reason for the failed attendance?

Consider if issuing the letter NCO02 – Implications of non-compliance is now appropriate. Ensure that you include details of the new appointment arranged and the entitlements that will be affected if they do not comply with this appointment.

When setting the new appointment / compliance expectations:

- Consider the Code of Claimant's Rights
- That your request is reasonable
- You are clear on what the client needs to do to comply (for example, is it attending 1 appointment, or a full rehabilitation programme)
- You are clear in the timeframe for complying with the request
- The request is achievable for the client to meet, that you are providing a reasonable notice period of any new appointment/s

NOTE What if the client had been issued a NCO02 letter and has complied with the request or appointment?

1) Ensure you have discussed the ACC165 and expectations with the client.

2) Edit the 'Non-Compliance Indicator' to show that the client is compliant

This process ends.

NOTE What if the client was previously non-compliant but has since become compliant?

1) Determine if entitlement payments can be backdated by referring to 'Seek Internal Guidance' and 'Decline Entitlement When Client is Non-compliant Policy' for more information

2 a) Create the relevant 'Extend Entitlement' tasks for Recovery Administration.

In the comments, include:

- The vendor
- The purchase order
- The date for the entitlements to restart - either the date the appointment was attended or the date that information was provided, and the reason for this as it may not align with the day that entitlements were suspended
- Any other details about entitlements affected

2 b) For Reinstatement of Weekly Compensation.


Refer to "Reinstate Weekly Compensation" Pro-mapp page, Procedure point '1.0 Review client payment request'

3) Generate and send the 'NCO04 Restart entitlements decision' letter.

4) In Eos, edit the 'Non-Compliance Indicator' to show that the client is now compliant.

This process ends.

 **PROCESS** Seek Internal Guidance

 Decline Entitlement When Client is Non-compliant Policy

NOTE What if it's established Weekly Compensation can be restarted?

In Eos, add a Follow Up Entitlement Task. The task will need to be transferred to the Centralised WC queue.

For further guidance on weekly compensation refer to the process below.

 **PROCESS** Request Set Up of Weekly Compensation Payments

b Determine whether the client's non-compliance is an unreasonable failure or refusal or not.

NOTE What constitutes an unreasonable failure or refusal?


When a client does not meet their responsibility to achieve independence from ACC in a timely and appropriate way, including:

- behaving in a way that grossly disregards the reasonable requirements imposed by ACC
- having unrealistic expectations within the intent of the rehabilitation provisions of the Accident Compensation Act 2001. Refer to the legislation linked below.

 Legislation - Suspending, Cancelling or Declining entitlements
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

NOTE What if you are not sure how to proceed?

Refer to 'Seek Internal Guidance'

 **PROCESS** Seek Internal Guidance

c Create a Contact to document your decision



Has the client already been issued a NCO02?
Recovery Assistant, Recovery Coordinator, Recovery Partner

YES.... Continue


NO....  NEXT ACTIVITY

4.0 Advise client of non-compliance implications
Recovery Assistant, Recovery Coordinator, Recovery Partner

a Create the NCO02 - Implications of non-compliance - claimant' letter.

Edit the letter to include:

- details and date of the new appointment if one has been arranged (ensuring client has enough notice for the new appointment)
- the entitlements that will be affected if the client does not comply.

 NCO02 - Implications of non-compliance - claimant


b Create a Reminder action 1-2 days prior to the appointment, send a notification to help ensure attendance. Some clients may need a Contact action depending on communication needs. Update the Engagement Life area.

c Create a Reminder action 1-2 days after the appointment to confirm whether the client attended.

5.0 Suspend or stop entitlements
Recovery Assistant, Recovery Coordinator, Recovery Partner

a Review the client's current supports and entitlements.


b Determine whether to suspend or leave active each of the client's current entitlements.

 Accident Compensation Act 2001, Section 117 (3): Corporation may suspend, cancel, or decline entitlements
<https://legislation.govt.nz/act/public/2001/0049/latest/>

 Code of ACC Claimant's Rights
<https://legislation.govt.nz/regulation/public/2002/0390>

NOTE How do you determine whether to suspend each entitlement?

Refer to 'Seek Internal Guidance'

 **PROCESS** Seek Internal Guidance

c Edit the Non-Compliance Indicator to show the client is non-compliant.

NOTE How do you add the Non Compliance Indicator?

1. Click on "Add" to add an indicator
2. Select "Non Compliance Indicator" in the drop down box.
3. Set the Status to the appropriate selection and add any details in the "Details" box.
4. Enter in the appropriate "From Date"
5. OK.

d Go to Stop Supports to finalise the Non-Compliance Process and to Stop the Supports affected by this decision.

The letter to confirm this decision is - SPD998 Suspension or cessation of entitlement - client / Option 4 Non-Compliance.

NOTE Ensure that you clearly state what the client was required to comply with and did not comply with and what the client must do to be able to re-comply.

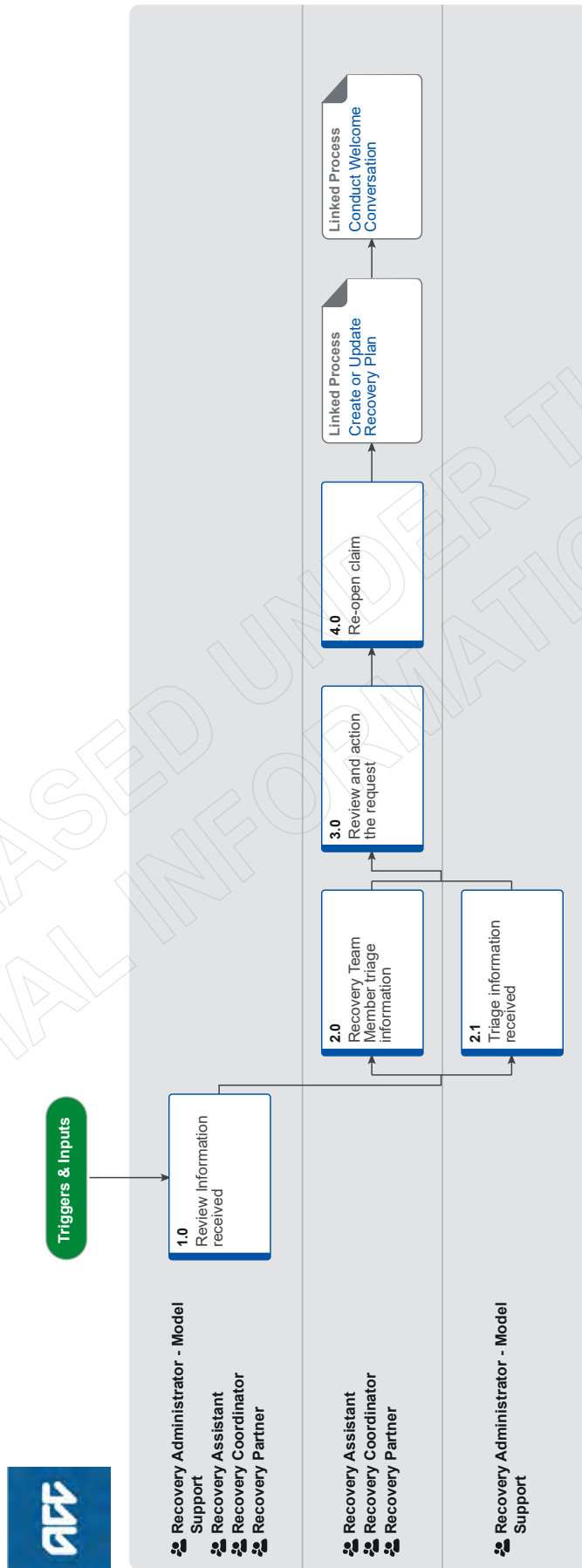
 **PROCESS**

Stop Supports

Recovery Assistant, Recovery Coordinator, Recovery Partner

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

RELEASED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

To identify and re-open claims that require further management or assessment post closure so that the client can receive assistance.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review Information received

Recovery Administrator - Model Support, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Check if the request or information received is for a Mental Injury with Sensitive claim ticked on the General screen.

NOTE What if the request is for a sensitive claim and you are a Recovery Assistant, Coordinator or an Recovery Administrator with Model Support?

1) If it's a phone call from the client or someone acting on behalf of the client, "handshake" the call to Partnered Recovery Huntline (MI Huntline [s 9(2)(a)]) This process ends.

2) If it's an email or task:

- Create an 'NGCM Action attached request task'
- Transfer the task to the department queue who previously managed the claim or to the Partnered department queue if the claim has not been previously managed. If you do not have access to sensitive claims, you will need to create the task at client party level. This process ends.

2.0 Recovery Team Member triage information

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine if the information contains a statement about or request for the client.

NOTE What if it is information only and no further action is required?

Close the task. This process ends.

NOTE What if there is a request or recommendation for entitlement and/or supports?

Go to Activity 3.0 Review and action request.

2.1 Triage information received

Recovery Administrator - Model Support

- a Check if it is a task for a claim which has been administered by a Third Party (Third Party Administrator - TPA).

NOTE What if it is a TPA claim?

Transfer the task to the TPA Support queue. This process ends.

- b Check if the document received is a completed ACC5937 Authority to Act

NOTE What if it is an ACC5937 Authority to Act

Go to 'Obtain Authority to Act (ATA) process. This process ends.

PROCESS Obtain Authority to Act (ATA)

- c Use the Re-open claim Decision Tree to determine next steps.

3.0 Review and action the request

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Transfer the task into your name.
- b Determine if you need to contact the client and /or provider to discuss the request for an entitlement or support.

NOTE What if you can complete the request in isolation?

Action the request and close the task. This process ends.

- c Discuss with client/provider to determine if the request is appropriate.

NOTE What if the request is not appropriate and the client does not need support?

Record the conversation as a 'contact' on the claim. Close the task. This process ends.

NOTE What if you can action the request without opening the claim?

Action the request. Record the conversation as a 'contact' on the claim. Close the task. This process ends.

- d Determine if the client requires on going support.

NOTE What if the client requires ongoing support?

Go to Activity 4.0 Re-open claim.

4.0 Re-open claim

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine if the claim was previously managed by Assisted, Supported, or Partnered, the claim should be automatically transferred to the last team who managed the claim.

NOTE What if the claim has never been managed?

- If the claim require active management, transfer the claim to the Team decided by the EMD (Engagement Model Decision)
- If the claim require a cover decision the claim should remain with Claims Assessment

NOTE What if you're transferring a claim from NGCM Actioned Cases to Assisted, Supported or Partnered Recovery?

Follow "Transfer a claim" system steps

Transfer a claim (Eos Online Help)

NOTE What if you don't have the system access to transfer the claim?

Go to 'Transfer a Claim from a BAU Action Cases Department' process


PROCESS Transfer a Claim from a BAU Actioned Cases Department

b Consider if the claim should stay in your team or transfer the task to the relevant Recovery team (consider the Engagement Model decision requirements)

NOTE What if you are unsure which team should manage the client?

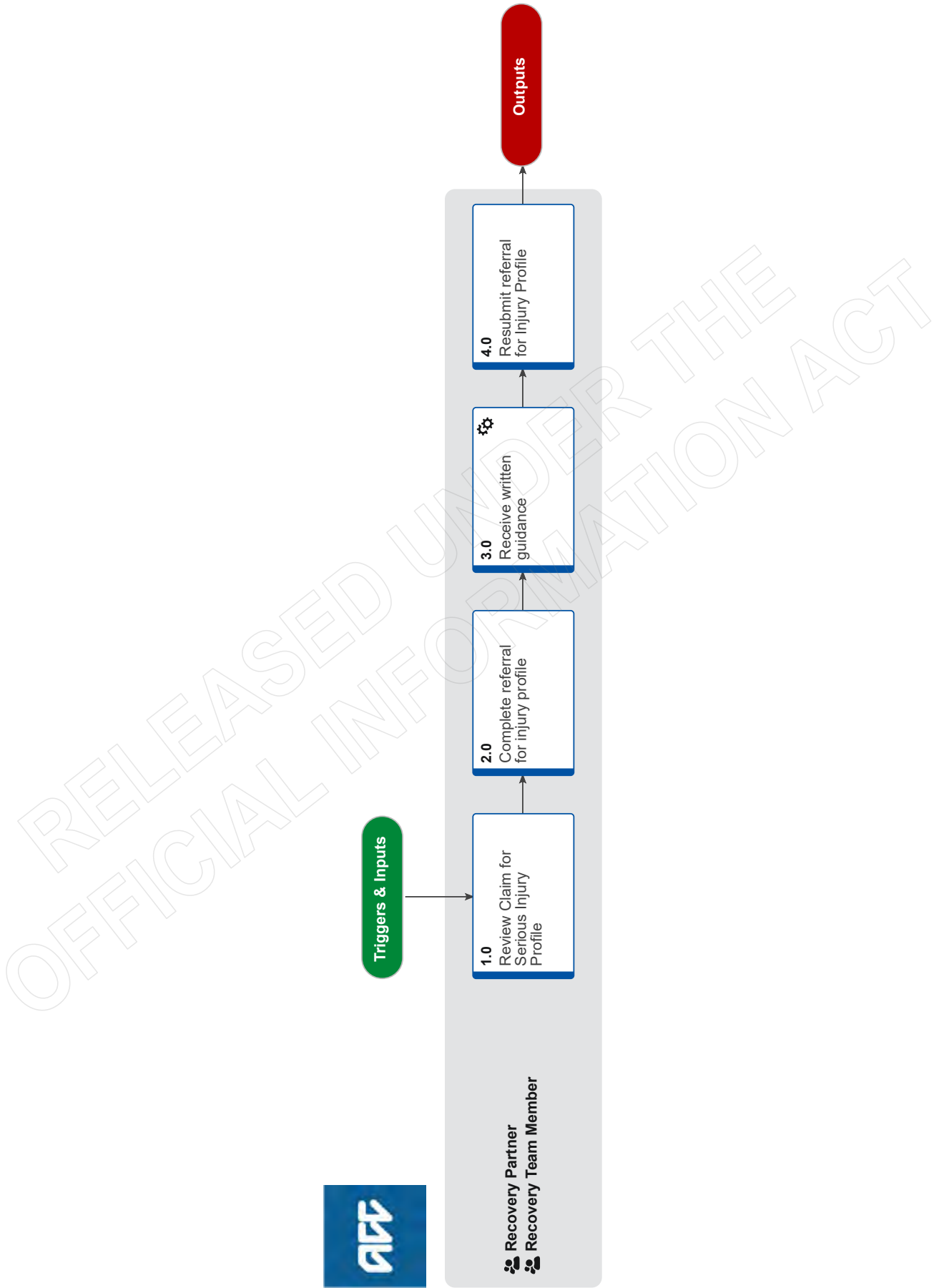
Go to Transition Claim process.

 **PROCESS** Transition Claim

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Conduct Welcome Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

RELEASED UNDER THE
OFFICIAL INFORMATION ACT





Summary

Objective

To refer and assign a Injury Profile to any claim to assist ACC Actuaries determine the money to put aside (reserve) to fund the support and services the client will need for the rest of their life i.e. claim liability.

Background

Injury profiles are a broad description of the type of injury and injury severity. The way the injury occurred is not a factor in this consideration.

Profiling is completed based on clinical evidence about the outcome of the injury. A profile is considered when all the relevant information is received to support the profiling decision.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review Claim for Serious Injury Profile

Recovery Partner, Recovery Team Member

- a Review claim for potential profiling.

NOTE What claims are eligible for injury profiling?

Clients with the following injury descriptions should be considered for injury profiling.

- Severe traumatic brain injury (profile 05) Glasgow coma scale (GCS) 8 and under, assessed post resuscitation or on admission to an Accident and Emergency Department AND a recorded post-traumatic amnesia (PTA) of eight days or more
- Moderate traumatic brain injury (profile 06) GCS 8 and under, assessed post resuscitation or on admission to an Accident and Emergency Department AND a recorded PTA up to and including seven days OR GCS 9 and higher, assessed post resuscitation or on admission to an Accident and Emergency Department AND a recorded PTA of eight days or more.
- Incomplete spinal cord injury profile (profile 10) Lesion at any level AND ASIA D (including clinical syndromes such as cauda equine syndrome)
- Paraplegia (Profile 03) Lesion at T2 and below AND ASIA scale A, B or C
- Low level tetraplegia (profile 02) Lesion at C6 to T1 AND ASIA scale A, B or C
- High level tetraplegia (profile 01) Lesion at C5 and above (including injury at C5/6 level) AND ASIA Scale A, B or C
- Comparable diagnosis (profile 8) Conditions with comparable severity to other profiles. Examples of injury types that could be considered are:
 - Multiple limb amputations
 - Burns to at least 50% of the body (or less depending on the areas of the body affected)
 - Complete bi-lateral blindness
 - Bi-lateral brachial plexus avulsion or rupture
- Profile 11 - Holding Profile due to insufficient information or client presentation is unclear.

Examples are recently accepted Treatment Injury claims that present as per the above examples, non accidental injuries to children and where recovery from Traumatic Brain Injury is progressing well and the long term impact is unclear

NOTE What supporting documents should you be looking for?

- Discharge and Emergency department notes ie confirm medical diagnosis from DHB or confirm level of spinal cord lesion and ASIA scale from DHB, Auckland or Burwood Spinal units
- Rehabilitation notes ie report from either DHB or active rehab facility such as ABI rehab confirming GCS and PTA
- Scans

NB:

If the client has been transferred to a rehabilitation facility (such as ABI or Burwood) the client MUST have completed that rehabilitation with discharge documentation on file before SI profiling can be considered.


In the event an adult has not been able to complete the Westmead assessment (or equivalent) for post traumatic amnesia (PTA) it is recommended a Neuropsychological assessment report is on file before being referred for profiling.

In the event an infant/child has sustained a TBI please defer for profiling until reaches, at least three years old with documentation on file of:

- child development report/s
- Neurologist or Pediatrician report/s
- complete DHB records to include operation reports/imaging and pediatrician and neurological outpatient clinic records.

NOTE What if you're missing Clinical notes?

If clinical information is missing and needed, refer to the Request clinical records process

 **PROCESS** Request Clinical Records

4.0 Resubmit referral for Injury Profile

Recovery Partner, Recovery Team Member

- a Review the reminder task to resubmit a Written Guidance request for an injury profile to be considered.
- b Refer to Activity 2.0 and continue with the process.

2.0 Complete referral for injury profile

Recovery Partner, Recovery Team Member

- a Complete a referral.

NOTE How do you request an Injury Profile?

Seek Internal Clinical Guidance.

Refer to the [Seek Internal Guidance] process.

 **PROCESS** Seek Internal Guidance

NOTE Serious Injury requests should not be referred as a high or medium priority

3.0 Receive written guidance


Recovery Partner, Recovery Team Member

- a In Eos, open the NGCM - Written Guidance task and review the guidance provided in the [Add Info] tab.

 Receive Written Guidance (Recovery Team Member)

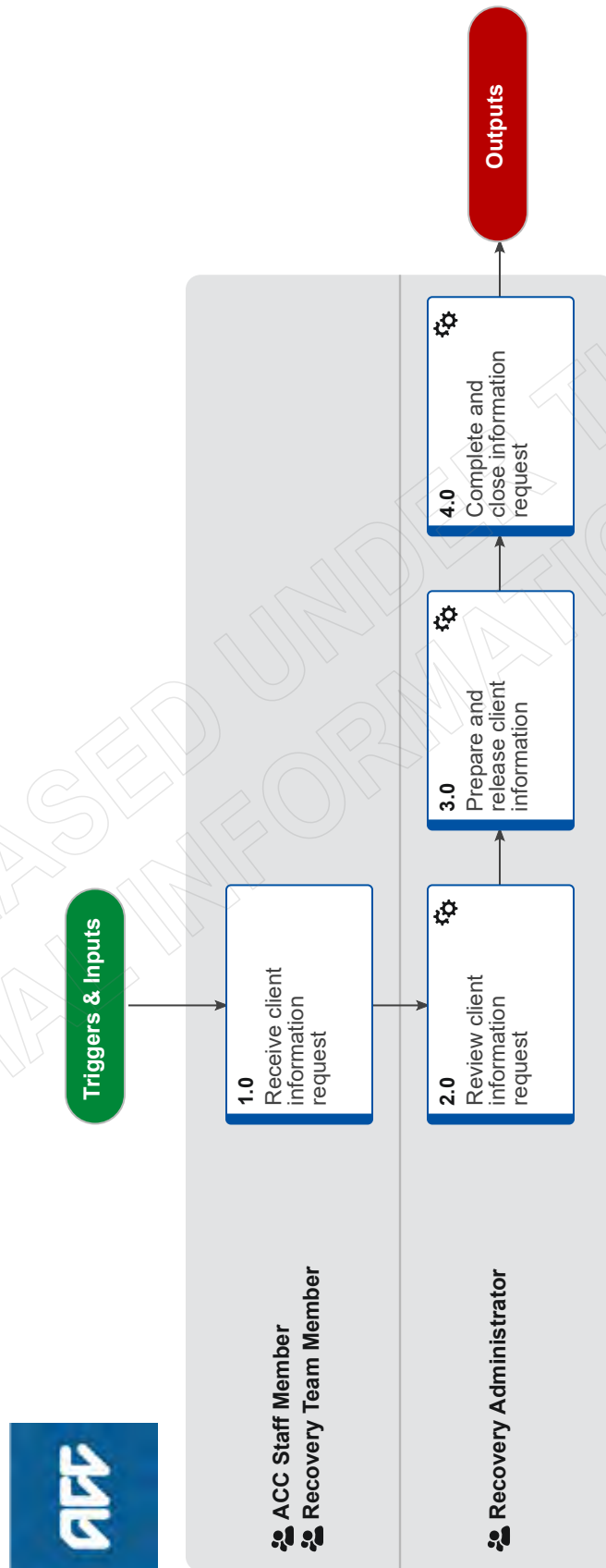
NOTE What if the guidance advises to resubmit request when more information is available?

Add an action in the Recovery Plan to review the Injury Profile in 3 months post injury.

 Add or Update Actions

NOTE What if the guidance advises that no profile is necessary?

Continue with managing the claim.





Summary

Objective

The purpose of this process is to provide client information within the legislative timeframes when ACC receives an information request from a government agency.

Background

These information requests fall under the Official Information Act 1982 and have a deadline of 20 working days from the receipt of request.

This process is for staff in the Recovery Administration Team.

Owner

[Out of Scope]

Expert

Procedure

1.0 Receive client information request

ACC Staff Member, Recovery Team Member

- a If you receive a request for client information from a government agency, on the Recovery Plan create a 'NGCM – Admin Request' task for the Recovery Administrator to action and note the details.

2.0 Review client information request

Recovery Administrator

- a Review the task.
- b Check that the client's details on the request for information match Eos:
 - Customer name
 - IRD number
 - Date of birthThe last known address does not need to match. Refer to guidelines for 'Confirming requirements for client information requests'.

NG GUIDELINES Confirming Requirements for Client Information Requests

NOTE What if the client's details on the information request do not match Eos?

If the details do not match, return the request to the relevant government agency, stating that the details do not match and we are unable to complete the request.

Select the appropriate email address:
For Inland Revenue, email:
ChildSupportTauranga@ird.govt.nz
For the Ministry of Social Development, email:
Client_Support_Debt_Management@msd.govt.nz

3.0 Prepare and release client information

Recovery Administrator

- a Collate the requested information.

NOTE What information can IR or MSD request from ACC?

Inland Revenue (IR) and the Ministry of Social Development (MSD) can request information from ACC relating to a client's weekly compensation, ie how much we've paid the client and when.

- b In Eos, create an email for the requestor. Copy the requestor's questions and supply the information. It is a breach of the client's privacy to supply information that the requestor did not ask for. For examples of requests and additional guidance, refer to NG GUIDELINES Respond to a Government Agency Information Request.

NG GUIDELINES Respond to a Government Agency Information Request

- c In Eos, send the email, using the details required for the government agency.

NOTE What details are required for the Ministry of Social Development?

Vendor code: VAQ371. Add as an 'Other Agent'.
Subject: MSD Information Request – Attn: [Requestor's name]
Send the email to:
Client_Support_Debt_Management@msd.govt.nz (unless specifically requested otherwise).

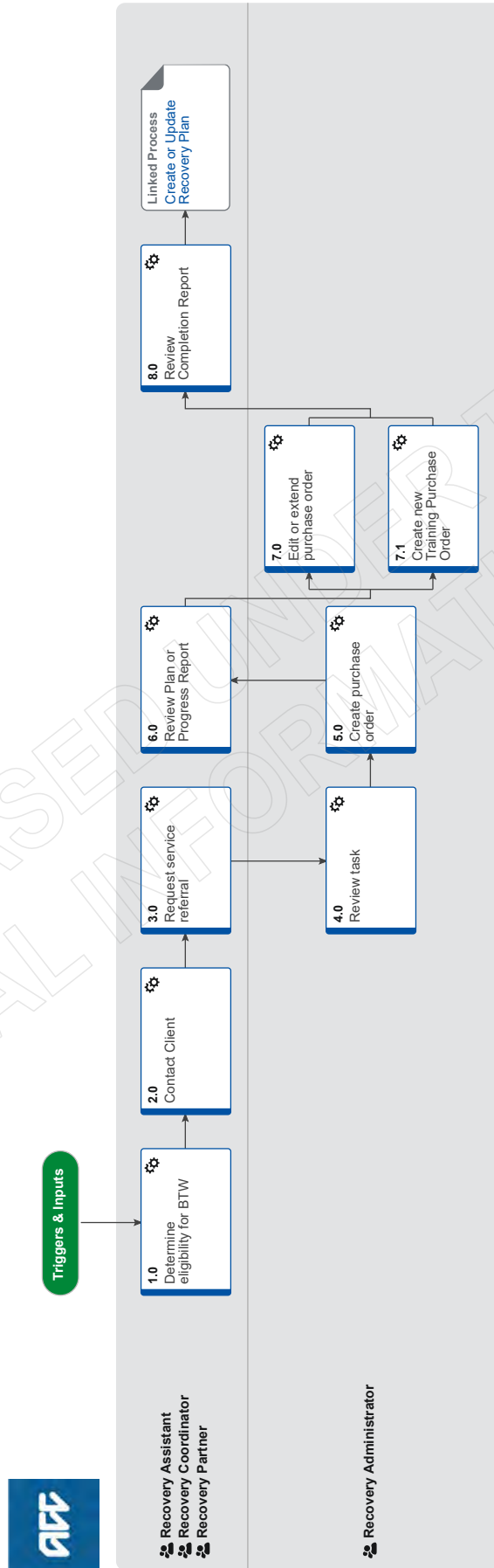
NOTE What details are required for Inland Revenue?

Vendor code: VAQ180. Add as an 'Other Agent'.
Subject: IRD Information Request – Attn: [Requestor's name]; Claim Number; ACCID
Send the email to:
ChildSupportTauranga@ird.govt.nz (unless specifically requested otherwise).

4.0 Complete and close information request

Recovery Administrator

- a File the email correspondence in Eos.
- b Close the task in Eos.



Summary

Objective

To support a client to return to the workforce.

Background

The Back to Work (BTW) service is part of the Vocational Rehabilitation Services (VOC) contracts. For details of these contracts, refer to the service page in Promapp.

The Back to Work service is for those clients who have lost their pre-injury role, but need assistance to regain capacity for the pre-injury work type, obtain new employment, become vocationally independent, or increase their employment participation. The provider will tailor the service to accommodate each client's specific needs and address any barriers to achieving the outcome stated on the referral. The service can be delivered over 3 stages, but depending on their progress they may not have to advance beyond stage one. This service is only for those entitled, or likely to be entitled to weekly compensation.

For more details, refer to the Back to Work service page.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine eligibility for BTW


Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, open Te Kete and review the client's current circumstances.


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.

 Vocational Services Roadmap

 Deemed Cover and Entitlements Policy

- b** Review the following to understand how BTW would benefit your client.

 Back To Work (BTW) Services Service Page

 Vocational Rehabilitation Services Overview (VOC) Service Page

- c** Check the client meets one of the following criteria for Vocational Rehabilitation Services:
- they are entitled to weekly compensation or Loss Of Potential Earnings (LOPE)
 - likely to be entitled to weekly compensation if we don't provide vocational assistance
 - no longer entitled to weekly compensation because they've reached the NZ Superannuation Qualifying Age (NZSQA)
 - on parental leave.

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

Consider an alternative service for the client. This process ends.

- d** Consider the following to determine if BTW is appropriate for your client:

- if a S103 outcome is the goal you are seeking for your client. An Initial Occupational Assessment (IOA) and Initial Medical Assessment (IMA) is not required prior to referring your client to this service.
- if a vocational independence outcome (VI) is the goal you are seeking for your client. An IOA and IMA is required prior to referring your client to this service.

NOTE What if BTW service is not appropriate at this time?

Consider an alternative service for the client. This process ends.

- e** Determine the correct level of support required.

NOTE What if you consider your client will require a more complex VOC service?

Send the referral for stage one and two.

NOTE What if I'm unsure if my client will require a more complex VOC support?

Send the referral for the initial set up only.

NOTE What if your client has lost their pre-injury employment but should make a full recovery?

If your client has lost their pre-injury job, but is expected to make a good recovery, you may use a BTW service to request assistance with returning the client to their pre-injury work type. You should evidence in your referral that the client is expected to make a full recovery from their injury and this is the focus of the BTW service.

You should include relevant information with the referral so that the BTW provider is able to document the range of tasks and activities required in the client's pre-injury role.

Your referral should request that the BTW provider assesses and comments upon the client's current functional capacity to return to their pre-injury work type, and lists the expected timeframes and any other activities (such as a Functional Rehabilitation programme) required to support the client to regain capacity for their pre-injury work type.

Finally, the referral should indicate that if the provider ascertains that the client currently has the capacity to return to their pre-injury role, they should write a letter to the certifying medical practitioner to request the appropriate medical clearance.

Before making the referral, you may wish to discuss the client's needs with the treating providers (Physio, GP etc.).

2.0 Contact Client

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Contact the client or authority to act by their preferred method of communication.

NOTE What if you are unable to contact the client?

1) Attempt a maximum of two contacts over two full working days before leaving a voicemail or sending a notification to request client contact.

2) If you are unable to reach the client, extend the task for an additional two working days and note in the task description that this is the second attempt to contact the client.

3) On the task due date and if there has been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach them by phone letter. The CM04 letter will be populated with client injury details, however you need to update the letter as follows:

'We recently tried to contact you about your injury that happened on [date of accident auto]. I tried calling you to talk about how we may be able to help you recover from your injury/injuries, but haven't managed to get in touch. It would be good to hear from you on how you are progressing or discuss what other support we could offer, please give me a call or email me to arrange a convenient time for me to call you back.'

4) Extend the task date as appropriate to take into account postal delivery and note in the task description this is the third attempt to contact the client and the CM04 letter has been sent.

5) On the task due date and if there has been no contact from the client and they are continuing to receive support, seek internal guidance to determine next steps.

6) If you're in Partnered and no contact is made with the client after 3 attempts, you must contact the provider, GP or other verified contact on the claim.

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

 Identity Check Policy

NOTE What if you determined your client doesn't meet the VOC criteria?


Discuss alternatives with your client. Record this conversation as a contact on the claim. This process ends.

- c** Check the client has granted ACC the authority to collect medical and other records.

 View Client Consent


NOTE What if the client has not granted ACC authority to collect medical and other records?

Go to (NGCM) Obtain Client Authority to Collect Information. Once received, return to this process.

 **PROCESS** Obtain Client Authority to Collect Information

- d** Discuss the following with your client:

- why you are recommending them for this service and a reminder of their rights and responsibilities
- the intended outcome of the service is for them to become "work ready"
- advise the client the service consists of tailored, flexible interventions to meet their needs

 Client Legislative Rights and Responsibilities Policy

- e** Confirm your client understands the purpose of the service and agrees to participate.

NOTE What if the client does not agree to participate?

Find out why the client does not want to participate, consider their reasoning and alternatives. Record this as a contact on the claim. If you are unsure how to proceed go to (NGCM) Seek Internal Guidance.

 **PROCESS** Seek Internal Guidance

- f** Advise the client:

- the Provider will contact them to schedule an appointment
- they are able to have a support person with them
- the Provider will send ACC a plan, progress and completion reports

- g** Check if the client requires a copy of the plan, progress report and completion reports.

NOTE What if the client wants to receive reports?

Record this in the Vocational Life area in the Recovery Plan.

- h** Check if the client has a preferred Provider.

NOTE What if the client has a preferred Provider?

Using the Contracted Suppliers by Geographic Area of Coverage doc, confirm the Provider is contracted for this service and add as a participant on the claim.

If they are not a contracted provider for this service advise alternative Providers to your client and add as a participant on the claim.

 Manage Participants (Eos Online Help)


 Contracted Suppliers by Geographic Area of Coverage

- i** In Salesforce, record the conversation as a contact on the claim.

- j** Add the Agreed Intervention to the Recovery Plan.

NOTE What if you are unsure how to add an Agreed Intervention?

Go to (NGCM) Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

3.0 Request service referral


Recovery Assistant, Recovery Coordinator, Recovery Partner

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

- previous/most recent Vocational Rehabilitation documents
- recent medical information
- current medical certificate
- ACC45
- Individual Recovery Plan
- Curriculum Vitae

NOTE What if there is information missing?

Go to (NGCM) Request Clinical Records. Once received, return to this process.

 **PROCESS** Request Clinical Records

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



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

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

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg Medical records and reports from claim: 100XXXXXXXXX.

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

c 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.

If the claim is a complex mental injury (CMI) claim and you are unable to do the redactions yourself, send an email to Recovery Administration (recoveryadmin1@acc.co.nz) and include the document to be redacted plus your redaction instructions. If you have Adobe Pro and are able to do the redactions yourself, ensure you redact all appropriate information.

d In Eos, create a document group titled 'Back to Work' and add the applicable documents to the group.

-  Manage document groups

e In Eos, generate a Vocational Rehabilitation referral task for a 'Back to Work'. For further information refer to Referring Tasks to Recovery Administration - Principles.

-  Creating Manage Referral Tasks - System Steps
-  Referring Tasks to Recovery Administration - Principles



f Complete the mandatory fields in the e-form.


NOTE What information do you need to include in the task/e-form?

Refer to the 'Manage Referral Task Templates document'

NOTE What if you are asking the provider to complete a function component?

Back to Work Initial Functional rehabilitation requires prior approval from ACC. Ensure you are adding the functional codes for approval in your task to admin. VRB15

-  Manage Referral Task Templates
-  Service Contracts and Contracted Providers - MFP spreadsheet

-  Disclosure of Care Indicator Information to Third Parties Policy

g Consider the timing of the task. The tasks route to the Recovery Administration team with an 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 3.0 Request service referral.

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

4.0 Review task

Recovery Administrator

a Following the task assignment in Salesforce, navigate to Eos and select 'Do Task' from your task queue.

b Check if the task is NGCM - Send Vocational Referral.


NOTE What if this is a NGCM - Admin Request task?

Go to Activity 7.0 Edit or extend purchase order or Activity 7.1 to Create a new Training Purchase Order.

c Review the task to ensure it has the required information to complete the referral form

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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below

-  Principles of Working in the Administration Team


NOTE What if you receive a NGCM - Admin Request task for a re-referral as the Provider is unable to accept a referral?


Continue to Activity 5.0 Create Purchase Order.

5.0 Create purchase order

Recovery Administrator


a In Eos, generate a Purchase Order using referral type Back to Work.

-  NG GUIDELINES Purchase Order Details - Back to Work

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

NOTE What if this is a re-referral?

Locate the original Purchase Order and continue with this process.

-  Creating purchase orders using general + QE

b Identify and select a BTW vendor using the Geographic Location search.

NOTE What if this is a re-referral?

Update the original Purchase Order with the new Provider and continue with this process.

-  Contracted Suppliers by Geographic Area of Coverage

NOTE What if a preferred vendor has been specified in the task?

Select the vendor from the Contracted Supplier by Geographic Area Coverage list. Go to task (d) Approve Purchase Order. If the preferred vendor is not available, contact the referring recovery team member for advice on alternate vendor.


- c** Add the selected Vendor as a participant on the claim.

 Manage Participants (Eos Online Help)

- d** Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Refer to the system steps below.


 Request Authorisation for a Purchase Order - System Steps

- e** Select 'Add documents' and generate the ACC98 referral for Back to Work.

- f** Add additional information received in the task to the referral. For guidance refer to the Admin Template - Back to Work.

 Admin Template - ACC98 Back to Work Referral

- g** Perform privacy checks on the documents in the group.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks


 Privacy Check Before Disclosing Information Policy

- h** Complete the documents and convert them into non-editable PDFs.

NOTE What if there is a document group?

Open document group and link the ACC98 to the group and email to the vendor.

- i** Create and send an email using 'Requests and referrals' template.

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

NOTE What if the email is too large to send as a single email?

Contact the vendor and ask if the referral can be sent by courier. If yes, confirm correct physical address then go to Prepare and Send Client Information by Courier then return to this process. Otherwise, send by email.

- j** In Salesforce, close the referral task.

6.0 Review Plan or Progress Report

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Eos, open the ACC7431 Back to Work initial and progress report.

 ACC7431 BTW Initial and Progress Report

NOTE What if the Provider requests an Initial Functional Rehabilitation component?


Back to Work Initial Functional Rehabilitation requires prior approval from ACC. If approved send request to Recovery Admin to update the Purchase Order with VRB15 code

NOTE What if the provider requests that the client would be more suitable for a Pathways to Employment?


Advise the provider that you consider the referral is the most appropriate for your client.

NOTE What if the Provider or client advised they failed to attend?

Go to Manage Non-Compliance.

 **PROCESS** Manage Non-Compliance

- b** Perform privacy checks on the report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Privacy Check Before Disclosing Information Policy

- c** Determine the suitability of the recommendations or request.

NOTE What if you are unsure about recommendations made in the plan?

Contact the Provider to discuss and negotiate changes. Record this conversation as a contact on the claim. Once an amended report is received (if applicable) return to this process.

NOTE What if the Provider has contacted you to request the Back to Work Service is put on hold?

Discuss the rationale for this request. Based on this discussion, if you decide to put the Service on hold, create a NGCM - Edit Manage Referral Purchase Order with the following information:

- hold start date.
- the hold timeframe.
- purchase order number.
- purchase order code VRSTOP.

Otherwise advise the Provider your decision to decline. Record this conversation as a contact on the claim.

NOTE What if the Provider has contacted you to request the Back to Work Service is reinstated?

Create a NGCM - Edit Manage Referral Purchase Order with the following information:

- reinstatement date for the service.
- new end date for the service.
- purchase order number.
- purchase order code VRGO.

NOTE What if the Provider requests an Obtain Work Trial set-up or monitoring?

No prior approval is required for billing the first Obtain Work Trial set-up and Obtain Work Trial monitoring.

If an additional Obtain Work Trial is requested, review the request from the Provider.

- Check if any barriers identified in the previous Obtain Work Trial have been addressed. If not, these barriers should be addressed prior to approval of an additional Obtain Work Trial.
- Check the Obtain Work Trial job is a work type stated in the Initial Medical Assessment as currently medically sustainable or likely to be medically sustainable.
- Check medical certification has been received from the client's Medical Practitioner.

If the above eligibility criteria are met, consider approving the additional Obtain Work Trial.

To approve this, create an 'NGCM - Edit Manage Referral Purchase Order' task requesting the purchase order be updated with the Obtain Work Trial set-up and monitor codes and notify the provider.

- d Check if the plan has identified additional vocational training components.

NOTE What if the report identifies vocational training components to be paid directly to a third party provider?

Create a NGCM - Admin request task to create a new purchase order. Provide the service item code VT01 for vocational training excluding computer training or VT02 for computer training, vendor code, cost and date range who should be advised of the approval (Training vendor or BTW provider).

NOTE What if the report identifies vocational training components to be paid by the Back to Work Service provider?

Create a NGCM - Edit Manage Referral Purchase Order to add the component to the existing purchase order. Provide service item code VT01 for vocational training excluding computer training and VT02 for computer training, vendor code, cost, purchase order number and date range.

- e Check if the plan has identified the client requires progression to Stage 2, 3 or exceptional of the Back to Work Service. Consider the Provider's rationale as to why Stage 2, 3 or exceptional is required.

NOTE What if you have determined Stage 2, 3 or exceptional is appropriate?

Create a NGCM - Edit Manage Referral Purchase Order' task requesting the purchase order is updated as progress report.

NOTE What if you have determined Stage 2, 3 or exceptional is not appropriate?

Contact the Provider to discuss their rationale. Based on this discussion, if you decide Stage 2, 3 or exceptional is required Create a NGCM - Edit Manage Referral Purchase Order requesting the purchase order is updated as per the providers rationale and the progress report. Otherwise advise the Provider your decision to decline. Record this conversation as a contact on the claim.

- f Check if the client has requested copies of the reports in the Vocational Life area of the Recovery Plan.

NOTE What if the client has requested copies?

Send the reports by the clients preferred method of communication.

NOTE What if the GP or another party request copies of the report?

Provide a copy to the GP and any other stake holders as you consider appropriate (ensuring the client has given permission)

NOTE What if the client advises there is information in the report which is factually incorrect?

Contact the Provider and request the incorrect is updated on the report and an amended report is provided. For further guidance refer to Managing a client's request to change personal information.

- Managing a client's request to change personal information

NOTE What if the client advises they disagree with the opinion provided the assessor in the report?

The client can supply a 'statement of correction' to ACC which is then included with the report. This means any time the report is sent out, the statement of correction must be sent as well.

7.0 Edit or extend purchase order

Recovery Administrator

- a Based on the type of request check the following has been provided in the task:

STAGE 2, 3 or exceptional:

- Purchase Order Number
- Purchase Order Code
- Date range

Obtain Work Trial:

- Purchase Order Number
- Purchase Order Code
- Date range

ON HOLD:

- Purchase Order Number
- hold start date
- the hold timeframe
- purchase order code VRSTOP

REINSTATE:

- Purchase Order Number
- reinstatement date for the service
- new end date for the service
- purchase order code VRGO

NOTE What if there is information missing?

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

- Principles of Working in the Administration Team

- b In Eos, to locate the purchase order:

- click on "Search for a claim"
- select the "Purchase Order / ACC32 Number" tab
- paste the purchase order number into the 'purchase order number' field
- select "Open"

- c Update the purchase order using the following instructions:

- select "Add" to add a new line
- select the 'Intervention' then 'Ok'
- search for the purchase order code
- select 'Add to list' then 'Ok'
- add the information provided in the task then 'Ok'

- d Approve the purchase order.

NOTE What if the request is for a VRSTOP or VRGO?


No approval required. Save the purchase order, this process ends.

NOTE What if the purchase order requires a higher delegation?

Refer to the system steps below.

- Request Authorisation for a Purchase Order - System Steps

- e Create and send an email using the 'Purchase Order Approval and Extension' template.

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

f In Salesforce, close the task.

NOTE What if you're unsure how to progress?

Go to Seek Internal Guidance

 **PROCESS** Seek Internal Guidance

7.1 Create new Training Purchase Order


Recovery Administrator

a Check the following has been provided in the task:


- Purchase Order Code
- Name of vendor
- Date range
- Cost
- Confirmation of where to send the approval

NOTE What if there is information missing?

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

 Principles of Working in the Administration Team

b In Eos, generate a Purchase Order using General+QE.

 Creating purchase orders using general + QE


c Add the selected Vendor as a participant on the claim.

 Manage Participants (Eos Online Help)

d Approve purchase order.

NOTE What if the purchase order requires a higher delegation?

Refer to the system steps below.

 Request Authorisation for a Purchase Order - System Steps

e Create and send an email using the 'Purchase Order Approval and Extension' template.

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

f In Salesforce, close the task.

 **PROCESS**

Create or Update Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner


8.0 Review Completion Report

Recovery Assistant, Recovery Coordinator, Recovery Partner

a In Eos, open the ACC7980 Back to Work completion report.

 ACC7980 BTW Completion Report

b Perform privacy checks on the report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

 Privacy Check Before Disclosing Information Policy

c Check if the client has requested copy of the report in the Vocational Life area of the Recovery Plan.


NOTE What if the client has requested a copy?

Send the reports by the clients preferred method of communication.

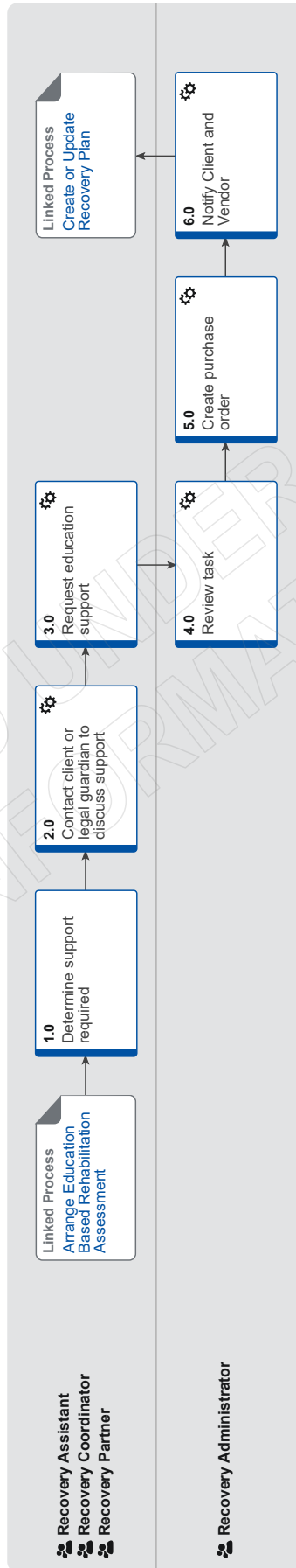
d Open the Agreed Intervention in the Recovery Plan and add the outcome.

NOTE What if you are unsure how to add the outcome?

Go to Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

e Determine the next steps to progress the client's recovery.



Summary

Objective

To action a request or need for support so the client receives it at the right time during their recovery journey. In many cases setting up supports takes place after a social assessment has been completed.

Background

Social supports provide assistance to restore a client's independence to the maximum extent practicable. This assistance may include providing non-acute rehabilitation, residential support, aids and appliances, attendant care, housing modifications or transport for independence. We contract with providers to assess clients' needs for social rehabilitation assistance

These are supports for clients aged 21 or under who are undertaking early childhood, primary, intermediate or secondary level education and require injury related support.

Owner [Out of Scope]
Expert [Redacted]

Procedure

PROCESS **Arrange Education Based Rehabilitation Assessment**
 Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Determine support required

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review the approved Education based rehabilitation assessments (EBRA) and identify the type of support requested. For more information on education supports, refer to the policy page below.

 About education support Policy

NOTE **What if an Education Based Rehabilitation Assessment has not been completed?**

Go to the process below

PROCESS Arrange Education Based Rehabilitation Assessment

2.0 Contact client or legal guardian to discuss support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Contact the client or legal guardian and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- b Explain that you are referring the client for this support, why the support is required and what their rights and responsibilities are. Make sure the client or legal guardian understands and agrees with the support.

 Client Legislative Rights and Responsibilities Policy

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

Refer to the process below

PROCESS Obtain Authority to Act (ATA)

NOTE **What else do you need to discuss with the client?**

Advise the client that the provider will be in touch to arrange the support.

NOTE **How do you manage participants on a claim?**

The Recovery Team Member must ensure all known participants are loaded on the claim and then removed when they are no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

- c In Salesforce, add a contact to record the conversation with the client/guardian.

NOTE **What do you have to do to document your decision?**

To document your decision please refer to the '(NGCM Document Recovery Decisions' process below.

PROCESS Issue Recovery Decision

- d Ensure to add the support as an intervention in the Recovery Plan.

NOTE **How do you update the Recovery Plan?**

Go to the process below.

PROCESS Create or Update Recovery Plan


3.0 Request education support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a In Eos, create a document group specific to the support approved. In the document group description field enter the service type 'Education Support worker service', 'Teacher Aide service' or 'Tutor service' and today's date. Refer to the system steps below to confirm how to create a document group.


NOTE **What documents do you need to include?**

A completed ACC345 Education Support Assessment Report or a recently completed Support Need Assessment Report

 Manage document groups

- b Perform privacy checks on the documents.

 Privacy Check Before Disclosing Information Policy

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE **What if information needs to be redacted?**

Send a NGCM admin request task to say please call when available- redactions needed to be applied to referral file/document.

 NGCM - Redact information from PDF documents


- c In Eos, select the vendor (service supplier) and check if they are registered.


NOTE What if the service supplier is registered but not active?

Contact Health Procurement to have the registration activated.
Provide the service item codes that are required.

NOTE What if the service supplier is not registered as a vendor with ACC?

Email the service supplier the document 'Register to be a vendor'.
This has a link for the supplier to register online at acc.co.nz.

 Register to be a vendor.docx

 Service Contracts and Contracted Providers - MFP spreadsheet

- d** In Eos generate a 'NGCM - Admin Request' task to Recovery Administration for Education support services.

NOTE What details do you include in the task?

- Service Type that needs to be implemented – Education Support Worker, Teacher Aide or Tutor.
- Additional information relevant to the specific service type such as reports, documents and forms to be included.
- The name of the registered vendor recommended in the ACC345 Education Support Assessment Report .
- The name and contact details of the pre-school.
- Purchase order service items codes required.
- Hours per week.
- Start date.
- Length of time.

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.

 Disclosure of Care Indicator Information to Third Parties Policy

 NG GUIDELINES Purchase Order Details - Education Support

 Contracted Suppliers by Geographic Area of Coverage

- e** Consider the timing of the task. The tasks route to the Recovery Administration team with an 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 request is required in the future, set a reminder task for the future date when the service will be required. When the reminder task comes up send a task to Recovery Administration to continue with the process. Consider the contract timeframes and SLAs as specified in the service page.


4.0 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?


If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below.


 Principles of Working in the Administration Team

5.0 Create purchase order

Recovery Administrator

- a** In Eos, generate a purchase order for the approved support. Refer to the purchase order documents below for more information.

 Creating purchase orders using general + QE

 NG GUIDELINES Purchase Order Details - Education Support

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

- b** Locate contracted vendors via the Geographic Location search, this must be done even if the vendor details are provided in the task. Once selected add the vendor as a 'Vendor - Contracted' participant in Eos.

 Manage Participants (Eos Online Help)


 Contracted Suppliers by Geographic Area of Coverage


NOTE How do you search for a vendor


Refer to 'Search for a party'.


 Search for a Party

- c** Approve the purchase order and the generate the relevant purchase order documents, for new purchase orders and extensions, as shown below.

 ACC5967 Terms of agreement for education support services


 EDS01 Education support approve - client

 EDS05 Letter of agreement for tutors and teachers aide - school

 ACC255 Kōrero mai - Working together

NOTE What if you do not have the delegation to approve the purchase order?

- 1) Save the purchase order.
- 2) Create and send a Request Authorisation task to a Recovery Administration Leader for a purchase order approval.
Follow the link below.

 Request Authorisation for a Purchase Order - System Steps

6.0 Notify Client and Vendor

Recovery Administrator

- a** Check the client's preferred communication channel (SMS, email, etc), and if the client has a safe contact (if this has not been included in the referral task). Consider the email and instant messaging policy below.

 Email and Instant Messaging Policy

NOTE How do you confirm if the client has a safe contact?

Refer to View a safe contact (Eos Online Help)

 View a safe contact (Eos Online Help)

- b** Send the relevant approval letters to the client or legal guardian. If sending via email ensure you have replied to the message quarantined email required.

NOTE How do you send a notification to a client?

Refer to Create a Notification - System Steps.

 Create a Notification - System Steps


- c** Create and send an email to the vendor using the appropriate email template, and attach the relevant documents.

NOTE What if the approval is for Education Support Worker services?

Send an ACC5925 Education Support Worker referral form


NOTE What if the approval is for a Teacher Aides and Tutor services?

Send an ACC5967 Terms of agreement for education support services form for the vendor to sign and return

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

NOTE What if the vendor requires the documents to be sent via courier?


Refer to the packing guide below.

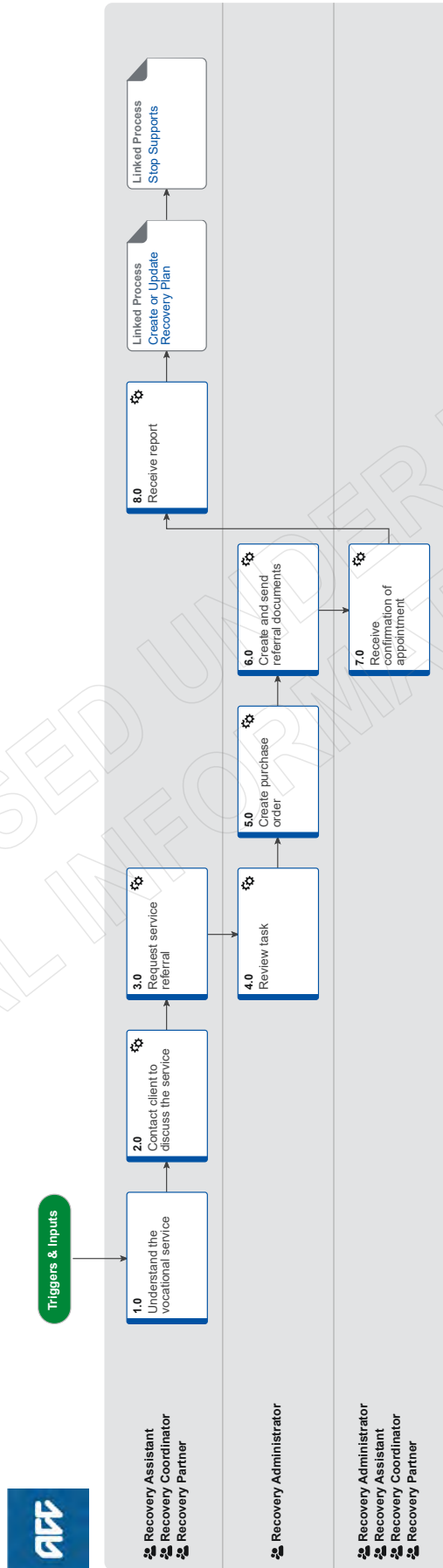
 Packing guide.docx

- d** Close the referral task

NOTE What if you are advised by a Provider they are unable to accept a referral?

Go to Activity 5.0 (a) and complete a re-referral.

 **PROCESS Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner



Summary

Objective

To assist a client to search for employment.

Background

The Job Search service is part of the Vocational Rehabilitation Services (VOC) contracts. For details of these contracts, refer to the service page in Promapp.

The Job Search service is for those clients who are considered Vocationally Independent and require assistance to job search during the three-month period before their weekly compensation entitlement ends. It should be offered to all clients assessed as Vocationally Independent, participation is voluntary

For more details, refer to the Job Search service page.

Owner

[Out of Scope]


Expert

Procedure

1.0 Understand the vocational service

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review information on providing the Job Search service, including what's involved and any prerequisites.

 Gather Additional Information or Advice

NOTE **Where do you find information about this service?**


Read the information about the Job Search service and VOC on the links below.

-  Job Search Service Page
-  Vocational Rehabilitation Services Overview (VOC) Service Page

- b Confirm the client's eligibility for the Job Search service.

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

2.0 Contact client to discuss the service

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Check that the client has granted ACC the authority to collect medical and other records.


 View Client Consent

NOTE **What if the client has not granted ACC authority to collect medical and other records?**

You will need to obtain the client's authority to collect medical and other records. Refer to (NGCM) Obtain Client Authority to Collect Information.


 **PROCESS** Obtain Client Authority to Collect Information

- b Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

 Identity Check Policy

- c Explain that you are referring them to the Job Search Support service, what the service will do and what their responsibilities are. Ensure that your client understands and agrees with the referral

Note that this service is entirely voluntary for the client.

 Client Legislative Rights and Responsibilities Policy


NOTE **What else do you need to discuss with the client?**

- the provider will be in touch to arrange a suitable appointment
- they are welcome to have a support person accompany them
- the provider will send us a report which we will send them a copy of.

Ensure your client understands the purpose of the service and the possible outcomes. The reasons for the support should be based on the agreed vocational rehabilitation recorded on the client's Recovery Plan (RP).

NOTE **What if the client does not agree to participate?**

This service is voluntary, therefore if the client does not wish to participate, cancel the service and close the referral.


 Decline Entitlement When Client is Non-compliant Policy

- d In Salesforce, add a contact note as a record of the conversation.

- e Add the agreed intervention to the Recovery Plan.


NOTE **How do I update the Recovery Plan?**

Go to (NGCM) Create or Update Recovery Plan.

 **PROCESS** Create or Update Recovery Plan

NOTE **How do you manage participants?**

The Recovery Team Member must ensure all known participants are loaded on the file and then removed when they are no longer relevant. For information on how to manage participants, refer to Manage Participants (Eos Online Help).

 Manage Participants (Eos Online Help)

3.0 Request service referral

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a In Eos, find all the documents that need to be sent along with the referral.

NOTE **What documents do you send with the referral?**

- VIO6 Notification of vocational independence and end of weekly compensation - client letter
- Vocational Independence Occupational Assessment (VIOA) report and CV
- Most recent Back to Work report.

NOTE What do you do if you don't have all the information to complete the referral?

If you require further information, follow the process link below.
Once you have requested the information required, create a reminder action and set the target date for when you expect to receive the information.

 Gather Additional Information or Advice

b Perform privacy checks on documents.


 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

Check documents:


- are relevant to the referral
- do not contain any third-party information
- do not contain any unnecessary sensitive personal information.

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

 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, before adding the document to the document group.

 NGCM - Redact information from PDF documents

c Create a referral-specific document group and enter 'Job Search service' and today's date in the document group description field.

d Add the documents to the group.

NOTE What if there are documents from other claims that are relevant to the assessment?

When a request for a referral is required and the supporting documents are on another claim, it is important to transfer the documents to the relevant claim. This will ensure the right documents support the recovery decisions for each claim.

To transfer documents from one claim to another:

- Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
- Open PDF document from email link
- File the PDF away to the relevant claim
- Repeat these steps if there is relevant documents on multiple relevant claims

The PDF should also be renamed something short but relevant, and identify which claim number the information came from, so it is included/printed in further referrals or copy files. E.g. Medical records and reports from claim: 100XXXXXXXXX


Please do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.


 Manage document groups


e Generate a Vocational Rehabilitation referral task to Administration for a 'Job Search service'.

NOTE How do you refer a task to Recovery Administration?

Please see Referring Tasks to Recovery Administration - Principles for further information and guidance.

 NG GUIDELINES Purchase Order Details - Job Search

 Referring Tasks to Recovery Administration - Principles

 Service Contracts and Contracted Providers - MFP spreadsheet

NOTE How do you generate and send a referral task to Administration for the service?

Go to NGCM Create a Referral Task.

 Creating Manage Referral Tasks - System Steps

 Contracted Suppliers by Geographic Area of Coverage

NOTE What information do you need to include in the referral task?

- Geographic location
- Vendor preference, if applicable
- Client's covered injury
- Return to work outcome target date is 3 months from the date the VI decision was issued
- Provide the correct service code. Refer to the Purchase Order guidelines.

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

- Call Recovery Administration
- Give the Recovery Administrator who answers the call the claim number
- The Recovery Administrator will open the claim in Eos and find the task on the claim
- Transfer the task into the Recovery Administrator's name. This will move it to their personal Eos queue and stop it from being reallocated by Salesforce.

NOTE What if the request is required in the future?

If the request is required in the future, set a reminder task for the future date when the service will be required. When the reminder task comes up send a task to Recovery Administration to continue with the process. Consider the contract timeframes and SLAs as specified in the service page

NOTE What are the SLAs?


The referral tasks route to the Recovery Administration team with an SLA of 24 hours.

f Complete all the mandatory fields and any additional information to be included in the ACC98 referral form.

NOTE What if your client has a Care indicator?

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of Care Indicator Information to Third Parties Policy

4.0 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 the target date needs clarification?


Target date clarification may need to be sought in the following situations:

- Target date has passed
- Target date is in 0-6 weeks time
- You are unsure of the target date based on the information provided

If this is the case, go to NG PRINCIPLES Working in the Administration Team in below Note.

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




If required information is missing from the task, or you need guidance on working within the Administration Team, go to NG PRINCIPLES Working in the Administration Team.

 Principles of Working in the Administration Team

5.0 Create purchase order

Recovery Administrator

- a** In Eos, generate a Purchase Order for the specified referral and use the entitlement type: VRJ02.

-  Creating purchase orders using general + QE
-  NG GUIDELINES Purchase Order Details - Job Search
-  Purchase Order - Handy Hints on how to create and edit POs



- b** Identify and select the vendor.

NOTE What if a vendor has not been specified?


If no vendor has been specified, select an appropriate contracted vendor for the referral type in the client's geographic area.

NOTE What if the Vendor hasn't been added as a participant?

Add the Vendor as a participant.

-  Manage Participants (Eos Online Help)
-  Contracted Suppliers by Geographic Area of Coverage


- c** Locate the contracted vendor via the Geographic Location search, once selected add the vendor as a 'Vendor - Contracted' participant in Eos.

-  Contracted Suppliers by Geographic Area of Coverage

- d** Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Refer to the 'Request Authorisation for a Purchase Order - System Steps'.

-  Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a limited payment error message when authorising the purchase order?

If you have received a request to amend a purchase order or create a purchase order for client reimbursements, change the limited payment indicator.

- 1). In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2). Select 'OK'.
- 3). Go back to the purchase order to authorise.

Once you have authorised the purchase order and notified the vendor please remember to change the Limited Payment List Indicator to 'Yes'.

6.0 Create and send referral documents

Recovery Administrator

- a** Create the referral for the Job Search service.

-  ACC98 ACC referral for Vocational Services

- b** Populate with any extra information noted on the referral task.

- c** Check the task to ensure all relevant information is captured before you exit the document.

NOTE What does a quality referral look like?


Refer to Admin Template - Job Search Referral.

-  Admin Template - ACC98 Job Search Referral


- d** Ensure you have completed the document (to convert the document into a non-editable pdf).

- e** Link the referral to the document group 'Job Search service'.

- f** Perform privacy checks using NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.

-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks


- g** Create an email using the Requests and referrals template, attach the referral and documents from the group and select the most appropriate email address (commonly listed under General Purchasing).

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

- h** Send the referral to the vendor.

NOTE What if the Vendor requires the documents to be sent via courier?

Go to Prepare and Send Client Information by Courier process.

-  **PROCESS** Prepare and Send Client Information by Courier

- i** In Salesforce, closed the assigned referral task.

7.0 Receive confirmation of appointment

Recovery Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive confirmation of the appointment from the provider and file the email away to Eos.

NOTE What if the provider is unable to accept the referral?

If the provider is unable to accept the referral, then resubmit the request with a new provider.

NOTE What if the client fails to attend the appointment?

If the client fails to attend the appointment or take part in the activities, you should find out why.
If they no longer want to participate, cancel the service.


8.0 Receive report

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive notification that the ACC5956 Job Search - Initial Plan and Completion Report has been attached to the claim.

NOTE What will the provider submit to ACC?


Providers are expected to submit a report using the ACC5956 form. They will provide an initial report, an update on progress when exceptions occur to the service and a completion report.

 ACC5956 Job Search Initial Plan and Completion Report

- b Review the report. Refer to Job Search Service Page for guidance.

 Job Search Service Page

- c Perform privacy and relevancy checks on the report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- d Discuss with the provider any questions you have and agree on a timeframe for completing an amended report, if required.

- e Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.


 Identity Check Policy

- f Discuss report and provide a copy to the client.

NOTE What if the client requests that the report is changed or incorrect?


A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc). If it is the opinion of an assessor or provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Refer to Managing a client's request to change personal information (CHIPS).

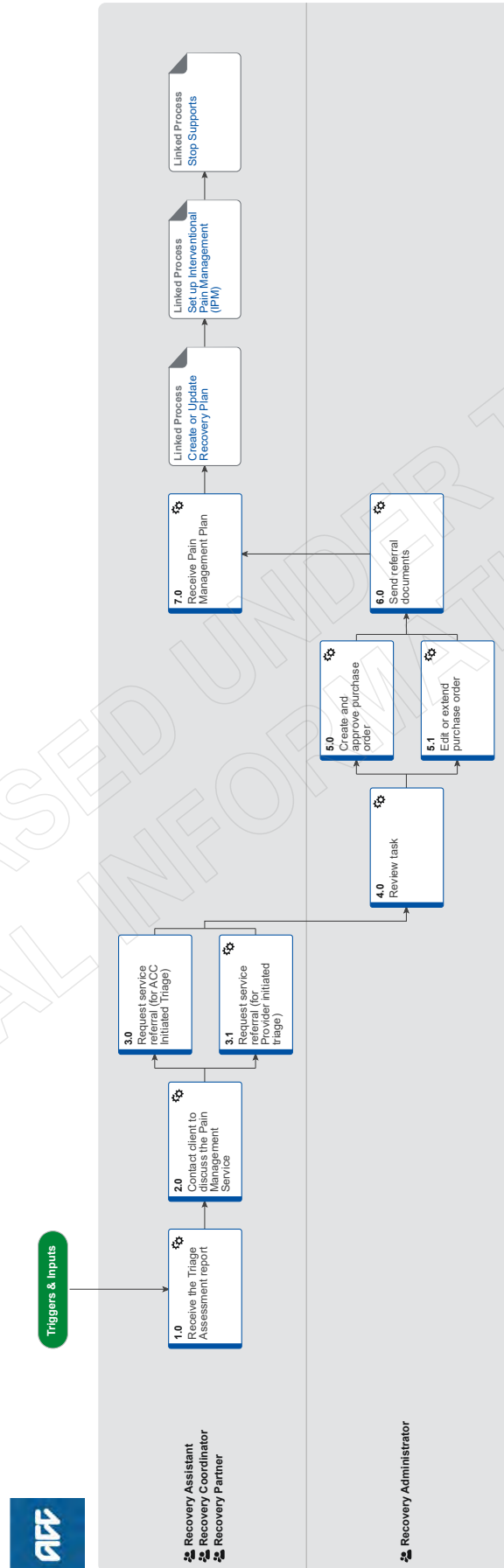
 Managing a client's request to change personal information

- g In Salesforce, add a contact note as a record of the conversation.

- h Update the Recovery Plan with the outcome of the intervention.

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Stop Supports**
Recovery Assistant, Recovery Coordinator, Recovery Partner



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Summary

Objective

To consider whether a client should be referred into a Pain Management Service following receipt of the pain management triage assessment report and set up the program.

Background

The Pain Management Service has been designed to improve clients' outcomes and experience by reducing the impact of pain following an injury.

The Pain Management service is for clients who:

- have, or are at risk of developing, pain-related disability following an injury.
- have persistent pain that is preventing them from returning to work or usual activities.
- have persistent pain and significant pain-related disability.

The Pain Management Service has been designed to provide clients with a multi-disciplinary approach to help the client achieve the following goals:

- return the client to either their usual daily activities and/or work (in conjunction with the Vocational Rehabilitation Service) or the highest level of independence achievable.
- enable clients to use pain management strategies to reduce the impact of pain on their day-to-day functioning.
- increase the client's knowledge about the pain they are experiencing.

Owner

[Out of Scope]

Expert

Procedure


1.0 Receive the Triage Assessment report

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review the ACC7984 Triage assessment report to confirm which plan is being recommended. Refer to Pain Management Services Service Page for guidance.

NOTE What if a triage assessment has not been completed?

Triage assessment is mandatory for entry into pain management services. Return to process [set up pain management triage process] to refer for triage assessment. This process ends.

-  **PROCESS** Set Up Pain Management Triage Assessment

NOTE What if there is a request for a Tertiary Service?

Triage assessments for entry into Tertiary Service is optional.





The Tertiary Service provider may complete their own triage assessment regarding suitability of their service, along with other onward referral options if their service is not appropriate. Ideally this will be part of good communication with other treating clinicians involved in the client's care.

All requests for Tertiary Delivery Services (Outpatient and Intensive) will need to be reviewed by a Recovery Support Advisor in the first instance (via hotline and written if requested by the Advisor).

- When there is a psychology clinical question this is to be reviewed by a Psychology advisor.
- Where there is possible Complex Regional Pain Syndrome (CRPS) this is to be reviewed by a Medical advisor

Continue to Activity 2.0 if the request is supported by the Recovery Support Advisor

-  **PROCESS** Seek Internal Guidance

-  Identify Claims for Rapidly Deteriorating Clients
-  Overview of Tertiary Services for Pain Management Service Page
- b** Perform Privacy and Relevancy checks on the received report.
-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
- c** File away the report to Eos. When Filing Away, include a description for the document.
-  NGCM Filing Away - System Steps
- d** Read the triage report to consider recommendations.

NOTE You need to consider the following:

- Has a new diagnosis been identified? Confirm cover
- Are the recommendations appropriate? If recommendations do not fit with the client's situation, respond to the provider to seek clarification
- Does the client meet entry criteria for pain services?
- Are there alternative options identified to pain services? Discuss with client and consider referral to other services, process ends here

NOTE What if the request is for a repeat service?

Repeat pain services will only be in exceptional circumstances.

Seek internal guidance prior to making a decision on repeat services.

NOTE What if there is a recommendation for a Group Programme?

Prior approval is not required for eligible claimants to enter Group Programme services. This is a trial until 30 June 2024.

Ensure you have details of the supplier providing the Group Programme and update the recovery plan. Process ends here.

-  Seek Internal Guidance


NOTE What if the recommendation is not to proceed with Pain Management services?


There will be situations where other services outside Pain Management are recommended. Consider the recommendations for the client and action as appropriate. This process ends.

NOTE What if you are declining a Pain Management service recommendation

Contact the provider that submitted the ACC7984 Triage assessment report to discuss the decision and reason for the decline


- e Provide a copy of the triage assessment report to the client and key stakeholders, if required.

 Disclosure of Clients' Health Information to Employers Policy


 Send letters from Client Recovery and Claims Assessment

NOTE What if the client requests that the report be changed or claims that is incorrect?

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, Incorrect name spelling) etc. If it is the opinion of an assessor or Provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

 Managing a clients request to change personal information

- f Update the agreed intervention as appropriate on the recovery plan.

 Pain Management Services Service Page

2.0 Contact client to discuss the Pain Management Service

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a Contact client to discuss recommendations.

NOTE What if the recommendation is to approve the service?

Contact the client to discuss recommendations and gain clients agreement to participate in the recommended level of service. If ACC have not previously discussed the Pain Management Service with the client, remind client of their rights and responsibilities and update the recovery plan

NOTE What if the decision is to decline the recommended service?

- Phone the client to advise the decision.
- Advise the client the reasons why, and offer alternatives to the client.
- Generate the SER01 Decline Service and modify as needed and send to the client as per their communication preference.
- Ensure that the provider has been made aware of the decline decision.

 SER01 Decline service - client letter

- b Update salesforce recovery plan. If the original triage referral was made by ACC, proceed to activity 3.0.

NOTE What if you are approving a Pain Management Service that was not referred by ACC?

Proceed to Activity 3.1 Request service referral (for Provider Initiated Triage Referral) and update the recovery plan with the Pain management services agreed intervention

NOTE What if you want to use a different provider for Pain Management Service?

Discuss with client why you are considering a different provider eg already on a SAW, previously established relationship. Proceed to activity 3.1 Request service referral (for Provider Initiated Triage Referral) to setup a new purchase order for the provider to carry out for the recommended services.

3.0 Request service referral (for ACC Initiated Triage)

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Create NGCM Edit Manage referral Purchase Order Task.

NOTE What information do you need to include in the Edit manage referral purchase order task?

ACC initiated referral – AMEND current purchase order


- Purchase order number:
- Vendor name & ID:
- Service code and name of support:
- Date range (Generally six months):
- Document group name (if relevant):


Information to include in approval email to provider

- Care indicator details (if applicable):
- Any other relevant information to assist provider with programme planning & implementation (including known barriers or special conditions not identified in the triage report, any changes in client circumstances, any clinical or Recovery Support recommendations or advice received since triage):

NOTE How do you refer a task to Recovery Administration?

Refer to the 'Referring Tasks to Recovery Administration - Principles' process for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

 NG GUIDELINES Purchase Order Details - Pain Management Services

3.1 Request service referral (for Provider initiated triage)

Recovery Assistant, Recovery Coordinator, Recovery Partner


- a In Eos, create a referral-specific document group and enter 'Pain Management service' in the document group description field.
- b Locate the documents that need to be sent with the specified pain management service referral.

NOTE What documents do you send with the specified pain management service referral?

- Most recent medical certificate
- GP notes
- Specialist notes
- Imaging results
- Physiotherapist notes
- Pain screening results (Orebro) – (if on file)
- Integrated Rehabilitation Assessment (IRA) – (if on file)
- Most recent/current vocational rehabilitation documents eg Back to Work, Stay at Work, Standalone Workplace Assessment Reports
- Any written guidance information from Recovery Support
- Signed ACC6300 or ACC6300D Authority to collect medical and other records. NOTE: If verbal consent was provided please note this in the task eform for Recovery Admin.

NOTE What do you do if you don't have all the information to complete the referral?

If you require further information, follow the process link below.
Once you have requested the information required, create a reminder action and set the target date for when you expect to receive the information.

 **PROCESS** Request Clinical Records

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

NOTE What if there are relevant documents on other claims?

Create a copy and transfer to the other claim.

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

Provide a short and descriptive title to the document properties in the PDF and state the claim number the information came from eg Medical records and reports from claim: 100XXXXXXXXX

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


- d** Perform privacy checks on documents.

 Privacy Check Before Disclosing Information Policy

NOTE What do you need to check?

- Check that all documents:
- are relevant to the referral
 - do not contain any third-party information
 - do not contain any unnecessary sensitive personal information

For details on what checks you need to complete before sending documents out, refer to NG SUPPORTING INFORMATION Inbound and Outbound Document Checks.


 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if Mental Injury Claim information needs to be sent from a Physical Injury Claim?


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

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

Send an email to Recovery Administration (recoveryadmin@acc.co.nz) or (recoveryadmin1@acc.co.nz for complex mental injury) and include the document to be redacted plus your redaction instructions, before adding the document to the document group.

 NGCM - Redact information from PDF documents

- e** Add the documents to the group.


 Manage document groups

- f** Locate the Pain Management Service Provider, using the Contracted Suppliers by Geographic Area of Coverage and add them as a participant on the claim.

 Contracted Suppliers by Geographic Area of Coverage

NOTE How do you add a participant?


Refer to the system steps below.

 Add a participant

- g** In Eos, at Recovery Plan level, Add Activity, select Choose Activity and create "NGCM - Admin Request" Task.

NOTE How do you refer a task to Recovery Administration?

Refer to the 'Referring Tasks to Recovery Administration - Principles' process for further information and guidance.

 Referring Tasks to Recovery Administration - Principles

NOTE What information do you need to include in the admin request task?


Provider initiated referral – CREATE new purchase order

- Vendor name & ID (Clearly name any Vendors to be excluded if you are changing provider):
- Service code and name of support:
- Date range (Generally 6 months):
- Document group name (if relevant):
- Reason for referral
- Expected Outcome
- Rehabilitation goals and targets agreed by client & ACC:
- Care indicator details (if applicable):
- Any other relevant information to assist provider with programme planning & implementation (including known barriers or special conditions not identified in the triage report, any changes in client circumstances, any clinical or Recovery Support recommendations or advice received):

NOTE What if your client has a Care Indicator?

You need to clearly outline this in the e-form.

Refer to Disclosure of Care Indicator Information to Third Parties Policy for more information on how information is disclosed.

 Disclosure of care indicator information to 3rd parties policy

 NG GUIDELINES Purchase Order Details - Pain Management Services

- h Consider the timing of the task. The task routes to the Recovery Administration team, with an SLA of 24 hours.


4.0 Review task

Recovery Administrator

- a In 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 there is information missing?

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

 Principles of Working in the Administration Team

- c Determine if task requires a new purchase to be created, or a current purchase order to be amended.

NOTE What if the task is 'edit manage referral purchase order' labelled 'ACC initiated referral – AMEND current purchase order'?

Proceed to activity 5.1 to edit or extend purchase order.


NOTE What if the task is labelled 'Provider initiated referral – CREATE new purchase order'?


Proceed to activity 5.0 to create and approve purchase order.

5.0 Create and approve purchase order

Recovery Administrator

- a In Eos, generate a Purchase Order for the service referral using the guideline below.

 Creating purchase orders using general + QE

 NG GUIDELINES Purchase Order Details - Pain Management Services

- b Locate contracted vendors via the Geographic Location search which must be done even if the vendor details are provided in the task. Once selected, add the vendor as a 'Vendor - Contracted' participant in Eos.


 Contracted Suppliers by Geographic Area of Coverage


- c Approve the Purchase Order.

NOTE What if the Purchase Order requires a higher delegation?


Save the Purchase Order. Create and send a Request Authorisation task to a Recovery Leader for a Purchase Order approval.

Refer to the link below.

 Request Authorisation for a Purchase Order - System Steps

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

- d Create and send an email to the Provider using the 'Purchase Order Approval and Extension' template including any additional information provided by the Recovery Team Member. You do not need to create a referral document

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

- e Go to activity 6 Send referral documents

5.1 Edit or extend purchase order

Recovery Administrator

- a In Eos, locate the purchase order

NOTE How do I locate the Purchase Order?

1. click on "Search for a claim"
2. select the "Purchase Order / ACC32 Number" tab
3. paste the purchase order number into the 'purchase order number' field
4. select "Open".

- b Update the purchase order


NOTE How do I update the Purchase Order?

1. select "Add" to add a new line
2. select the 'Intervention' then 'Ok'
3. search for the purchase order code
4. select 'Add to list' then 'Ok'
5. add the information provided in the task then 'Ok'.


- c Approve the Purchase Order.

NOTE What if the purchase order requires a higher delegation?

Refer to the system steps below.

 Request Authorisation for a Purchase Order - System Steps

- d Create and send an email to the Provider using the 'Purchase Order Approval and Extension' template. You do not need to create an additional referral document

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


- e In Salesforce, close the task.

- f Go to activity 6 Send referral documents.

6.0 Send referral documents


Recovery Administrator

- a Create and send an email to the Provider using the 'Purchase Order Approval and Extension' template adding any additional information received in the task to the email. You do not need to create an additional referral document

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

NOTE What if the Vendor requires the documents to be sent via courier?

Go to Prepare and Send Client Information by Courier process.

 **PROCESS** Prepare and Send Client Information by Courier

NOTE What if the referral is for a Tertiary pain management service?

Create and send an email to the Tertiary Pain Management Provider using the 'Purchase Order Approval and Extension' template adding the below information into the email

We have approved Purchase Order number [xxxxxx] for:

Client Name:
Client contact details:
Client location:
Date of birth:

Service Code:
Date From:
Date To:
Total Units:



Reason for referral:

Expected outcome:

- b** Perform privacy checks using Inbound and outbound document checks.

NOTE What if the referral contains sensitive personal information?

If the referral contains unnecessary sensitive personal information, refer to NG PRINCIPLES Working in the Administration Team, for information and guidance on redactions, password protecting documents and sending passwords to providers.

-  Principles of Working in the Administration Team
-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- c** Create and send an email to the client attaching the PAI01 Approve Pain Management service letter and the PAIIS01 All about the Pain Management service.

- d** In Salesforce, close the assigned task.

NOTE What if you have been advised by a Provider they are unable to accept a referral?

Go to activity 5.0a and complete a re-referral.

7.0 Receive Pain Management Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive ACC6272 Pain Management Plan Report and file away the report to Eos.

-  NGCM Filing Away - System Steps

NOTE What is the ACC6272 Pain Management Plan?

Once the client has been assessed, the Pain Management provider will submit an ACC6272 Pain management plan, review, update and completion report. The report contains the client's pain management plan, their progress and the final completion report.

- b** Review the report. Refer to Pain Management Services Service Page for guidance.

NOTE What if the assessment includes a request to transition to Community Services Level Two?

Prior approval from ACC is required. The Provider should provide evidence to ACC that there has been a change in the client's clinical presentation or overall condition, that they now meet criteria for Community service level two and any other services outside of pain management services have been ruled out.

Only the Transition fee is payable in addition to the payment for Community Service Level One. Do not load a Community Service Level Two code if a Community Service Level One code has already been loaded.

If approving, create a NGCM Admin Request task to instruct Recovery Administration to update the existing purchase order with the transition fee service code.


Notify the provider and client if ACC are approving, declining or looking into the request to transition to Community Services Level Two. For more information on Community Services Level Two refer to the Service page below.

-  Community Services Stage Two Service Page

NOTE What if the assessment recommends request for Tertiary Inpatient services

The provider should provide detailed rationale for inpatient services. Discuss with your team leader and use the decision tree to consider if clinical guidance is required.

If approving, create a NGCM Admin Request task to instruct Recovery Administration to update the existing purchase order. Notify the referring provider and client if ACC are approving, declining or looking into the request.

-  Overview of Tertiary Services for Pain Management Service Page

NOTE What if the client requires accommodation for Tertiary inpatient services at TARPS/ Auckland DHB

By agreement, ACC will be fully funding transport and accommodation costs during the service (Mon – Fri) for clients engaging in tertiary inpatient services at TARPS (The Auckland Regional Pain Service). Ensure the accommodation is of good standard and that the needs of the client have been considered eg: adequate cooking facilities, accessibility, transport, location.

Discuss the option of continued funded accommodation over the two middle weekends if that will be more cost effective than transporting them to and from their home, or if the additional travel is likely to negatively impact their condition.

Generate a 'NGCM - Entitlement Request' task requesting to set up accommodation using Service code PN3ACC

NOTE What if the Pain Management Plan suggests incidentals (such as a gym membership or pool pass)?


The purpose of these is to allow the provider to use resources to optimize a client's participation within their community based pain management service

We do not usually fund gym memberships or pool passes these except in specific circumstances. They may be included if they are:

- Required to enable to client to achieve their wellbeing and functional goals; and
- Limited to the duration of the service.

Incidentals can be invoiced directly by the provider without purchase order approval
Only one incidental code can be invoiced per claim without prior approval.

Refer to the Incidentals Service Page for more information.

 **PROCESS** Incidentals Service Page

NOTE What if the vendor advises that the client failed to attend the Pain Management Service referral?

If the client fails to attend or take part in the Pain Management Service and there doesn't appear to be a reasonable explanation for not attending, then go to 'Manage Non-Compliance' process below.

It is the responsibility of the vendor to notify ACC of a 'Did Not Attend' (DNA) as soon as possible within 3 business days of the missed appointment.

 **PROCESS** Manage Non-Compliance


NOTE What are the maximum number of DNAs permitted for this service?

A maximum of two DNAs per claim are permitted with this service however, DNAs are not payable for courses purchased on a package basis eg group education, community or tertiary residential courses.

NOTE What task do you send to Recovery Administration if a PO needs to be amended to accommodate a DNA?


Create an 'NGCM Edit Manage referral Purchase Order Task' task to request the Purchase Order be updated with the DNA. Include Purchase order number, PNDNA service code and the date of the DNA.

Refer to the 'Referring Tasks to Recovery Administration - Principles' process below, and also the associated System Steps for further information and guidance.


 Referring Tasks to Recovery Administration - Principles


 Pain Management Services Service Page

c Perform Privacy and Relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

d Provide a copy of the report to the client and key stakeholders, if required.

 Disclosure of Clients' Health Information to Employers Policy


 Send letters from Client Recovery and Claims Assessment

NOTE What if the client requests that the report be changed or claims that it is incorrect?

A client can request that information held by ACC is changed or updated if it is factually incorrect (ie: wrong DOB, incorrect name spelling etc).


If it is the opinion of an Assessor or Provider, the client can supply a 'statement of correction' to ACC which is then included with the report. This means that any time the report is sent out, the statement of correction must be sent as well.

Refer to Managing a client's request to change personal information.

 Managing a client's request to change personal information

e Update the Recovery Plan with the outcome of the intervention.

 **PROCESS** Create or Update Recovery Plan
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** Set up Interventional Pain Management (IPM)
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** Stop Supports
Recovery Assistant, Recovery Coordinator, Recovery Partner

Summary

Objective

This policy defines vocational rehabilitation. Use this policy to understand:

1. What is vocational rehabilitation
2. Eligibility to vocational rehabilitation
3. Vocational Rehabilitation and the Recovery Plan (RP) / Individual Rehabilitation Plan (IRP)
4. Preferred vocational rehabilitation options
5. Requirements for vocational rehabilitation
6. Duration of vocational rehabilitation
7. Legislation Reference

Owner

[Out of Scope]

Expert

Policy

1.0 What is Vocational Rehabilitation

- a** We define Vocational Rehabilitation (VR) as the assistance necessary to achieve a meaningful and sustainable vocational outcome, whether this be to assist a client to return to work or where this is not reasonably practical, prepare the client for work readiness.

The goal of VR is to assist the client to:

- Maintain employment ('Return to my preinjury role'); or
- Obtain employment ('Return to a lighter work type'); or
- Regain or acquire vocational independence ('Work and manage my life'). Refer to the Vocational Independence Journey for more information.

 Vocational Independence Journey

2.0 Eligibility to Vocational Rehabilitation

- a** We must provide VR to any client who has a covered personal injury and is either:
- entitled to weekly compensation or Loss Of Potential Earnings (LOPE)
 - likely to be entitled to weekly compensation if we don't provide vocational assistance
 - no longer entitled to weekly compensation because they've reached the NZ Superannuation Qualifying Age (NZSQA)
 - on parental leave.

We must start to consider VR as soon as we decide that a client is likely to be eligible.

3.0 Vocational Rehabilitation and the Recovery Plan (RP)

- a** All clients who could be entitled to VR must have a Recovery Plan (RP).

You must develop the RP within 13 weeks of the client's injury being accepted for cover.

When determining a client's VR you must take into account the VR outcome agreed in their RP.

For more information see:

-  Recovery Plan Policy
-  Create or Update Recovery Plan

4.0 Preferred Vocational Rehabilitation options

- a** You must determine whether the client can return to the same employment and employer they had before their incapacity. If this isn't possible, decide which of the following is the most reasonable and practical option for the client:

- return to a different kind of employment with their previous employer
- return to the same kind of employment with a different employer
- use their experience, education, or training in a different kind of employment with a different employer
- help the client to use as many of their pre-injury skills as possible to get employment.

5.0 Requirements of Vocational Rehabilitation

- a** The vocational rehabilitation provided to a client must meet the following criteria:

- be likely to achieve the vocational goals recorded in the client's RP
- cost-effective and perhaps help to reduce other costs, such as weekly compensation
- appropriate in the client's circumstances
- sustainable by the client in the long term
- tailored to the client's needs and abilities, especially if they have a serious injury

NOTE Examples

A client's pre-injury work required them to have a specific tertiary qualification. They can't return to that particular type of work. We can provide rehabilitation assistance to support them in doing other similar work that also uses that qualification

A client's brain injury means they can never return to their previous level of employment. We aim to return them to the closest equivalent level of employment that their injury will allow them to sustain





6.0 Duration of Vocational Rehabilitation

- a We must provide VR for the minimum period necessary to achieve the client's vocational outcome in their RP, but typically must not provide it for longer than 3 years (which needs not be consecutive).

ACC can provide VR for longer than 3 years at its discretion if it still fulfils the requirements of VR. Technical guidance should be sought in this circumstance.

We must resume VR, with the client's agreement, if they are unable to sustain their return to work or work readiness after the initial VR. You must note the agreement in their RP.

7.0 Links to Legislation

-  Accident Compensation Act 2001, Section 85 - Corporation liable to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 86 - Matters to be considered in deciding whether to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 87 - Further matters to be considered in deciding whether to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 88 - Vocational rehabilitation may start or resume if circumstances change
<http://legislation.govt.nz/act/public/2001/0049/latest/D>

If...	you must...
you work in the Short Term Claim Centre (STCC)	<ul style="list-style-type: none">• complete the RPC six weeks after the date of injury, or• complete the RPC at any other stage during a client's recovery if their rehabilitation is not progressing as expected
you work in a branch	complete the RPC at any stage during the claim if rehabilitation is not progressing as expected
psychosocial flags or pain issues are evident	complete the RPC as soon as possible to determine if the client is a high risk and a referral for a pain service is appropriate

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Summary

Objective

Education Based Rehabilitation Assessment (EBRA) is used to determine the child or young person's injury-related education support needs and to identify options for addressing these needs.

Owner

[Out of Scope]

Expert

Procedure

1.0 Who is this service for?

- a Children and young people are eligible for EBRA if they are aged from 0 to 21 years and meet one of the following criteria:
 - attend a licensed early childhood centre (including home-based care) or primary, intermediate or high school
 - are exempt from enrolling at school and are home-schooled under section 21 or 22a of the Education Act 1989, or under section 26 but not subsection (1)(b)(iii)
 - are being taught at home while enrolled at Te Aho o Te Kura Pounamu, the Correspondence School.

 Education Act 1989
<http://www.westlaw.co.nz/maf/wlnz/app/document?do>

2.0 Key features

- a • ACC contracts with EBRA assessors to assess the child or young person's injury related educational needs
- Assessor meets with the child or young person and their family/whānau and visits the Early Childhood Education (ECE) centre or school
- Assessor should advise a range of options to address the identified injury-related needs, including the use of supports is already available in the early childhood education centre or school.

3.0 Complexity

- a If the assessment is considered to be complex the assessor will complete the complexity framework tool which will determine whether the assessment will be paid as complex. For more information see also complexity framework tool.


 Complexity Framework Tool Service Page

4.0 Making a referral

- a To get the best value from the assessment it is recommended that you obtain the following information from the school to send with the referral for assessment:
 - Most recent Individual Education Programme (IEP)
 - Any recent reports or information provided by the school or learning centre
 - Any recent assessments undertaken with the child/ young person



5.0 Reporting

- a Once the assessor has completed the assessment they return the completed ACC345 Education Support Assessment Report form to ACC.




 ACC345 Education Support Assessment Report

6.0 Service details

a Task Description

-  Making An Assessment Referral Service Page
-  About Social Rehabilitation Assessment Suppliers Service Page

7.0 Resources

-  About education support Policy
-  Set Up Education Support Process
-  Education support workers Service Page



Summary

Objective

The following is a summary of all indexation rates since 1 July 1992. For detailed information about how these apply, refer to the relevant table for the type of support and the Act covering it.

Owner





[Out of Scope]

Expert

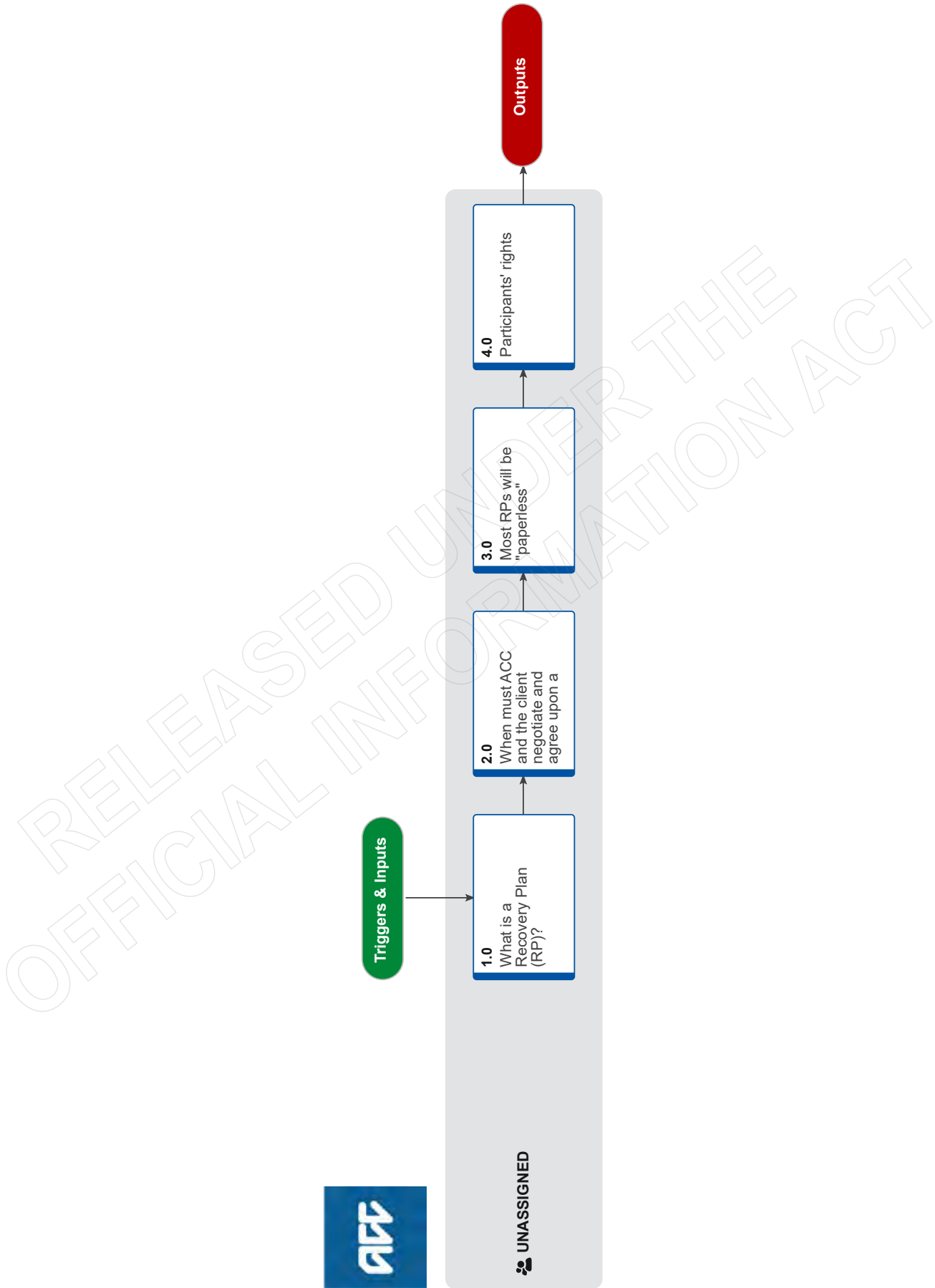
Policy

1.0 Percentage increases

a Indexation increases

-  Weekly Compensation Indexation Rates
 -  Annual Indexation Policy.
 -  Percentage increases since 1975 (1992 Act) Policy
 -  Indexation - Percentage Increases
-

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UNASSIGNED



Summary

Objective

Refer to this guidance to understand what a Recovery Plan is, when ACC and clients must negotiate and agree on the Recovery Plan, and how ACC record this agreement.

1. What is a Recovery Plan (RP)?
2. When must ACC and the client negotiate and agree upon a Recovery Plan
3. Most RPs will be "paperless"
4. Participants' rights

Owner

[Out of Scope]

Expert

Procedure

1.0 What is a Recovery Plan (RP)?

UNASSIGNED

- a** While not referred to as an IRP, RPs are required to follow the same legislative requirements for developing an IRP. The RP is therefore a legal document as identified in the Accident Compensation Act 2001 (AC Act).

An RP is an agreement between the client and ACC that details vocational and social interventions to assist in a client's recovery.

The RP outlines the actions required to help the client reach key milestones in their recovery; it contains when the action will happen, and who is responsible for completing them.

When discussing the RP, ACC and the client should identify any obstacles to recovery and develop actions or interventions to address them. This should be included in the RP.

A Recovery Plan must be updated when the client's circumstances change, and the agreed interventions no longer apply or cannot be completed.

2.0 When must ACC and the client negotiate and agree upon a Recovery Plan

UNASSIGNED

- a** Recovery Team members and the client will discuss and create a Recovery Plan.

Legislatively, a Recovery Plan (called an IRP in the AC Act) must be prepared for all claims where social or vocational rehabilitation is being provided and where a claim is expected to exceed 13 weeks duration.

- b** A Recovery Plan is not required for clients that require a one-off treatment and who self-manage in Enabled up to 13 weeks.

- c** All social and vocational rehabilitation assistance provided must be included in the Recovery Plan.

Recovery Plans are developed in agreement with the client. Agreed interventions, supports and goals are added and updated through regular conversations and check-ins.

The client's signature is not required to confirm their agreement; however, their agreement should be documented in a contact note following a discussion of the plan.

Once the Recovery Plan is agreed, the actions can be implemented.

- d** Where the client does not provide verbal agreement to either one or more parts or all of the RP, ACC will either:
- await an email response from the client confirming the plan, or
 - send a copy of the proposed plan to them, seeking their agreement.

After a reasonable period, the case owner must follow up with the client before the plan is finalised as agreed. In these cases, a copy of the finalised plan with review rights will be sent to the client.

- e** If the plan is that the client will return to their employment or other employment, an employer can be given an opportunity to participate in the preparation of the recovery plan. This does not mean they need to see a copy of the plan, nor do they have the right to review.

3.0 Most RPs will be "paperless"

UNASSIGNED

- a** Recovery Team members do not need to send hardcopies of the RP to clients unless:
- the client specifically requests a copy; or
 - the client has not verbally agreed to the RP and we seek the client's agreement; or
 - the RP is 'agreed as finalised'; or
 - the client is not able to return to their pre-injury employment, and the recovery plan has been updated to reflect that the client will have their vocational rehabilitation needs assessed by the Initial Occupational Assessment (IOA) and Initial Medical Assessment (IMA); or
 - the client has attended their Initial Occupational Assessment (IOA) and Initial Medical Assessment (IMA) appointments, indicating that the Vocational Independence (VI) process may commence

NB: emailing the plan is considered a hardcopy

- b** Recovery Team members must inform clients that they can review the plan and request a copy of their RP at any time. The RP can be sent electronically or as a hard copy.

The client has the right to review the plan, even it had been previously agreed.

4.0 Participants' rights

UNASSIGNED

a Schedule 1, clause 7 of the AC Act relates to participants' rights, including:

- the client's right to information about the rehabilitation they are entitled to, including the vocational independence process and the Recovery Plan process
- the right to have a support person present when preparing a Recovery Plan
- the consequences of agreeing to the Recovery Plan
- the lead health practitioner's and employer's right to participate in preparing the Recovery Plan
- ACC's responsibility to meet the costs of preparing an Recovery Plan

The client can disagree with or challenge anything that is proposed in their Recovery Plan, including any decisions made about their rehabilitation. If this happens the Recovery Team member must make every effort to reach agreement with the client.

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Calculate Weekly Earnings – Self-Employed

Summary

Objective

The documents below are to be used for claims where the client becomes unable to work due to their injury from 1 July 2010. This information relates to ACC's application of the Accident Compensation (AC) Act 2001 from 1 July 2010.

- 1) Overview
- 2) Single employment at the date the client was unable to work
- 3) For the short-term period
- 4) For the long-term period
- 5) Multiple employment at the date the client was unable to work
- 6) For the short-term period
- 7) For the long-term period
- 8) Abatement
- 9) Indexation
- 10) Eligibility for an increase to the minimum full-time earner rate
- 11) Eligibility criteria
- 12) Full-time employment
- 13) Eligibility stops if employment would not be full-time

Owner

[Out of Scope]

Expert

Procedure

1.0 Overview

- a The calculation of short and long-term periods of weekly compensation depends if the client held single or multiple employments at the date they first or subsequently became unable to work due to the injury (date of first incapacity 'DOFI' or date of subsequent incapacity 'DOSI').

Weekly compensation is subject to change through abatement and indexation.

2.0 Single employment at the date the client was unable to work

- a If a client has only one employment type at the date they first or subsequently became unable to work due to the injury (DOFI or DOSI) and weekly earnings have been calculated, the bases for the short and long-term weekly compensation calculations are as follows.

3.0 Single employment - for the short-term period

- a The base weekly compensation is calculated at 80% of weekly earnings.

Note: Employees and shareholder employees are not eligible for an adjustment to the minimum weekly earnings rate for the short-term period, if they have a low level of weekly earnings.

If the weekly earnings of a self-employed person fall below the minimum weekly earning rate, they may have their weekly earnings set at the minimum rate if, they are liable to pay the minimum annual earner levy. In this case, base weekly compensation is 80% of the applicable weekly earnings minimum rate, subject to abatement and indexation.

4.0 Single employment - for the long-term period

If the client's weekly earnings are...	then...
less than the minimum weekly earnings rate	their weekly earnings can be set at the applicable minimum weekly earnings rate if they were either: <ul style="list-style-type: none"> • in full-time employment, ie worked an average of 30 hours per week in the four weeks prior to the incapacity • liable to pay the minimum annual earner levy base weekly compensation is 80% of the applicable minimum weekly earnings rate See Eligibility for an increase to the full-time earner rate
above the minimum weekly earnings rate	base weekly compensation is calculated at 80% of weekly earnings

For the long-term period.PNG

5.0 Multiple employment at the date the client was unable to work

- a If a client has more than one employment type at the date they became unable to work due to the injury (DOFI or DOSI), including more than one permanent employment, weekly earnings for each employment are calculated and then aggregated into one weekly earnings figure. The short and long-term periods for weekly compensation are calculated as follows.

6.0 Multiple employment - for the short-term period

- a Short-term base weekly compensation is calculated at 80% of weekly earnings.

If ...	and...	then...
one of the client's employments in the short-term period is self-employment	- their weekly earnings for that employment are below the applicable minimum weekly earnings rate - they are liable to pay the minimum earner levy they are eligible to have their weekly earnings for that employment set at the minimum weekly earnings rate	This weekly earnings figure is then aggregated with the weekly earnings from the other employment held at DOFI/ DOSI

For the short-term period.PNG

7.0 Multiple employment - for the long-term period

If the client's aggregated weekly earnings are...	then...
less than the minimum weekly earnings rate	their weekly earnings can be set at the applicable minimum rate if they were either: <ul style="list-style-type: none"> • in full-time employment, ie worked an average of 30 hours per week in the 52 weeks prior to the incapacity • Liable to pay the minimum annual earner levy base weekly compensation is 80% of the applicable minimum rate See Eligibility for an increase to the full-time earner rate.
above the minimum weekly earnings rate	base weekly compensation is calculated at 80% of weekly earnings

For the long-term period2.PNG

8.0 Abatement

- a Base weekly compensation can be reduced by abatement if the client receives earnings while they are unable to work or not fully working because of the injury.

9.0 Indexation

- a On 1 July each year, an annual indexation is applied to weekly compensation. Minimum full-time earner rates are also adjusted on 1 July each year. If a client's weekly earnings are below the adjusted rate and they are otherwise eligible for an increase, their weekly compensation is increased from 1 July.

10.0 Eligibility for an increase to the minimum full-time earner rate

- a Accident Compensation Act 2001, Schedule 1 Clause 42 sets the criteria for eligibility for an increase to the minimum rate after five weeks of the client's inability to work. Eligibility for an increase is only considered when all weekly earnings calculations have been aggregated into a single weekly earnings figure and the weekly earnings figure is below the minimum full-time earner rate.

See Minimum earner rate - full-time earners.

NOTE Legislative amendment to clause 42 - who does this affect?

From 6 September 2023, employees, shareholders, and previously ineligible self-employed clients can receive an uplift to the Minimum full-time Weekly Compensation rate during the short-term calculation period (Weeks 1-4 of the Weekly Compensation entitlement). The change aligns the eligibility to self-employed clients who are currently eligible for an uplift to the minimum rate during the short-term calculation period if they were liable to pay full-time levies. The change is legislative and was introduced in The Accident Compensation (Access Reporting and Other Matters) Amendment Act 2023.

For clients who are first unable to work on or after 3 August 2023, 6 September will fall within the short-term calculation period. If these clients are eligible for the uplift on the 6 September, their weekly compensation will be increased from that date.

-  Weekly compensation indexation (2001 Act) Policy
-  Accident Compensation Act 2001, Schedule 1 Clause 42
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

11.0 Eligibility criteria

- a To be eligible for an increase to the minimum full-time earner rate, immediately before the client became unable to work they must have been either:
 - in full-time employment
 - liable to pay the minimum annual premium. This applies to self-employed only. See Calculate weekly earnings - self-employed.

If either of the above criteria is met, weekly earnings can be increased to the minimum full-time earner rate.

If a recent or established non-PAYE shareholder employee cannot show that they received earnings immediately before they became unable to work, they are not eligible to receive weekly compensation. This includes long-term weekly compensation paid at the minimum full-time earner rate.

Refer to Calculate Weekly Earnings - Shareholder Employee

-  Calculate Weekly Earnings – Shareholder Employee

12.0 Full-time employment

- a Full-time employment is defined as employment averaging 30 hours (paid) per week over the four weeks prior to the date the client first or subsequently became unable to work (DOFI or DOSI). Note that it can also be a lesser number of hours if the person's employment contract defines the lesser hours as full-time.

For:

- permanent and non-permanent employees, details of the hours worked each week in the four weeks prior to DOFI are declared on the Welcome Conversation Transcript.
- shareholder employees and self-employed clients, these hours are declared on the ACC004 Questionnaire for self-employed or shareholder employee form or obtained in Welcome Conversation Transcript.

-  ACC004 Questionnaire for self-employed or shareholder employee

13.0 Eligibility stops if employment would not be full-time

- a A client is only eligible for the increase to the minimum rate for any period when, if it were not for the injury, they would have been in full-time employment.

ACC can assume that the client would have continued in full-time employment, unless information to the contrary is received. For example, the work could be seasonal, and full-time work would end at the close of the season.

If ACC is aware that employment would not have been full-time beyond a certain date, reduce the long-term weekly earnings figure to its base weekly earnings rate, updated for any applicable indexation.

If there is evidence the client would have resumed full-time employment in the next season, they are eligible to be reinstated at the minimum for the duration of that season.

Unless the above applies, once assessed for the minimum, the client stays on the minimum even if their base weekly earnings would have been subsequently increased by indexation to a level above the minimum.



Summary

Objective

This information is for case owners and payment processing staff when dealing with requests for reimbursement of client rehabilitation costs.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** If a client asks to be reimbursed for rehabilitation costs they must make their request in writing and include original receipts. However, their request does not need to be on one of our standard forms.

You can accept any written request as long as it clearly identifies the client, the claim, the support requested and is accompanied by evidence of payment eg. an invoice or receipt.

When you have the client's request and receipts go to one of the following relevant pages for instructions to approve the support and reimburse the client:

- Who processes client reimbursements
<https://go.promapp.com/accnz/Process/6f72a6ea-caa>
- Deciding pharmaceutical entitlement funding
- Reimbursing Non-Emergency Travel Costs
- Reimbursing parking costs for attending assessments
- Managing Aid or Appliance Requests

- b** Note: there is no change to the current ACC86 Weekly care summary – PO - client, ACC249 Request for reimbursement of pharmaceutical costs or ACC250 Claim for Transport Costs processes.

Clients are required to submit these forms when requesting reimbursement or payment for the support they are claiming.

If a client is seeking reimbursement for multiple types of support and has completed their request on one of the above forms or in writing, it is sufficient to accept as a written request for multiple types of support and can be used instead of staff completing an ACC161 Proforma invoice form.

- ACC86 Weekly Care Summary.doc
- ACC249 Request for reimbursement of pharmaceutical costs
- ACC250 Reimbursement of client travel expenses
- ACC161 Proforma invoice form

2.0 Examples

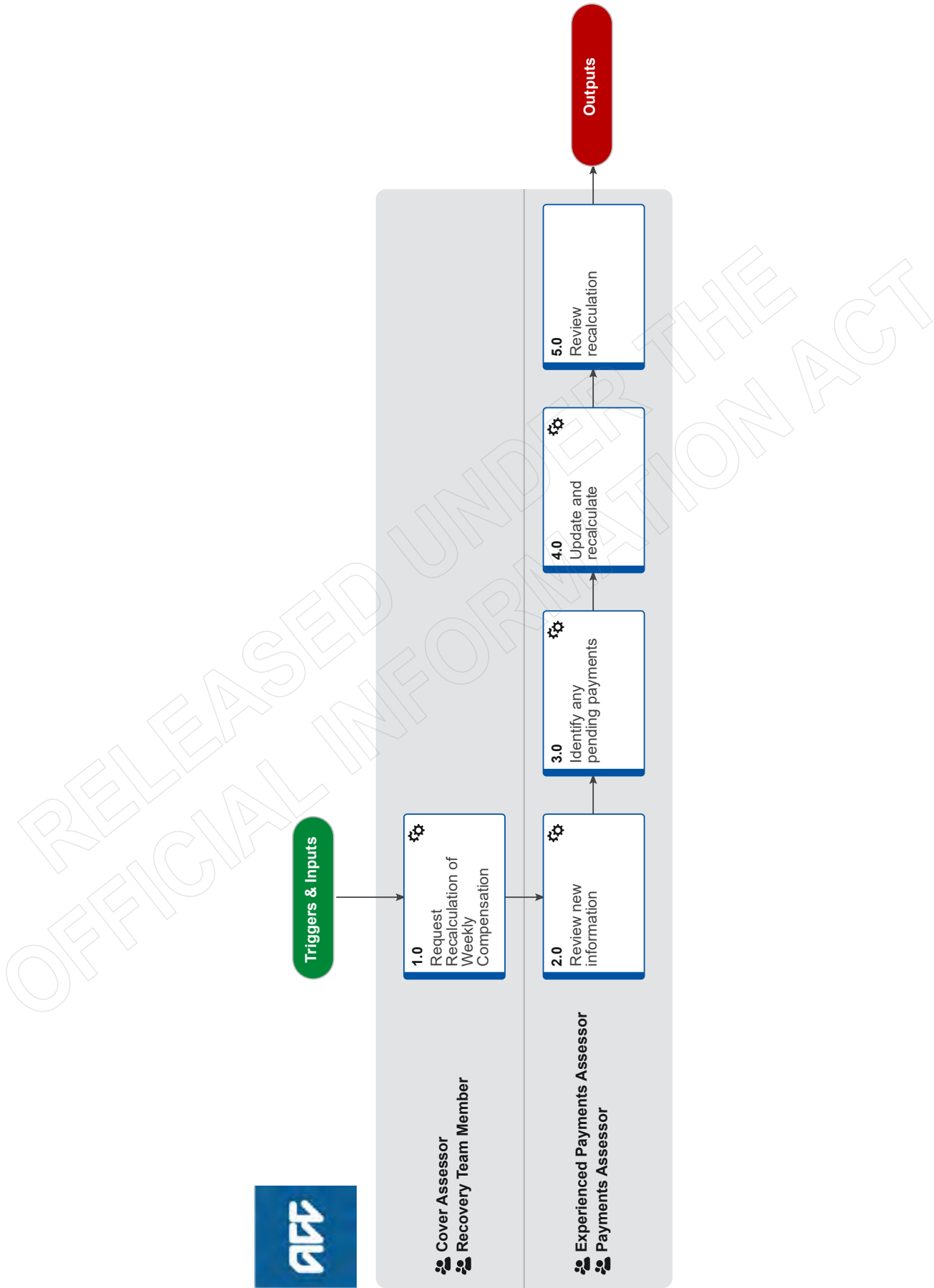
- a** • A client sends an ACC249 form for prescription reimbursement and also wants to be reimbursed for a taxi. They do not need to fill out an ACC250 form for the taxi. The taxi receipt is included with the request to reimburse the prescriptions

- A client sends in a receipt for crutches along with a letter asking to be reimbursed. The case owner saves the documents to the claim and creates a purchase order to reimburse the client

- A client gives receipts to their case manager during a meeting but is unable to fill out a form. The case manager sets up a purchase order and completes an ACC161 Proforma invoice form to make the payment.

3.0 Exceptions

- a** • An ACC161 Proforma invoice form must be completed:
 - if there isn't a written request from the client
 - to pay a vendor when the invoice has been addressed to the client and the case owner wishes to pay the vendor directly
 - for any costs associated with a review or appeal.



Summary

Objective

Use this procedure to recalculate a weekly compensation entitlement (including fatal weekly compensation) where a rate has previously been established so that the client receives the correct payment.

Background

The following are scenarios that may result in a recalculation:

- New earnings information
- Revisit a period of incapacity that has already been paid
- A change in the number of claimants for a Fatal WC claim
- Third party deduction being added (this is covered in the Manage Client Third Party Deduction procedure).

Where there has been an overpayment, you will need to assess and action the overpayment prior to processing the recalculation to ensure that the payment is correct.

Owner

[Out of Scope]

Expert

Procedure

1.0 Request Recalculation of Weekly Compensation

Cover Assessor, Recovery Team Member

- a** In EOS, create a Setup Weekly Compensation Task with the specific details of your request for recalculation.

NOTE What information should I provide to the payments team?

You should provide specifics of exactly what requires reassessment; for example link documents to your task or provide context on:

- Change of DOFI/DOSI dates
- Updated or New Employment or Earnings Information on file
- Any memo's or technical specialist recommendations


2.0 Review new information

Experienced Payments Assessor, Payments Assessor

- a** In Eos, receive and review new information from the client or employer about the weekly compensation.

NOTE What if the client is receiving a Section 60 Permanent Incapacity payment?

Go to the 'Recalculate Weekly Compensation - Section 60' procedure.

-  **PROCESS** Recalculate Weekly Compensation - Section 60

- b** Check if there is a Kiwisaver deduction. If there is, we will not be able to recalculate the claim. Reach out to a level two Payments Assessor for guidance.

NOTE How to check if there is a Kiwisaver deduction


Check in the clients party record under tax codes. Check the current tax code as well as all previous tax codes loaded.

- c** Determine what part of the calculation needs to be changed by checking whether the DOFI or DOSI, earnings information, or employment details need to be added, edited, or removed.

3.0 Identify any pending payments

Experienced Payments Assessor, Payments Assessor

- a** In Eos, check the Payment History for any pending payments, including deductions, to establish what action you can take.

-  Recalculating weekly compensation payable due to change in third party deduction

NOTE What if the payment status is blank?

These payments have been approved but they haven't reached the batch process for payment and don't need to be stopped for recalculation. Go to Step 3.0 Update and recalculate.

NOTE What if the status is 'PendingActive'?

These payments have been approved, and have been batch processed but hasn't reached the client's bank account so you can stop all the individual transactions for the payment.

NOTE What payment transactions can be stopped?

- The following must be stopped individually:
- Weekly Compensation payment
 - IR tax
 - any Third Party deductions.

- b** Stop all payment transactions that you've identified.

NOTE What if there aren't any payment transactions that need to be stopped?

Go to activity 3.0 Update and recalculate entitlement.

-  Stop a pending payment

4.0 Update and recalculate

Experienced Payments Assessor, Payments Assessor





- a** Check if there have been any overpayments raised that relate to the period being recalculated.

NOTE What if there's an overpayment pending a recovery decision that needs to be cancelled?

- Move all document and contacts from the Overpayment subcase to the Weekly Compensation subcase
- Close all tasks on the Overpayment subcase
- Cancel the overpayment subcase

NOTE What if there's an overpayment that needs to be cancelled where a recovery decision has already been made?


- Remove all Overpayment adjustments (write offs)
- Remove all Recovery Plans (no recovery)
- Stop all Recovery Plans (partial recovery)
- Move all documents and contacts from the Overpayment subcase to the Weekly Compensation subcase
- Close all tasks on the Overpayment subcase
- Cancel the overpayment subcase

-  View overpayment information
-  Remove an overpayment adjustment
-  Remove or stop a recovery plan
-  Cancel overpayment sub case

- b** In Eos, update the earnings, employment, or work pattern on the collection point as required.


NOTE What if the Calculation is for a PAYE Employee?

You need to refer to the Set Up Weekly Compensation - PAYE (Complex) procedure

 **PROCESS** Set Up Weekly Compensation - PAYE

NOTE What if the calculation is for a Self-Employed or Non-PAYE Shareholder?

You need to refer to the Set up Weekly Compensation - Self-Employed and Non-PAYE procedure

 **PROCESS** Set Up Weekly Compensation - Self-Employed and Non-PAYE

NOTE What if Fatal Weekly Compensation has been paid and new earnings information is received for the deceased?

This will trigger a recalculation of the FWC which will also impact on any dependents entitlements. If there is a resulting overpayment the Manage Overpayment task will route to the Centralised WC queue.

- c** Check whether the client is receiving an Advance Payment.

NOTE What if they are receiving an Advance payment?

Remove the Advance calculation before updating the earnings information

NOTE What if there is an overpayment created for MSD reimbursement?

Then you must write this debt off before you can perform a recalculation. Select 'Debt write off' from the list of write off options.

 **PROCESS** Write Off Client Debt

 Remove an advance payment

NOTE What if an overpayment decision has already been made and communicated to the client for the period I am recalculating?

If the overpayment amount has changed then you need to issue a new letter to the client with the updated overpayment amount should be issued revoking the original decision that was made.

If you need assistance with this you can contact the Overpayments Decision Unit for help.


- d** Check if the recalculated period had MSD reimbursements

NOTE Does a new ACC2300 need to be sent to MSD for a recalculated period of entitlement?

No. If there was previously an MSD reimbursement processed there will already be an ACC2300 on file with the period of reimbursement confirmed.

NOTE What if the recalculated weekly compensation rate is higher than the original rate for the period of MSD reimbursement?

Send a WC06 with the newly calculated rate along with the original WC06 sent previously

 **PROCESS** Reimburse Ministry of Social Development

NOTE What if the recalculated weekly compensation rate is lower than the original rate?

Proceed to step 5.0

5.0 Review recalculation

Experienced Payments Assessor, Payments Assessor

- a** Review the calculated payments and initiate payments for approval.

NOTE What if the recalculation outcome results in an overpayment?

Then, when initiating payments for approval you'll need to complete the overpayment information section to inform the approver why the recalculation resulted in an overpayment. Adding this information will also assist you when assessing the overpayment for a recovery decision:

- overpayment reason
- party in error
- team responsible (only if ACC is party in error)

NOTE What if the recalculation effects a payment schedule of due events that exceeds 2 years?

You will receive a validation message alerting you that the system will perform the calculation off-line as it will take longer than usual. You're able to carry out other work while this calculation is performed and the system will send you a task when it is complete. Once complete you need to return to the claim and carry out any further activities required.

 Initiate payments for approval

- b** Send the task that initiated the recalculation to the Centralised Weekly Compensation Approval queue.


NOTE What if the task is about a sensitive claim?

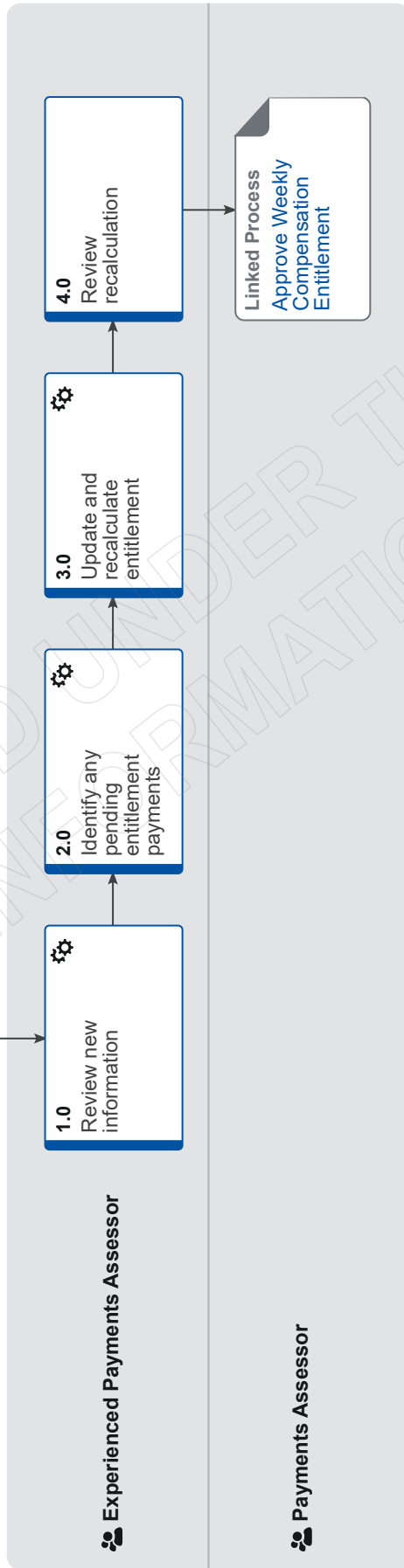
If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims Approvals queue.

NOTE What information should be sent to the client after the recalculation is approved?

A reassessment letter must be sent to the client for any recalculation regardless of whether there is an underpayment, overpayment or no change to payments, include an ACC255.

 Reassessment Letter

 ACC255 Kōrero mai - Working together





Summary

Objective

To recalculate a weekly compensation entitlement where a rate has previously been established using a client's Section 60 payments as an additional earnings source. As ACC must pay the Section 60 rate as a minimum amount, this procedure requires you to assess whether the weekly compensation rate on the subsequent claim is higher or lower than the Section 60 rate following your recalculation. This is to ensure the client is paid the correct rate.

Background

Section 60 payments are weekly payments made to clients who have been permanently incapacitated. These payments continue until the client turns 65 or dies, and must be considered as earnings for calculating weekly compensation for a subsequent injury.

The following scenarios may result in a recalculation of entitlements:

- ACC receives new earnings information
- ACC needs to revisit a period of incapacity period already paid
- ACC adds a third party deduction (this is covered in the Manage Client Third Party Deduction procedure)

When there has been an overpayment, you need to assess and action the overpayment prior to processing the recalculation to ensure that the entitlement is correct.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review new information

Experienced Payments Assessor

- Receive and review new information from the client or employer about the subsequent injury (non Section 60) claim. For PAYE earner types, pay particular attention to the payment cycles due to a mix of monthly reporting and pay day reporting cycles. Payments must align with the start of the incapacity so that the client is not overpaid.

- Determine what part of the calculation needs to be changed by checking whether the DOFI or DOSI, earnings information, or employment details need to be added, edited, or removed.

Recalculating weekly compensation payable due to change in third party deduction

- In Eos, open the subsequent injury weekly compensation subcase and check the payment periods tab to determine whether we're paying weekly compensation on that claim.

NOTE **What if the relevant payment periods have a period type 'Do Not Pay' and status reason 'Overlapping WC Period'?**

This means the Section 60 rate was higher than the original weekly comp rate and we're paying on the Section 60 claim. Ensure you check the Section 60 permanent incapacity weekly comp subcase to confirm that we're paying on that claim.

Go to Activity 3.0 b. and recalculate the weekly compensation rate on the subsequent injury claim.

View payment periods summary

Weekly compensation payments for a client who is receiving payments under section 60

2.0 Identify any pending entitlement payments

Experienced Payments Assessor

- In Eos, check the Payment History on the subsequent injury claim for any payments, including deductions, and review the Payment Event Interface (PEI) Status to establish what action you can take.

NOTE **What if the payment PEI Status is blank?**

These payments have been approved but they haven't reached the batch process for payment and don't need to be stopped for recalculation. Go to activity 3.0 Update and recalculate entitlement.

NOTE **What if the PEI Status is 'PendingActive'?**

These payments have been approved and have been batch processed but haven't reached the client's bank account so you can stop all the individual transactions for the payment.

NOTE **What payment transactions can be stopped?**

The following must be stopped individually:

- Weekly Compensation entitlement
- IR tax
- Any Third Party deductions.

- Stop all payment transactions that you've identified.

Stop a pending payment

NOTE **What if there aren't any payment transactions that need to be stopped?**

Go to activity 3.0 Update and recalculate entitlement.

3.0 Update and recalculate entitlement

Experienced Payments Assessor

- Check if there have been any overpayments raised that relate to the period being recalculated on the subsequent injury claim.

View overpayment information



NOTE **What if there's an overpayment pending a recovery decision that needs to be cancelled?**

- Move all document and contacts from the Overpayment subcase to the Weekly Compensation subcase
- Close all tasks on the Overpayment subcase
- Cancel the overpayment subcase

NOTE **What if there's an overpayment that needs to be cancelled where a recovery decision has already been made?**

- Remove all Overpayment adjustments (write offs)
- Remove all Recovery Plans (no recovery)
- Stop all Recovery Plans (partial recovery)
- Move all documents and contacts from the Overpayment subcase to the Weekly Compensation subcase
- Close all tasks on the Overpayment subcase
- Cancel the overpayment subcase

Remove an overpayment adjustment


-  Remove or stop a recovery plan
-  Cancel overpayment sub case

b In Eos, update the earnings, employment, or work pattern on the collection point as required. For guidance on updating this information, refer to the procedures linked in the Notes below.

-  Using section 60 payments as source of earnings


NOTE What if the calculation is for a PAYE Employee?

Then you need to refer to the Set Up Weekly Compensation - PAYE (Complex) procedure

-  **PROCESS** Set Up Weekly Compensation - PAYE


NOTE What if the calculation is for a Self-Employed or Non-PAYE Shareholder?

Then you need to refer to the Set up Weekly Compensation - Self-Employed and Non-PAYE procedure

-  **PROCESS** Set Up Weekly Compensation - Self-Employed and Non-PAYE


NOTE What if the client is receiving an advance payment?

Remove the advance calculation before updating the earnings information

-  Remove an advance payment

NOTE What if there is an overpayment created for MSD reimbursement?

You must write this debt off before you can perform a recalculation. Select 'Debt write off' from the list of write off options.

-  **PROCESS** Write Off Client Debt

c On the subsequent injury claim, determine whether the weekly compensation rate is now higher or lower than the Section 60 rate and take the steps outlined in the Notes below to adjust the periods and rate on the subsequent injury claim as needed.

NOTE What if the weekly comp rate on the subsequent injury claim was originally higher than the Section 60 rate and it remains higher after recalculation?

Go to Activity 4.0 a. and initiate for approval.


NOTE What if the weekly comp rate on the subsequent injury claim was originally higher than the Section 60 rate but it's now lower than the Section 60 rate after recalculation?


Because these weekly compensation entitlements are managed on separate claims, Eos cannot automatically adjust the rate to the correct amount. This means you'll need to manually adjust the periods and rate on the subsequent injury claim to ensure the client is paid correctly.

- For each period that has paid on the subsequent injury claim, apply a manual override using the Section 60 rate as the 'Amount'. For further detail on how to apply an override, go to the Apply a Top Up or Override Payment procedure linked below.

- For each period that hasn't yet been paid, edit the payment period and apply the 'Do Not Pay - overlapping WC period' status for all periods.

- On the Section 60 claim, edit each payment period to 'Calculate and Pay' from the end date of the last period paid. This will ensure the payments now come from the Section 60 claim, not the subsequent injury claim.

-  **PROCESS** Apply a Top Up or Override Payment

-  Override weekly compensation payments

-  Edit a payment period

NOTE What if the weekly comp rate on the subsequent injury claim was lower than the Section 60 rate originally and remains lower after recalculation?

Ensure the payment periods on the subsequent injury claim are set to 'Do Not Pay - overlapping WC period'. This will ensure the payments continue to come from the Section 60 claim.

Go to Activity 4.0 a. and initiate for approval.

NOTE What if the weekly comp rate on the subsequent injury claim was lower than the Section 60 rate originally but is now higher than the Section 60 rate after recalculation?


Because these weekly compensation entitlements are managed on separate claims, Eos cannot automatically adjust the rate to the correct amount. This means you'll need to manually adjust the rates and periods on the subsequent injury claim to make sure the client is paid the correct rate.


- For each period already paid on the Section 60 claim where the subsequent injury rate is now higher, calculate the difference between the new rate and the Section 60 payment amount.

- On the subsequent injury claim, apply a manual top-up payment for the difference for each period. For more information, go to the Apply a Top Up or Override Payment procedure linked below.

- For each period of approved incapacity that hasn't yet paid on the Section 60 claim, edit the payment period and apply the 'Do Not Pay - overlapping WC period' status.

- On the subsequent injury claim, from the end date of the last period paid, edit each payment period to 'Calculate and Pay'. This will ensure payments now come from the subsequent injury claim, rather than the Section 60 claim.

 **PROCESS** Apply a Top Up or Override Payment

 Top up weekly compensation payments

 Edit a payment period

4.0 Review recalculation

Experienced Payments Assessor

a Review the calculated payments and initiate payments for approval.

 Initiate payments for approval

NOTE What if the recalculation outcome results in an overpayment?

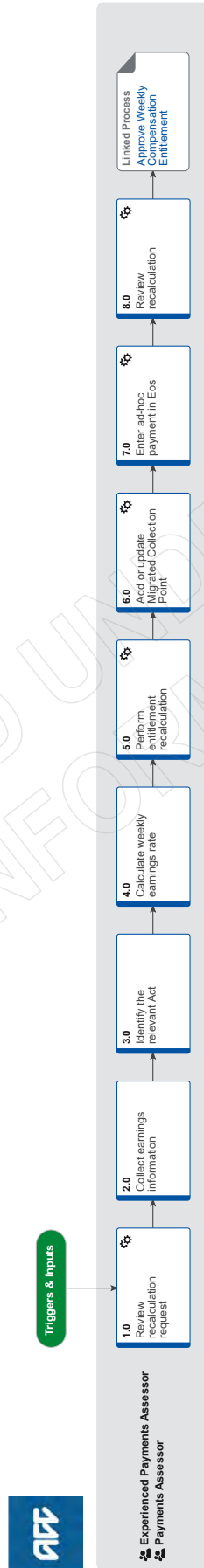
In this case, when initiating payments for approval you'll need to complete the overpayment information section to inform the approver why the recalculation resulted in an overpayment. Adding this information will also assist you when assessing the overpayment for a recovery decision:

- overpayment reason
- party in error
- team responsible (only if ACC is the party in error)

b Send the task that initiated the recalculation to the Centralised Weekly Compensation Approval queue. Ensure you provide enough detail in the description of the task so that the approver understands the action taken

 **PROCESS** **Approve Weekly Compensation Entitlement**
Payments Assessor

Recalculate Weekly Compensation Claims paid from Pathway v20.0



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Recalculate Weekly Compensation Claims paid from Pathway v20.0



Summary

Objective

This procedure states how to manage the recalculation of weekly compensation for claims that have been migrated from Pathway to Eos, specifically for recalculations that impact the period managed in Pathway before the claim was migrated to Eos, and new calculations pre-2010.

Background

This procedure covers the set up of weekly earnings base rate and calculation of entitlement for periods previously calculated outside of Eos and new calculations pre 2010. The process itself follows a similar path to standard weekly compensation (WC) set up, with complexity being found in the collection of historical earnings information, and the calculation of historical entitlements based on this information. The rate(s) determined through the Te Ara Hou calculator will need to be paid in Eos via an ad-hoc payment.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review recalculation request

Experienced Payments Assessor, Payments Assessor

- a** In Eos, confirm that the claim requiring recalculation was paid in Pathway and whether or not it was subsequently migrated to Eos.

NOTE **How do I know if the claim was paid from Pathway?**

Pathway Power BI reporting provides access to Pathway data, allowing access to Pathway information in a report format. To access Power BI reporting select the 'Launch PW' button in Eos.

- Power BI - Pathway Reports User Guide
- View a collection period

NOTE **What if the claim was only paid in Eos?**

Recalculation can be performed in Eos. Refer to 'Recalculate Weekly Compensation'.

This procedure ends.

- PROCESS** Recalculate Weekly Compensation

NOTE **What if the recalculation is only for a period after the claim was migrated from Pathway to Eos?**

Recalculation can be performed in Eos. Refer to 'Recalculate Weekly Compensation'

This procedure ends

- PROCESS** Recalculate Weekly Compensation

- b** Confirm whether or not Backdated Weekly Compensation is applicable.

NOTE **When should Backdated Weekly Compensation be applied?**

Backdated Weekly Compensation should be applied when there are arrears and/or a recalculated period greater than or equal to 90 days in duration. See the following business rules for more detail.

- Backdated weekly compensation eligibility
- Confirmation of a period of incapacity of 90 days or more

NOTE **What if Backdated Weekly Compensation is applicable?**

If Backdated Weekly Compensation is required, refer to 'Set Up Backdated Weekly Compensation'.

This procedure ends.

- PROCESS** Set Up Backdated Weekly Compensation

2.0 Collect earnings information

Experienced Payments Assessor, Payments Assessor

- a** Collect any earnings information required to proceed with the recalculation from Inland Revenue.

- Retrieve earnings from IR
- Use of Inland Revenue Real-Time Earnings Web-Service Policy

3.0 Identify the relevant Act

Experienced Payments Assessor, Payments Assessor

- a** Review the payment information to check that the Act has not already been determined.

NOTE **What if this claim has previously been paid from Pathway and the Act and Weekly Earnings rate(s) have already been established?**
Go to step 5.0 Perform entitlement recalculation.

NOTE **What if the request is for a reinstatement of Weekly Compensation and the claim was previously paid from Pathway?**

Use the original weekly compensation earnings rate calculation (after checking for accuracy). Go to step 5.0 Perform entitlement recalculation.

- b** Confirm the Date of First or Subsequent Incapacity (DOFI/DOSI).

- c** Use the Guide below to establish the correct Act(s) to assist with the calculation.

- Guide to establish the correct Act to calculate weekly compensation
- Transitional claims 1-7-99 to 31-3-02 (AI Act 98) Policy
- Transitional claims Policy

4.0 Calculate weekly earnings rate

Experienced Payments Assessor, Payments Assessor

- a** Check you have all the relevant information required to calculate the weekly compensation earnings rate.

NOTE **What relevant information do I need?**

- incapacity period(s).
- employment type
- earnings details
- earner status (if required)


- b** Manually calculate the weekly compensation earnings rate using the relevant guide based on the relevant Act.

NOTE What if the relevant Act is 1972 or 1982?

Refer to the Claims Manual for policy and instruction on calculating a client's weekly earnings rate.


NOTE What if the relevant Act is 1992?

Refer to the Payments Assessor guide to Weekly Compensation ARCI Act 1992.

 Payments Assessor guide to Weekly Compensation ARCI Act 1992


NOTE What if the relevant Act is 1998?

Refer to the Payments Assessor guide to Weekly Compensation AI Act 1998.

 Payments Assessor guide to Weekly Compensation AI Act 1998

NOTE What if the relevant Act is 2001?

Refer to the Payments Assessor guide to Weekly Compensation AC Act 2001.

 Payments Assessor guide to Weekly Compensation AC Act 2001

NOTE What if the relevant Act is 2010?

Refer to your current knowledge and Promapp procedures in regards to the Weekly Compensation AC Act 2001 (2010 Amendment).

NOTE What if you cannot determine the weekly earnings rate.

If the clarification is simple (less than 15 minutes estimated to clarify) contact Technical Services by phone. If clarification is likely to be more complex, send a Complete Internal Referral task to the Operations Support queue requesting assistance.

- c** Upload details of the calculated weekly compensation earnings rate onto the claim.

NOTE What details do I need to include?


- relevant Act(s)
- earner type
- earnings details
- calculation breakdown
- weekly earnings rate/s

5.0 Perform entitlement recalculation

Experienced Payments Assessor, Payments Assessor

- a** Enter the appropriate information into the Te Ara Hou calculator as per the guide to calculate the weekly compensation entitlement.

 Te Ara Hou Calculator

 Te Ara Hou Calculator Guide.docx

NOTE What if the calculation is for a Fatal Weekly Compensation entitlement?


Use the Te Ara Hou calculator to calculate the Fatal Weekly Compensation entitlement. You will then need to manually apportion the entitlement based on the relevant Act and number of dependants.


- b** Save the excel Te Ara Hou calculation into the internal weekly compensation folder.
- c** Export the calculation from the Te Ara Hou calculator as a PDF and upload to the claim in Eos.

NOTE What if the recalculated entitlement result is an overpayment?

Overpayments in these circumstances are non-recoverable. No further action is required. Refer to 'Write-off of overpayments generated by entitlements paid from Pathway' and 'Overpayment recovery decision of for overpayments generated by entitlements paid from Pathway'.

This procedure Ends.

 Write-off of overpayments generated by entitlements paid from Pathway

 Overpayment recovery decision for overpayments generated by entitlements paid from Pathway

6.0 Add or update Migrated Collection Point
Experienced Payments Assessor, Payments Assessor

- a** In Eos, add or update the Migrated Collection Point

NOTE What if the recalculated weekly earnings rate at the migration date has changed?

Update the Migrated Collection Point with the new 100% weekly earnings rate as at the migration date.

NOTE What if this is a new calculation and I need to pay ongoing in Eos?

Add the DOFI and/or DOSI date as normal. Then add the Migrated Collection Point.

 Add Migrated Collection Point.pdf

7.0 Enter ad-hoc payment in Eos
Experienced Payments Assessor, Payments Assessor

- a** In Eos, enter the Te Ara Hou weekly compensation amount as an Ad-hoc taxable payment.

NOTE What if the recalculated pre-migration weekly compensation amount is an underpayment?

Add the Ad-hoc taxable payment on the Weekly Compensation Entitlement subcase in the 'Other Entitlements' tab as an underpayment.

 Ad-Hoc Payment Underpayment.pdf

NOTE What if the pre-migration weekly compensation amount is a new payment?

Add the Ad-hoc taxable payment on the Weekly Compensation Entitlement subcase in the 'Other Entitlements' as a new payment.

 Ad-Hoc Payment New Payment.pdf

NOTE What if deductions need to be applied?

Apply any deductions to the total recalculated pre-migration weekly compensation ad-hoc payment as required.

NOTE What if MSD reimbursement needs to be calculated?

Refer to 'Reimburse Ministry of Social Development'.

For the pre-migrated weekly compensation period, apply these deductions to the Ad-hoc taxable payment.

For the migrated period paid out of EOS, apply as per normal process

 **PROCESS** Reimburse Ministry of Social Development

NOTE What if you need to recalculate MSD reimbursements made on an Ad-hoc taxable entitlement?

Refer to 'Recalculate MSD reimbursements made on an Ad-hoc taxable entitlement'

- PROCESS** Recalculate MSD reimbursements made on an Ad-hoc taxable entitlement

8.0 Review recalculation

Experienced Payments Assessor, Payments Assessor

- a** Review that the recalculation request is complete and that both the Ad-hoc taxable payment for the pre-migrated weekly compensation amount, and the post-migration EOS entitlements are accurate.
- b** Send an Approve Weekly Compensation Entitlement task to the Weekly Compensation Approval Complex queue detailing the recalculation request and payments for approval.

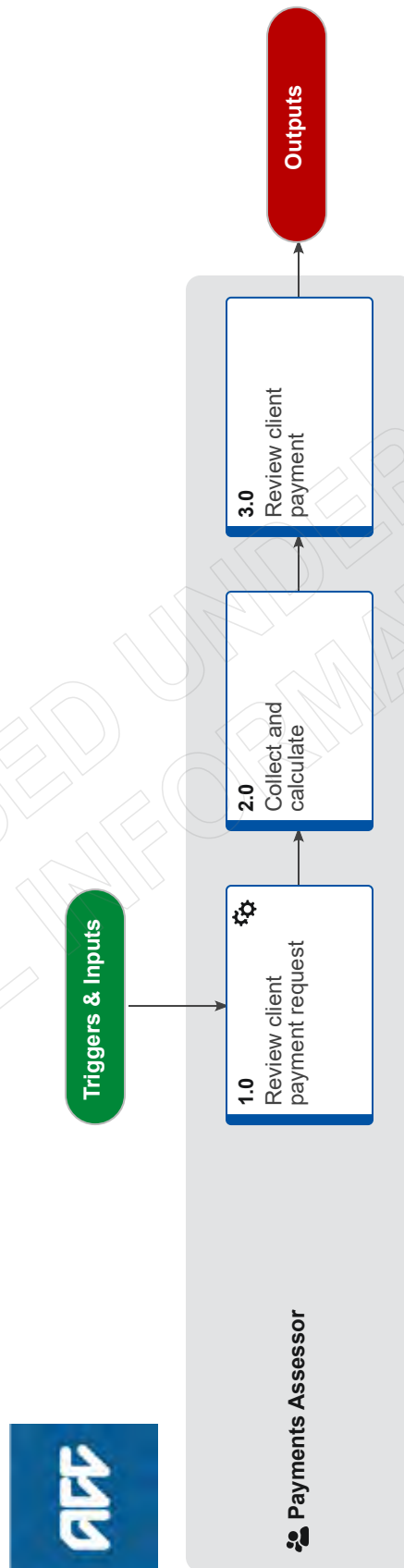
- Add an approval task

NOTE What if this was a Backdated Weekly Compensation request?

Refer to 'Set Up Backdated Weekly Compensation' Process to be sure this has been followed.

- PROCESS** Set Up Backdated Weekly Compensation

-
- PROCESS** **Approve Weekly Compensation Entitlement**
Experienced Payments Assessor, Payments Assessor
-





Summary

Objective

To show the key steps required to reinstate weekly compensation.
Use this procedure to recommence a client's weekly compensation entitlement, that had previously ceased

Owner

[Out of Scope]

Expert

Procedure

1.0 Review client payment request

Payments Assessor

- a In Eos, receive Setup Weekly Compensation task
- b Check non-standard e-form or task for information pertaining to the Weekly Compensation Reinstatement.

NOTE **What if the reinstatement period is backdated 90 days or more?**

If reinstating weekly compensation for 90 days or more in duration, refer to the Set Up Backdated Weekly Compensation procedure.

Process ends

- PROCESS** Set Up Backdated Weekly Compensation

- c Check that the client's Payment Preference (bank account) details are current

NOTE **What if the client's Payment Preference needs updating?**

Refer to the Manage Client Bank Account and Notification process.

- PROCESS** Manage Client Bank Account and Notification

- d Check client tax code is correct

NOTE **What if the tax code needs to be changed?**

Refer to Manage Client Tax Code process.

- PROCESS** Manage Client Tax Code

- e Check that the client's incapacity period has been approved for the weekly compensation reinstatement period.

NOTE **What if the incapacity period hasn't been approved?**

Request that the relevant Recovery Team Member approve this.

2.0 Collect and calculate

Payments Assessor

- a Determine whether abatement or Ministry of Social Development reimbursement is required.

NOTE **What if abatement is required?**

Refer to Manage Abatement

- PROCESS** Manage Abatement in Eos

NOTE **What if the client has been receiving an income-tested benefit?**

Refer to Reimburse Ministry of Social Development process.

- PROCESS** Reimburse Ministry of Social Development

- b Check for third party deductions that need to be end dated

NOTE **What if there are third party deductions that need to be end dated?**

Refer to Manage Client Third Party Deductions process.

- PROCESS** Manage Client Third Party Deductions

- c Check the original calculation is correct. For PAYE earner types, pay particular attention to the payment cycles due to a mix of monthly reporting and pay day reporting cycles. Payments must align with the start of the incapacity period so that the client is not overpaid.

NOTE **What if the original calculation was incorrect?**

Refer to Recalculate Weekly Compensation process.

- PROCESS** Recalculate Weekly Compensation

- d Create payable and non-payable periods as required

3.0 Review client payment

Payments Assessor

- a Check and change pay day if required

NOTE **What if a pay day change is required?**

Refer to Manage Client Pay Day process.

- PROCESS** Manage Client Pay Day and Pay Period

- b Review all calculated payments and indicate that they are ready for approval

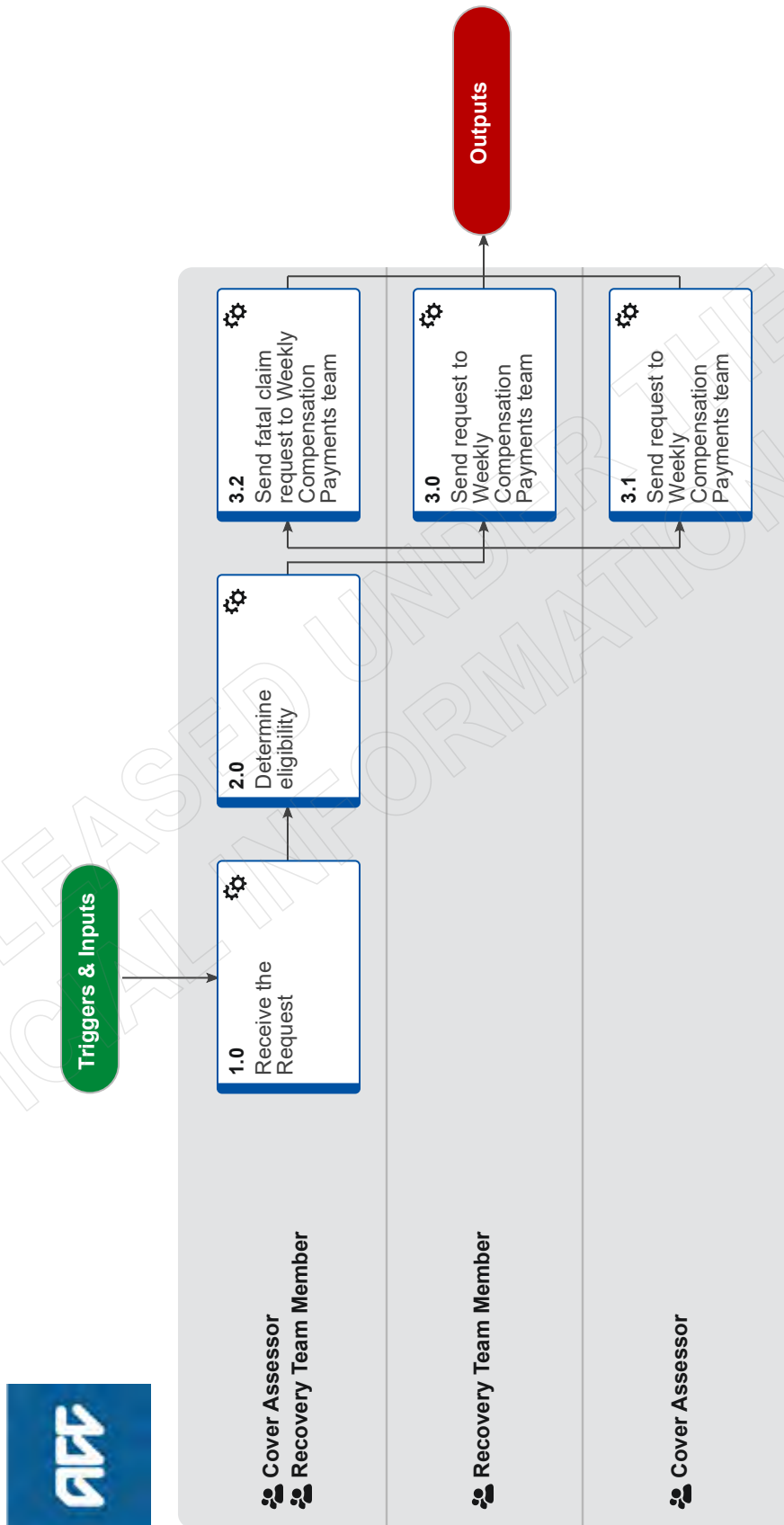
- View due events

- Initiate payments for approval

- c Send the Setup Weekly Compensation task to the Centralised Weekly Compensation Approval queue. Add any notes or instruction to the task description that the approver may require, such as fast track.

NOTE **What if you didn't receive a Setup Weekly Compensation task?**

Create an Approve Weekly Compensation Entitlements task. Add any notes or instructions to the task description that the approver may require, such as fast track. Send to the Centralised Weekly Compensation Approval queue.





Summary

Objective

To create the Setup Weekly Compensation task so that the Payments Team can set up the weekly compensation payment.

Note: if the backdated payments period is greater than or equal to 90 days in duration you must use the Backdated Weekly Compensation Procedure to request setup of entitlement.

Background

A client has applied for weekly compensation and a Case Manager needs to determine if they are eligible for weekly compensation. Once they are deemed eligible, information is gathered from the client, and the Case Manager adds the Set up WC task which auto-routes to the Centralised Weekly Compensation queue.

Owner

[Out of Scope]

Expert

Procedure

1.0 Receive the Request

Cover Assessor, Recovery Team Member

- a Review the request to see if an alternative process needs to be followed.

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 happens if the request comes through MyACC?

Refer to the information below for specific instructions for MyACC requests for weekly compensation.

- Supporting Information MyACC Tasks

NOTE What if the request is to transfer weekly compensation from one claim to another?

Refer to Promapp page 'Further Personal Injury'

- PROCESS** Determine Transfer of Weekly Compensation to a new claim due to Further Injury

NOTE What if the request is for Backdated Weekly Compensation (BDWC)?

Requests for backdated weekly compensation of 90 days or more have their own process. Refer to Promapp page 'Assess Backdated Weekly Compensation Request (BDWC)'

- PROCESS** Assess a Backdated Weekly Compensation Request

NOTE What if weekly compensation needs to be set up as part of a handback of an Accredited Employer claim?

Refer to Promapp page 'AEP Annual Claims Handback'

- PROCESS** AEP Annual Claims Handback

NOTE What if you need to Reinstate Weekly Compensation?

In EOS, at ACC45 level, complete the reinstatement information in the Non Standard WC Setup Eform. Create the 'Setup Weekly Compensation task (Employee, Self-employed, Shareholder, BDWC, Fatal), ensuring you select the appropriate task type based on employment type from the employment types noted in 3.1 c" (The Eform should link automatically), and the task will auto route to the Centralised Weekly Compensation queue.

Review the below business rule Criteria for reinstatement of weekly compensation payment of a client for further details.

- Criteria for reinstatement of weekly compensation payment of a client
- Full return to pre-injury role definition
- Add a Non standard WC set up Eform

NOTE What if you think the request is delayed?

Review the Delayed Request for weekly compensation criteria to determine this.

- PROCESS** Assess Delayed Request for Weekly Compensation (DRWC)

2.0 Determine eligibility

Cover Assessor, Recovery Team Member

- a Confirm the client's eligibility to receive weekly compensation.

- Eligibility Criteria for Weekly Compensation Policy
- Eligibility for weekly compensation for accidental death claims Policy

NOTE What are the eligibility criteria for weekly compensation payments?

The eligibility criteria for weekly compensation payments are:

- the claim for personal injury is accepted for cover under the Accident Compensation Act 2001, and
- ACC is responsible for managing the claim (that is, it is not a work-related personal injury suffered by an employee of an accredited employer), and
- the client has made a written or verbal application for weekly compensation, and
- the client is unable to work because of the personal injury under either section 103 or section 105.

NOTE What if the client's employment has been terminated prior to incapacity?

The extension of employment status criteria will need to be met in order to confirm eligibility. Refer to Promapp page 'Extension of Employment Status' for the criteria.

If the clients employment has been terminated prior to incapacity you will need to:

- Obtain the final pay details from their employer via the 'ACC040 Termination Pay Information Request Employer' form (generated in Eos)
- Explain to the client that this measure is required to determine their eligibility to weekly compensation

If completing a Welcome Conversation in Salesforce:

- Select the tick box under the Extension of Earner flowchart image to show this criteria applies and to prevent a Weekly Comp set up task being created at the end.
- Use the 'Gather remaining weekly comp info' reminder to show what documents have been sent and to whom as weekly compensation cannot be set up until this information is received.

 Extension of employment status Policy


NOTE What if the client's employment has been terminated post incapacity and the set up will include termination pay?

You will need to:

- Obtain the final pay details from their employer via the 'ACC040 Termination pay information request - employer' form (generate in EOS)
- Explain to the client that this measure is required to determine if abatement applies and avoid overpayment
- Create a reminder action in salesforce noting that once the ACC040 has been returned, continue the process as below and attach this information to the set up task at 3.0c

To continue on with the set up request (while waiting for the ACC040), if possible:

- Confirm the final date of employment and record this in the 'Additional notes relating to earner status' section in the Weekly Comp Tab of the Welcome Conversation
- Amend the loaded incapacity from the final date of employment to 'Yes' to abatement (to avoid an over payment)
- Add details about what the abatement period is for in the 'Additional Notes' section in the Setup Weekly Comp task pop out that happens at the end of the Welcome (if all non-negotiables are collected)
- Create a reminder action in Salesforce noting that once the ACC040 has been returned, review if abatement applies by following the Manage Abatement in Eos process
- Continue with the process as below

 **PROCESS** Manage Abatement in Eos

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

Decline the request, ensure the correct decision letter and fact sheets are sent to the relevant parties.

Send the:

- SPD999 - Decline entitlement decision - client (sent initially and every subsequent decline)
- ACC255 Working Together Factsheet (sent initially and every subsequent decline)

Check the Earner status under the employment tab and if appropriate, change to 'Non Earner' once the decline decision has been issued. Process ends.

For steps on issuing a decline decision see Issue Recovery Decision below:

 **PROCESS** Issue Recovery Decision

- b** Check if the Medical Certificate is valid and ensure the incapacity has been approved.


NOTE How does the Incapacity Table in Salesforce work?

- All incapacity on the claim (medical or approved) is sent to Salesforce when a Welcome Conversation is opened
- If Incapacity exists on the claim, you'll see this detail in the Roles and Responsibilities section of the Weekly Comp Tab
- Incapacity must be approved in Eos from the DOFI or DOSI date to be able to set up Weekly Compensation
- Use the [Approve Incapacity] button to be taken into Eos to add/approve incapacity
- Once incapacity has been added/approved, use the [Refresh] button and follow the message prompt to click on the 'Weekly Comp Tab' so new incapacity details are sent to Salesforce
- If approved incapacity does match the DOFI or DOSI date, a warning will show in the Roles & Responsibilities section

NOTE What if the Medical Certificate is valid but needs approving/adjustments (for example, extended, reduced, or there is a gap in incapacity?)


Incapacity needs to be approved in EOS to match the corresponding DOFI and/or DOSI period of entitlement and gaps in incapacity must be bridged before the request is sent to Payments. You can approve a gap in incapacity of up to 28 days (90 days for SI profiled claims) if the gap is in line with the client's injury.

See the "Maintain Weekly Compensation" process below:

 **PROCESS** Maintain Weekly Compensation

NOTE What if the medical certificate is invalid?

Inform the client that we cannot accept the medical certificate and ask they see their specialist or GP. If you are unsure if the medical certificate is invalid, refer to Rules for Medical Certificates for Inability to Work.

 **PROCESS** Rules for Medical Certificates for Inability to Work Policy

- c** Identify the appropriate next step in the process to take.

NOTE What if I'm a Recovery Team Member?

Go to activity 3.0

NOTE What if you are a Cover Assessor setting up support for an accepted Work Related Gradual Process Injury (WRGPI) claim for mesothelioma?

Go to activity 3.1

NOTE What if you are a Cover Assessor setting up support for an accepted fatal claim?

go to activity 3.2

NOTE What are the non negotiables required for clients who are employees?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred date - DOFI must be on this date or after it, never before it.
- Is client receiving an income tested benefit
- Correct fund code

3.0 Send request to Weekly Compensation Payments team (Recovery Team Member)

Recovery Team Member

a Ensure the Welcome Conversation has been successfully completed and documented.

- Non-negotiables met instructional video
- Non-negotiables missing instructional video

NOTE How do you document the welcome conversation?

Refer to the process below.

- PROCESS** Conduct Welcome Conversation

NOTE What if your request is for a DOSI (subsequent incapacity)?

You will still need to complete a Welcome conversation transcript or Weekly Compensation script for the subsequent incapacity with all relevant details for the DOSI (as you would a DOFI - First Incapacity).

For Recovery Team Members working in Salesforce, if a full Welcome Conversation is not required, only complete the Weekly Comp Tab then save at the Close Out Tab to prompt the Weekly Comp set up task at the end.

NOTE What if a self-employed or shareholder client advises their tax return hasn't been lodged for the most recently completed income year?

If the tax returns have been lodged for the previous financial year - We'll do an interim assessment based off the previous years return OR an estimate if the client will be lodging a return of less than the previous year (this can avoid an overpayment). The client nominates which they would prefer.

If the tax returns have not been lodged for the previous financial year either - we'll do an assessment based off an estimate of what the client will be lodging.

Refer to page Consider an Interim, Estimate or Advance of Weekly Compensation Policy.

Consider an interim estimate or advance of weekly compensation Policy

b Ensure all the information required by the payments team has been provided including the non negotiables for each employment type.

NOTE How do you resolve the Salesforce 'Weekly Comp information required' prompts?

Salesforce will alert you to any missing non-negotiable information for weekly compensation set up when saving at the Close Out Tab. Weekly Compensation should not be set up until this information is collected.

The following explains what each prompt means:

- DOFI/DOSI: a DOFI or DOSI date must have been entered
- Bank Account: a bank account must have been entered
- IRD Number: an IRD number must have been entered
- Gather necessary information to confirm Extension of Earner status applies: Weekly Comp cannot be set up until this information is gathered. If this does not apply to the client then untick the box under the flowchart image for this criteria
- MSD Benefits: this question must have been answered
- Work Type tick box required (Employed/Self-employed/Shareholder): the tick box for the clients income source must be ticked for Salesforce to identify this as the income source.
- Work Pattern: enter the client's work pattern in the relevant income source section
- Hours worked in the 4 weeks prior to incapacity: enter the hours the client worked in the 4 weeks prior to incapacity in the relevant income source section
- Earner Type (Perm/Non-Perm): Must have answered this question in the income source section (employee only)
- Days of leave without pay in the last 52 weeks: must have answered this question in the income source section
- Incapacity must be approved from DOFI/DOSI date: If you have approved incapacity in line with the DOFI or DOSI date entered, use the [Refresh] button to send the new incapacity details to Salesforce to resolve this error
- Further confirmation required for new/recent self employed earners. Refer to 'Request Set Up of Weekly Compensation Payments' promapp page: See the note for 'What is required for clients who are self-employed'.
- Further confirmation required for new/recent shareholder earners. Refer to 'Request Set Up of Weekly Compensation Payments' promapp page: See the note for 'What is required for clients who are shareholder employees'.


NOTE What if the request is for a future dated period of incapacity?


There must be an approved incapacity on the claim for the Weekly Compensation Set Up task to be processed by the payments team.

The Weekly Compensation Set Up task cannot be sent for processing if the request is more than seven days before the approved incapacity.

If the client does not have a medical certificate and you deem it appropriate, create a case owner incapacity approval.


If a case owner incapacity approval is not appropriate, direct the client to apply via MyACC or call back to complete their request when they have a valid medical certificate.

 **PROCESS** Medical Certification for Non-Serious Injury Claims


 Add approved incapacity without documentation

NOTE What is required for clients who are Self-Employed?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/DOSI)
- Incurred Date in EOS (general tab) the same as or before DOFI
- If the client is receiving an income tested benefit
- Fund code is correct
- Proof of self-employment if a client is considered new self-employed or has never lodged a return
- If 'recently' self-employed (has only passed 1 balance date prior to DOFI/DOSI) confirm whether the client has lodged their tax return and what date they started self-employment (so that the return is divided by the correct amount of full or part weeks). Also check if the client has any employee earnings in the 52 weeks prior to DOFI/DOSI.
- See 'Categories of self and shareholder employment' promapp page for Newly, Recently and Established criteria

 **PROCESS** Categories of self and shareholder employment


NOTE Where can you find information about how Self-Employed weekly earnings are calculated?

 **PROCESS** Calculate Weekly Earnings – Self-Employed

NOTE What is required for clients who are Shareholder Employees?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred Date in EOS (general tab) the same as or before DOFI
- If the client is receiving an income tested benefit
- How they receive their income (PAYE/End of year salary allocation)
- Fund code is correct
- Proof of employment if a client is considered a new shareholder employee

NOTE Where can you find information about how Shareholder Employee weekly earnings are calculated?

 **PROCESS** Calculate Weekly Earnings – Shareholder Employee

NOTE What is required when sending an ACC044 Statutory Declaration to a newly self employed client


Please cut and paste below into the body of the ACC044 as this contains the information required to confirm the client's self employment status.

I started being self-employed on:
..... (start date) (initial)
I will file end of financial year tax returns on 31 March (year) (initial)
I work hours (on average) per week:
..... (initial)
I understand that I am liable to pay ACC levies:
..... (initial)

NOTE Which is the correct task type?

- Task types are:
- Setup Weekly Compensation – Employee (For Employee Setup request)
 - Setup Weekly Compensation – Self Employed (For Self-employed Setup request)
 - Setup Weekly Compensation – Shareholder Employee (For Shareholder Employee (Both PAYE and Non-PAYE) Setup request)
 - Setup Weekly Compensation – BDWC (For LOPE and any Setup request greater than or equal to 90 days backdated entitlement)

- If the client has multiple employers:
- For Employee and Self-employed clients – Use the Setup Weekly Compensation - Self Employed task.
 - For Employee and Shareholder clients - Use the Setup Weekly Compensation – Shareholder Employee task.
 - For Self-employed and Shareholder clients – Use the Setup Weekly Compensation – Shareholder Employee task.

 Add a Weekly Compensation setup task (Eos online help)

 Link a document to a task in Eos

NOTE What if the information has been captured in the Client Welcome Conversation tool?

The Client Welcome Conversation tool is located under 'Pre-Salesforce Conversation Tools' on the NGCM Knowledge Landing page. If the information has been captured in this tool, then the Recovery Team Member will need to paste the information into the task description - rather than linking the transcript.

 NG TOOL Client Welcome Conversation

c Add any notes or instructions to the task description that the approver may require eg if fast tracking is required.

NOTE When should the Setup Weekly Compensation Task be set to high priority?

Only tasks for those clients that are vulnerable or in financial hardship are to be set to a high priority status.

d Process ends here.

NOTE What if you want to update the payment notification method?


Refer to system step below.

 Update the payment notification method

3.1 Send request to Weekly Compensation Payments team (Cover Assessor)

Cover Assessor

a Ensure the Weekly Compensation script has been successfully completed and documented.


 Add a weekly compensation script (EOS Online Help)

NOTE What if a self-employed or shareholder client advises their tax return hasn't been lodged for the most recently completed income year?

If the tax returns have been lodged for the previous financial year - We'll do an interim assessment based off the previous years return OR an estimate if the client will be lodging a return of less than the previous year (this can avoid an overpayment). The client nominates which they would prefer.

If the tax returns have not been lodged for the previous financial year either - we'll do an assessment based off an estimate of what the client will be lodging.

Refer to page Consider an Interim, Estimate or Advance of Weekly Compensation Policy

 Consider an interim estimate or advance of weekly compensation Policy


b Ensure all the information required by the Payments team has been provided.

NOTE What is required for clients who are employees?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred Date in EOS (general tab) the same as or before DOFI
- Earner Type [Permanent/Non-Permanent]
- Days of leave without pay in the last 52 weeks
- If the client is receiving an income tested benefit
- Fund Code is correct

NOTE What is required for clients who are self-employed?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred Date in EOS (general tab) the same as or before DOFI
- If the client is receiving an income tested benefit
- Fund code is correct
- Proof of self-employment if a client is considered new self-employed or has never lodged a return

 Confirm Self-Employed Person is an Earner Policy

NOTE What is required for clients who are shareholder employees?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week for the prior four weeks
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred Date in EOS (general tab) the same as or before DOFI
- If the client is receiving an income tested benefit
- How they receive their income (PAYE/End of year salary allocation)
- Fund code is correct
- Proof of employment if a client is considered a new shareholder employee

C In Eos, add the relevant Setup Weekly Compensation task.

NOTE Which is the correct task type?

Task types are:

- Setup Weekly Compensation – Employee (For Employee Setup request)
- Setup Weekly Compensation – Self Employed (For Self-employed Setup request)
- Setup Weekly Compensation – Shareholder Employee (For Shareholder Employee (Both PAYE and Non-PAYE) Setup request)
- Setup Weekly Compensation – BDWC (For LOPE and any Setup request greater than or equal to 90 days backdated entitlement)

If the client has multiple employers:

- For Employee and Self-employed clients – Use the Setup Weekly Compensation - Self Employed task.
- For Employee and Shareholder clients - Use the Setup Weekly Compensation – Shareholder Employee task.
- For Self-employed and Shareholder clients – Use the Setup Weekly Compensation – Shareholder Employee task.

 Add a Weekly Compensation setup task (Eos online help)




- d** Link the Weekly Compensation transcript to the task.
- e** Add any notes or instructions to the task description that the approver may require eg if fast tracking is required.
- f** Process ends here.

3.2 Send fatal claim request to Weekly Compensation Payments team

Cover Assessor, Recovery Team Member

- a** In Eos, confirm if the accidental death claimant or dependent has an existing:
 - Tax Code
 - IRD number
 - Bank Account

Validate these are correct. (If missing or incorrect – as below)

-  View a tax code
-  View party details
-  View a payment preference


NOTE What if the tax code is missing or incorrect?

Go to the Manage Client Tax Code to update this before creating the setup task. However, if it's a fatal claim, confirm the tax code for each dependent and include this information in the set up task.

 **PROCESS** Manage Client Tax Code


NOTE What if the IRD number is missing or incorrect?

Go to the Manage Client IRD Number to update this before creating the setup task.

 **PROCESS** Manage Client IRD Number

NOTE What if the bank account number is missing or incorrect?

Go to the Manage Client Bank Account and Notification before creating the setup task.

 **PROCESS** Manage Client Bank Account and Notification

- b** Capture client information (there is no script for a fatal weekly compensation set up).

NOTE What if the deceased client was not self employed, a non-PAYE shareholder or had an accountant?

No forms are required. The payments team will collect the earnings information.

However, if there is not an IRD number on the deceased party record, you will need to contact the family representative, so that the payments team can refer to IR RTE.

Once you have confirmed the deceased's IRD number, then continue to capture all the required information in the Setup Weekly Compensation - Fatal task.

NOTE What if the deceased client was self employed or a non PAYE-shareholder and they did not have an accountant?

Send the:

- ACD143 Self employed weekly compensation information request - party
- ACC748 Fatals questionnaire for self-employed or shareholder employee.

Once you receive the completed ACC748 back from the family, then continue to capture all the required information in the Setup Weekly Compensation - Fatal task.

- c** In EOS, add the Setup Weekly Compensation task, and manually re-route the task to the Weekly compensation complex queue.

NOTE What information should be included in the task description?

- IRD number of the deceased
- Accountant involved? Have family given permission? (as there will be a cost if ACC ask questions)
- Flag any pay periods that need editing (eg children in study)
- Flag any non-payable periods (eg imprisonment)
- Flag any hold periods (eg possible MSD)
- Spouse employed/ receiving MSD?

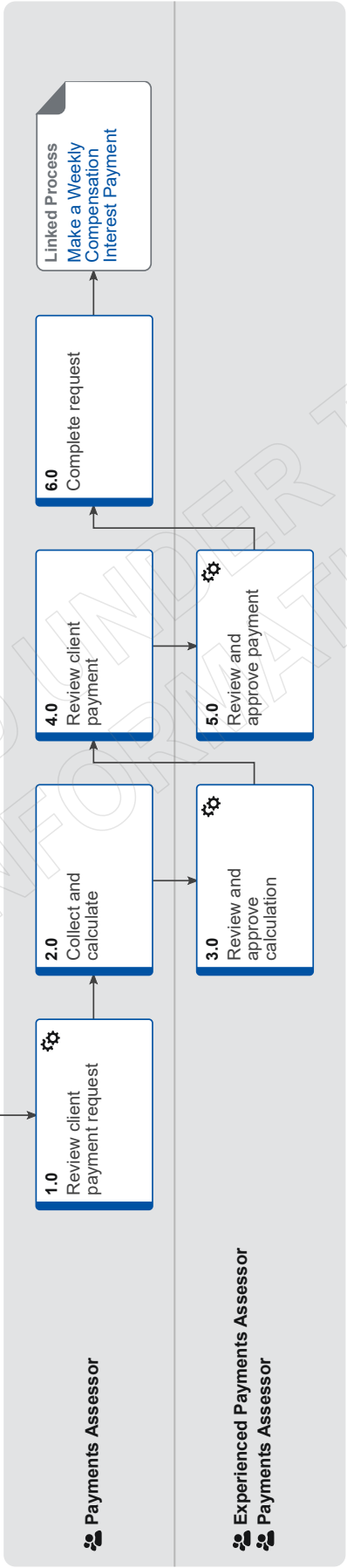
- d** This process ends.
-



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Triggers & Inputs



Summary

Objective

To show what to do when a request for payment of weekly compensation is received with a backdated portion of arrears or a recalculated period greater than or equal to 90 days in duration.

Background

We pay backdated weekly compensation (BDWC) to clients who are eligible for weekly compensation for periods in the past. We will consider backdating weekly compensation for various reasons, such as a late claim, a revoked decision, an overturned vocational independence decision, overturned suspension, a settlement, or a decision quashed at review or in court.

Front end users who request setup of backdated weekly compensation must ensure the proper documentation is included with the request so that we can proceed.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review client payment request

Payments Assessor

- a Determine what period(s) the backdated weekly compensation request applies to.

NOTE What if the backdated weekly compensation applies to a period of entitlement starting prior to 1 July 2010 or is a reassessment of a period previously paid outside of EOS?

This will have to be completed using the Te Ara Hou calculator.

Refer to the 'Recalculate Weekly Compensation Claims paid from Pathway' process below, while still following Backdated Weekly Compensation process where required.

PROCESS Recalculate Weekly Compensation Claims paid from Pathway

- b In Eos, review the backdated weekly compensation request to identify any instructions and to ensure all necessary information has been provided to calculate the entitlement the client is eligible for.

NOTE What information will you need?

- If it's 181 days or more, you will need a fully completed ACC6217 signed by a delegated authority or evidence on file that a delegated authority has approved the backdated period.
- Either a completed weekly compensation script, non-standard E-Form, or the requisite information to setup payments provided in a task
- Approved incapacity for all periods which require payment that align to the DOFI or DOSI period being calculated
- Payee details and verified bank account details (written verification)
- If there is an advocate on the claim, confirm if the payment should be made to the client or the advocate. Signed authority from the client is needed if the payment is to be made to an advocate or legal representative.

Backdated weekly compensation eligibility

NOTE What if the information on file is incomplete?

Contact the task requestor and ask them to collect or amend the required information. Template responses are available on the "Backdated Weekly Compensation - Payments Team Help Page" linked below.

Backdated Weekly Compensation - Payments Team Help Page

2.0 Collect and calculate

Payments Assessor

- a Review information to determine whether this is a new setup or a reinstatement of weekly compensation, and gather earnings from IR for both pre and post incapacity periods.

Retrieve earnings from IR

NOTE What if the client is PAYE?

Then refer to the Set Up Weekly Compensation - PAYE (Complex) process.

PROCESS Set Up Weekly Compensation - PAYE

NOTE What if the client is self-employed or non-PAYE?

Then refer to the Set Up Weekly Compensation - Self-Employed And Non-PAYE process.

PROCESS Set Up Weekly Compensation - Self-Employed and Non-PAYE

NOTE What if the process is LOPE?

Then refer to the Set Up Weekly Compensation - Loss of Potential Earnings (LOPE) process.

PROCESS Set Up Weekly Compensation - Loss Of Potential Earnings (LOPE)

NOTE What if the eligibility is for a BDWC reinstatement?

Refer to the Reinstate Weekly Compensation process, and complete Collect and calculate activities, then continue with this procedure.

PROCESS Reinstate Weekly Compensation

NOTE What if the complexity of the calculation is likely to result in an extended timeframe?

Contact the task requestor to inform them of the anticipated timeframe so they are able to appropriately support the client. The notification template is available on the 'Backdated Weekly Compensation - Payments Team Help Page'

Backdated Weekly Compensation - Payments Team Help Page

- b Finalise the calculation by applying any abatement based on post incapacity earnings collected.

NOTE What if need to apply abatement?


Refer to Manage Abatement procedure to complete request, then continue with this procedure.

PROCESS Manage Abatement in Eos

- c Check that the system derived NZSQA date is correct, this will need to be modified in the situations detailed in the notes below.


NOTE What if you are calculating a further injury period where the eligibility for BDWC is still in the first week of the further injury claim?
Then you will need to adjust the end date of eligibility (NZSQA) so that it is correctly calculated from the date the client first became eligible (date of first entitlement, DOFE) on the further injury claim, so that the NZSQA election date is correct.

NOTE What if the client was not paid any weekly compensation on the date they first became eligible for it (DOFE)?
Then the end date of their eligibility (NZSQA) will need to be adjusted from the subsequent date they became unable to work (date of subsequent incapacity, DOSI), so that the NZSQA election date is correct.

 Weekly Compensation and New Zealand Superannuation (pre-1 July 2019) policy

d Determine whether the client has any active collectable debt against any claim which meets the threshold for recovery.

NOTE What if the client has active collectable debt above the threshold owing, or the new calculation results in a new debt?
Then refer to the Assess Client Overpayment process.

 **PROCESS** Assess Client Overpayment

e Finalise the established rate of compensation.

f Go to 'Reimburse Ministry of Social Development' process to determine whether the client has received an income tested benefit during any period of the assess compensation period.

NOTE Refer to the Reimburse Ministry of Social Development process.

 **PROCESS** Reimburse Ministry of Social Development

NOTE What steps of the MSD process need to be completed?

Complete:
Activity 2.0, Review information and create request (Tasks b & c),
Activity 3.0, Review returned request, to determine whether the client has received an income tested benefit during any period being compensated, and then continue with this procedure.

NOTE What if there is an income tested benefit confirmed?

Do not send the WC06 to MSD at this time as you need approval of your finalised calculation first.

NOTE What if there is current MSD and ongoing incapacity?

If initial calculation needs to be checked, send setup task to the Weekly Compensation Approval Complex queue for initial calculation to be checked and approved before sending ACC2300 to MSD

g Consider creating future ongoing payments from the confirmed MSD handover date, once any MSD reimbursement has been approved.

h Create an Approve Weekly Compensation Entitlements task, update the description with the approval template, attach relevant documents and send to the Weekly Compensation Approval Complex queue

NOTE What is the approval template?
[Insert initials] [Insert date] BDWC [Insert type]
Payable Period:
WC Gross:
ACC6217 signed off:
Bank Account Verified:
DOFI:
DOSI:
Initial Setup Checked:
Abatement:
MSD reimbursement:
WINZ Reimbursement Period/Handover date:
Active Collectable Debt/Deductions:
Work Pattern:
Hours:
Payday:
Pay Period End Day:
Docs attached:
Notes:

3.0 Review and approve calculation Experienced Payments Assessor, Payments Assessor

a In Eos, review the approval request to ensure the client is eligible for BDWC, and to determine whether the calculation is accurate.


NOTE What should I be checking?

As per the internal peer review spread sheet, check that the BDWC process has been followed, as well as Weekly Earnings and Adjustments are accurate.

NOTE What if the BDWC calculation needs amending?

Return request to the relevant Payments Assessor with a description of the issue.

 Calculations for backdated weekly compensation

 Deductions to be made on backdated weekly compensation

 Indexation of backdated weekly compensation

b Complete a BDWC Approval Memorandum.

NOTE What if delegated approval is required?

Email the incomplete BDWC Approval Memorandum to the relevant delegation holder requesting they review the approval, sign as per their recommendation and return to you for approval completion.

NOTE What requires delegated approval and by whom?

- Backdated Weekly Compensation \$100k+ gross - \$500k gross - Client Service Leader
- Backdated Weekly Compensation over \$500k+ gross - Manager Operations Payments

- Employer Reimbursement Agreement \$100k+ gross - \$500k gross - Client Service Leader
- Employer Reimbursement Agreement over \$500k+ gross - Manager Operations Payments

 Delegations Framework

NOTE What if the claim requires Technical Services approval?

Complete an Internal Referral task and transfer the relevant approval to the Operations Support queue.

c Load the completed BDWC Approval Memorandum to the claim, attach to the task, note your approval (as well as delegated approval if gathered) in the task and return to the relevant Payments Assessor.

4.0 Review client payment

Payments Assessor

- a** Receive the Approve Weekly Compensation Entitlements task and review the response. Check the approval memo and carry out instruction as necessary.

NOTE What if I need to amend the calculation?

Make necessary changes to the calculation and return for approval.


NOTE What if advice returned from the Payments Assessor or Technical Services specialist, is to decline the BDWC request?

Return the request to managing site advising of the recommendation to decline BDWC.

- b** Check if MSD reimbursement is necessary.

NOTE What if MSD reimbursement is required?

Go to Reimburse Ministry of Social Development process to complete Collect and Calculate activity, then continue with this procedure.

 **PROCESS** Reimburse Ministry of Social Development

NOTE What if the MSD reimbursement request is over \$20k?

Request Delegated Approval from the delegation holder:

- MSD Reimbursement - \$20k gross - \$500k gross - Team Leader
Email the relevant delegation holder requesting they review the MSD reimbursement and add a contact to the claim with their recommendation of approval. ('WC - MSD reimbursement over \$20k delegated approval - Team Leader - [Insert Name]').

- MSD Reimbursement - \$500k+ gross - Technical Services
Complete an Internal Referral task and transfer the relevant approval to the Operations Support queue.

 Delegations Framework

- c** Recover any outstanding recoverable debt if applicable.


- d** Check whether we need to confirm client's tax code details.

NOTE When must I send a WC21 decision letter to confirm a client's tax code details?

- If the payment amount is greater than \$5000 gross before MSD deductions; and
- Contains current and/or a previous tax year period; or
- Is an underpayment of a payment belonging to the current tax year (paid previously).

NOTE What documentation should I include with the WC21 decision letter?

We should include the latest version of the ACC255 Kōrero mai Get in touch with us information sheet with the WC21 decision letter.

 ACC255 Kōrero mai - Working together

NOTE What if the WC21 period has previously been paid?

Then use the 'calculate and hold' functionality to hold your reassessed period until the client confirms how they would like their backdated payment to be taxed.

NOTE What if I don't need to confirm tax code details?

Use the client's previously elected tax code set in the system and go to Task e.

 Edit a tax code record

- e** Review the tax code details from the client, either verbally or in writing (i.e. ACC1566), or if no response after 10 days, update the client's tax code as necessary.

NOTE What if the client elects a tax code or elects the highest tax rate?

- Update the client's tax code as requested.
- Use the STC tax code option if the highest rate is elected.

- Consider 'holding' ongoing entitlement so it is not affected by the tax option for the BDWC payment.

- Ensure you go back to add the client's normal tax code back in, two days after the BDWC payment has been released.

 **PROCESS** Manage Client Tax Code

NOTE What if the client has a special tax certificate (STC) from IR?

- Ensure the STC tax certificate is addressed to ACC and apply the rate as directed.

- Consider 'holding' ongoing entitlement so it is not affected by the tax option for the BDWC payment.

- Ensure you go back to add the client's normal tax code back in, two days after the BDWC payment has been released.

 **PROCESS** Manage Client Tax Code

NOTE What if the client doesn't confirm a tax code within 10 days?

Use the client's elected tax code already set in the system.

- f** Update the notes on the Approve Weekly Compensation Entitlements task with the request for release in your task and send it to the Weekly Compensation Approval Complex queue.

NOTE Ensure you have updated the Backdated Weekly Compensation (including MSD reimbursement, bank account and tax code as necessary).

NOTE What if the payment schedule of due events exceeds 2 years?

You will receive a validation message alerting you that the system will perform the calculation off-line as it will take longer than usual. You're able to carry out other work while this calculation is performed, and the system will send you a task when it is complete. Once complete you need to return to the claim and carry out any further activities required.

 Initiate payments for approval

5.0 Review and approve payment

Experienced Payments Assessor, Payments Assessor

- a** In Eos, review the request for release of payment, referring to the BDWC Approval Memorandum to determine if the request for release is accurate.

NOTE What should I be checking?

- The BDWC Approval Memo is complete
- MSD reimbursement has been loaded if required (and delegated approval sought if required)
- Debt/Deductions have been considered if required
- Bank Account loaded as per payment request
- Tax Code loaded as per payment request (refer to completed WC21 and ACC1566 as necessary)
- Payment period / amount accurate as per approval

b Release the BDWC payment. Note your approval and release in the task, and return to the relevant Payments Assessor.

NOTE What if the payment is outside my delegation?

Then assign the task (with accompanying email notification) to a delegation holder for approval. Request they release the Backdated Weekly Compensation payment using the Approve a Weekly Compensation Payment system steps below, note their approval and release in the task, and return to the relevant Payments Assessor.

- Backdated Weekly Compensation \$100k+ gross - \$500k gross - Client Service Leader
- Backdated Weekly Compensation over \$500k+ gross - Manager Operations Payments
- MSD Reimbursement - \$20k gross - \$500k gross - Team Leader
- MSD Reimbursement - \$500k+ gross - \$1,000,000 gross - Deputy Chief Executive - Service Delivery
- MSD Reimbursement - \$1,000,000+ gross - Chief Executive Officer
- Employer Reimbursement Agreement \$100k+ gross - \$500k gross - Client Service Leader
- Employer Reimbursement Agreement over \$500k+ gross - Manager Operations Payments

 Delegations Framework

 Approve a Weekly Compensation payment

6.0 Complete request
Payments Assessor

- a** Contact the client if appropriate to advise of the payment, once the payment has been approved and released.
- b** Review and complete the ACC6218 on the claim, then create an internal referral task for technical services.

NOTE What description needs to be included in the task for technical services?

For approved interest entitlement please return the completed form as a NZCA141 Task to the 'Weekly Compensation Complex' Queue.

For declined interest entitlement please notify the recovery team member indicated on the ACC6218.

NOTE What if there is no 'all information' date on the ACC6218?

Indicate in the task description for technical services that this was not completed by the RTM.

NOTE What if the period between the 'all information' date indicated on the ACC6218 and the payment date is less than 30 days?


Notify the requesting recovery team member that interest does not appear to be eligible as payment has been made within 30 days of the all information date and for them to confirm interest eligibility through the Backdated Compensation Interest Eligibility Policy.

NOTE What sections of the ACC6218 may need to be updated prior to sending to technical services if it is not yet approved?

- "3. Period(s) of weekly compensation for which interest is requested: "Date(s) Paid""
Add in the date of the Backdated Weekly Compensation Payment.


- "4. Timeline of events: Events that have occurred after the BDWC payments task was generated."
Complete the timeline for events that have occurred after the final event entered by the recovery team member.

An exemplar of the ACC6218 and completion help guide are available on the "Backdated Weekly Compensation - Recovery Team Help Page" linked below.

 Backdated Weekly Compensation - Recovery Team Help Page

NOTE What if there is not a ACC6218 attached to the claim?

Create and transfer a 'NZCA141 - Investigation' task to the RTM that raised the setup task as the client may be eligible for interest on the late payment of weekly compensation.

 Interest on backdated weekly compensation policy

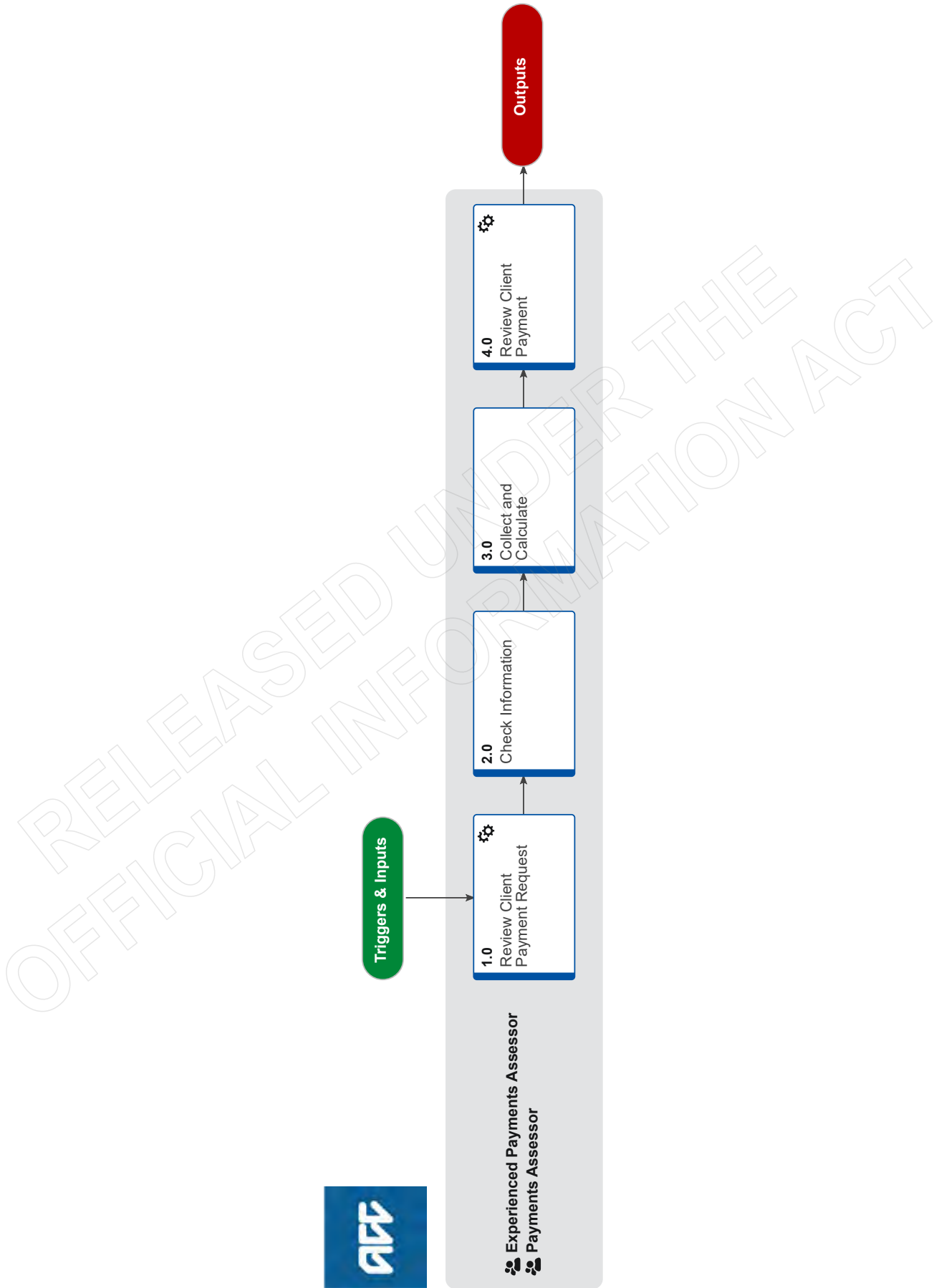
c Close any outstanding tasks related to the payment being approved. This process ends.

NOTE What if you released the Backdated Weekly Compensation using a tax code or bank account other than the clients preferred for ongoing payments?

Be sure to hold yourself a Follow Up Entitlement task as a reminder to adjust the tax code and/or bank account back to the correct one 2 days after the BDWC payment has been released, when applicable.

 **PROCESS** **Make a Weekly Compensation Interest Payment**
Payments Assessor

Set Up Weekly Compensation - Loss Of Potential Earnings (LOPE) v21.0



Set Up Weekly Compensation - Loss Of Potential Earnings (LOPE) v21.0



Summary

Objective

This process is used to set up and check weekly compensation for loss of potential earnings (LOPE) which is available to clients with long term injuries who were injured before the age of eighteen.

Background

To be eligible to receive compensation for loss of potential earnings, the client needs to be considered unable, because of their injury, to engage in full-time work for which they are suited due to their experience, education or training. They must also have been:

- not in employment immediately prior to their incapacity
- have sustained their injury before reaching the age of 18, or while engaged in full-time study or training which has been continuous since before they turned 18, and
- have now turned 18, and been unable to work (over the minimum earner rate) due to their injury for more than 6 months.

Owner [Out of Scope]
Expert [Redacted]

Procedure

1.0 Review Client Payment Request

Experienced Payments Assessor, Payments Assessor

- In Eos, receive Setup Weekly Compensation task
- Review the non-standard script and check the client meets LOPE eligibility using the policy below

NOTE What are the Non-negotiables that need to be covered within the LOPE Setup Weekly Compensation request?

- A Non-Standard Script containing DOFI/DOSI date
- Written Guidance from Technical Services
- Bank Account
- IRD number
- Tax Code
- Incapacity approved in EOS (in line with DOFI/DOSI) - Including the 6 month stand down period (26 full weeks = 182 days)
- Incurred Date in EOS (general tab) in line with DOFI

If incomplete, please push back to the Recovery Team Member to provide the required information to proceed.

Loss of Potential Earnings Policy

2.0 Check Information

Experienced Payments Assessor, Payments Assessor

- Check the claim for the information required to release a payment

NOTE What information is required to release a payment?

- IRD number
- Tax code
- Validated bank account

NOTE What if the bank account is deactivated, hasn't been entered or needs changing?
Refer to Manage Client Bank Account and Notification process.

PROCESS Manage Client Bank Account and Notification

NOTE What if a tax code needs to be changed or added?

Refer to Manage Client Tax Code process.

PROCESS Manage Client Tax Code

NOTE What if the IRD number needs to be changed or added?

Refer to Manage Client IRD Number process.

PROCESS Manage Client IRD Number

- Check that incapacity has been approved (Including the 6 month stand down period (26 full weeks = 182 days))

NOTE What if backdated weekly compensation is required?

Refer to Set Up Backdated Weekly Compensation process

PROCESS Set Up Backdated Weekly Compensation

View incapacity details

Establish a payment of backdated weekly compensation for 90 days or more Policy

3.0 Collect and Calculate

Experienced Payments Assessor, Payments Assessor

- Check for earnings information. Refer to the Use of Inland Revenue Real-Time Earnings Web-Service Policy for guidance.

Use of Inland Revenue Real-Time Earnings Web-Service Policy

Retrieve earnings from IR

NOTE What if Abatement is required?

Then refer to the Manage Abatement process.

PROCESS Manage Abatement in Eos

NOTE What if there is MSD benefit income?

Refer to Reimburse Ministry of Social Development process.

PROCESS Reimburse Ministry of Social Development

- Add a collection point.

Add a collection period from DOFI/DOSI

- Add collection point data.

Add LOPE to a collection point

NOTE What if there are other earnings?

Other earnings can only be used if the client was engaged in employment at Date of Accident and an earner at Date of Incapacity. To include, Refer to Set Up Weekly Compensation - PAYE Once completed, return to this procedure

PROCESS Set Up Weekly Compensation - PAYE

- Calculate loss of potential earnings

NOTE What if the client was engaged in employment at Date of Accident and an earner at Date of Incapacity and you have added other earnings in the collection point data?

The system will automatically base weekly compensation on the minimum earners' rate OR pre incapacity earnings whichever is higher.

e Create Weekly Compensation subcase.

 Set up a Weekly Compensation entitlement subcase


f Add full-time study periods if required


NOTE How would i know if there are any full time study periods?

A client is not eligible for compensation for loss of potential earnings during periods of full-time study or training.

Frontline should have investigated and confirmed any full-time study periods prior to you receiving the request to set up Loss of Potential Earnings Weekly Compensation, as per the 'Loss of Potential Earnings (LOPE) Policy' below.

An indicator on the RTE could be the client receiving a Student Allowance during a period of payable LOPE Weekly Compensation. This would need to be investigated.

 **PROCESS** Loss of Potential Earnings (LOPE) Policy

 View a party period

 Add a full time study period


 Set a preferred pay day

d Check payable and non-payable periods

NOTE How do I prevent Eos from displaying \$0 due events for LOPE stand down and full-time study periods?

Add a Do Not Pay period for the corresponding date ranges.

e Review all calculated payments and indicate that they are ready for approval

 View due events

 Initiate payments for approval

NOTE What if the payment schedule of due events exceeds 2 years?

You will receive a validation message alerting you that the system will perform the calculation off-line as it will take longer than usual. You're able to carry out other work while this calculation is performed and the system will send you a task when it is complete. Once complete you need to return to the claim and carry out any further activities required.

f Send the Setup Weekly Compensation task for Approval and Release. Add any notes or instruction to the task description that the approver may require, such as fast track.

NOTE What if I didn't receive a Setup Weekly Compensation task?

Create an Approve Weekly Compensation Entitlements task. Add any notes or instruction to the task description that the approver may require, such as fast track. Send to the Centralised Weekly Compensation Approval queue.

4.0 Review Client Payment

Experienced Payments Assessor, Payments Assessor


a Check that the system derived NZSQA date is correct. This will need to be modified in the situations detailed in the notes below.

NOTE What if you are calculating a further injury period where the eligibility for support is still in the first week of the further injury claim?

You will need to adjust the end date of eligibility (NZSQA) so that it is correctly calculated from the date the client first became eligible (date of first entitlement, DOFE) on the further injury claim so that the NZSQA election date is correct.

NOTE What if the client was not paid any ACC support on the date they first became eligible (date of first entitlement, DOFE)?

You'll need to adjust the end date of the client's eligibility (NZSQA) from the subsequent date the client became unable to work due to the injury (date of subsequent incapacity, DOSI) so that the NZSQA election date is correct.

 Weekly Compensation and New Zealand Superannuation (pre-1 July 2019) policy

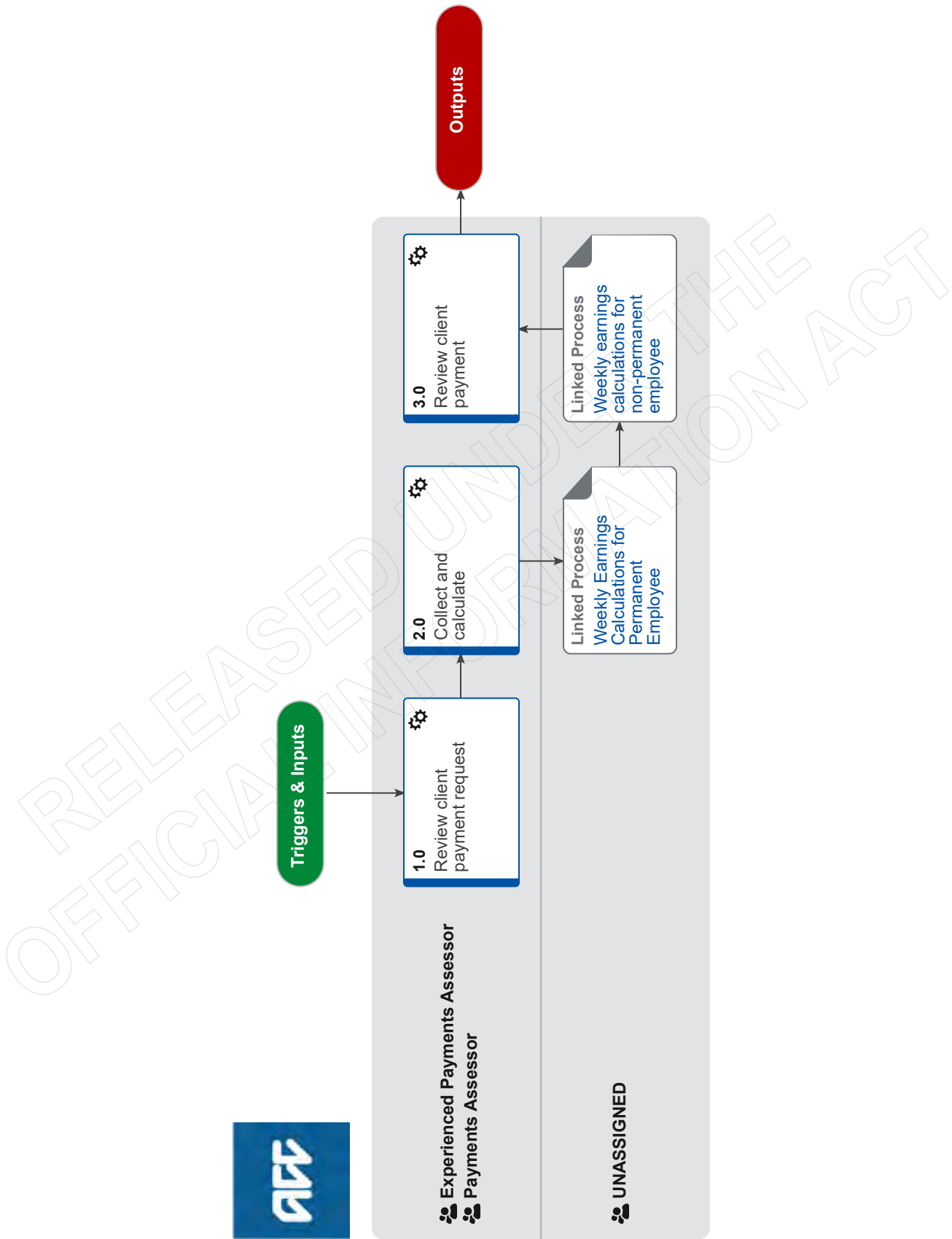
b Review and modify the client's Pay Period End Day as appropriate.

NOTE What Pay Period End Day should you choose?

- Pay Period End will default to Sunday – no change necessary unless the client requests an alternative day.

- ERA claims will default to the employers selected Pay Period End Day - no change necessary

c Review and modify the client's Pay Day if required.





Summary

Objective

The purpose of this procedure is to set up and pay new weekly compensation for permanent or non-permanent employees and PAYE shareholder employees.

Owner	[Out of Scope]
Expert	[Out of Scope]

Procedure

1.0 Review client payment request

Experienced Payments Assessor, Payments Assessor

- a Receive Setup Weekly Compensation task.
- b Review the Client Welcome Conversation Transcript or information provided via the MyACC Weekly Compensation Request for completeness.

NOTE What are the Non-negotiables that need to be covered within the Setup Weekly Compensation request?

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week
- Employment is permanent or non-permanent
- Incapacity approved in EOS (in line with DOFI/DOSI)

2.0 Collect and calculate

Experienced Payments Assessor, Payments Assessor

- a Create the collection period on the claim, this is either the Date of First Incapacity (DOFI) or DOSI if this is a subsequent incapacity on the same claim.

- 📄 Add a collection period from DOFI/DOSI

NOTE What if you need to adjust the collection period (DOFI/DOSI)?

You can only cancel the collection period, and this will also cancel the collection point, but earnings and employment information that was stored on the collection point will be retained in the collection point history for the employer.

Otherwise you can remove the period, provided the collection point status is pending active. This action will delete the collection point and associated information.

NOTE What if you need to remove the collection period?

Then refer to the steps to remove a collection period and collection point.

- 📄 Remove a collection period and collection point

NOTE What if you need to cancel a collection period?

Then refer to the steps to cancel a collection period and collection point.

NOTE What if you need to remove an incorrect collection point which has either been added in error, or because the claim details have subsequently changed?

Then refer to the steps to remove information from a collection point.

- 📄 Remove information from a collection point
- 📄 Cancel a collection period and collection point

NOTE What if you can't add a DOFI date?

Check the incurred date on the claim. The incurred date needs to match the DOFI date, or occur prior to the DOFI date. If this needs adjusted, contact the relevant Recovery Team Member.

NOTE What if you can't add a DOSI date?

Eos requires a DOFI to be added in all cases. You will need to add a DOFI then you can add the DOSI.

- b Gather earnings and employment information from Inland Revenue via RTE Web Service.

- 📄 Use of Inland Revenue Real-Time Earnings Web-Service Policy

- 📄 Retrieve earnings from IR

NOTE What if you click the RTE button and the information automatically populates in the collection point?

Proceed to 2.0e to review earnings information

NOTE What if the RTE returns an Employer Prime name and a Subsidiary account name?

On the collection point, load the employment as the Subsidiary account number (not the Prime number).

NOTE What if the RTE returns \$0.00 earnings?

You will need to contact the employer and/or client to determine why the earnings are \$0.00 and ensure this is accurate e.g. this may be due to unpaid leave, the client may have ceased employment, the client may be a different type of earner.

NOTE What if client was on a period of parental leave, or leave related to organ donation, at the time of their accident?

Read the Unpaid parental leave policy below.




What you need:

- to confirm the client has a current employment contract and they are an employee
- a written agreement with their employer giving:
- approval to go on parental leave
- a documented start date for parental leave
- an expected return to work (RTW) date

• If the client's incapacity commences during a period of parental leave and they were not working part or full-time at the time of the accident, gather earnings information for the 4/52 weeks prior to the parental leave start date.

• If the client's incapacity commences during a period of parental leave and they were back at work or engaging in other employment at the time of their accident, gather earnings information for the 4/52 weeks prior to the parental leave start date plus gather earnings information for the 4/52 weeks prior to the actual DOSI/DOFI date. Note, for these situations there are further steps you must complete which are documented within a Note at task e.

• If the client's incapacity commences during a period of leave related to organ donation, gather earnings information for 4/52 weeks prior to the date their payment period started. Payment period in this context refers to the period of earnings compensation they receive directly from the Director-General during their leave (max 12 weeks).

-  Unpaid parental leave policy
-  DOFI/DOSI for collecting earnings of a client on unpaid parental leave who has only one employer
-  DOFI/DOSI for collecting earnings of a client on unpaid parental leave who has multiple employers

C Review earnings information to assess eligibility for weekly compensation.

NOTE When can an employee have their employment status extended?




An employee can have their employment status extended if, at DOFI/DOSI, they had recently ceased employment, and they fit one of the scenarios detailed in policy below.

If the client meets the criteria for extension of employment status, please use the system steps for non-permanent PAYE


-  Extension of employment status Policy

NOTE What If the client is not eligible for weekly compensation?

Then discuss the situation with the managing team so that they can investigate further and potentially issue an SPD999 Decline entitlement decision letter to the client.

-  Eligibility Criteria for Weekly Compensation Policy
-  ACC255 Kōrero mai - Working together
-  SPD999 Decline entitlement decision - client

d Add collection point data and review the earnings information.

-  Add collection point information for a permanent employee

NOTE What if client was on a period of parental leave at the time of their accident?

On the collection point, load the Employment, then 'Add' a 'Parental Leave' Earnings and Exclusion Period from the start date of parental leave to the Last Day of parental leave (This may extend beyond the DOFI/DOSI).

- This will allow EOS to take earnings for the 4/52 weeks prior to the parental leave start date
- Calculate Weekly Compensation from the deemed DOFI/DOSI (Start of parental leave).
- Weekly Compensation to be paid from the expected return to work (RTW) date.

NOTE When do I need to follow up the earnings on the RTE?

- The difference between the short and long term is more than 20%
- The client has indicated in the script that they had unpaid leave, but haven't provided the dates.
- There are multiple payments for the same period showing in the RTE.
- If there are periods missing, or \$0.00 periods, showing in the RTE.
- If there has been an unusually large payment.
- If the claim is backdated

NOTE How do I calculate the 20% variance?

Divide the larger number by the smaller number. If the difference is larger than 1.2 then the difference is more than 20%

NOTE What if the client received Commission payments, back pay or a bonus relating to a specific period?

If a payment received cannot be related to an equivalent period of time, the earnings will apply to the period in which it was paid (Example: One-off taxable bonus).


If a payment received relates to a specific period of time, the payment should be considered as earnings in that period (whether that be pre or post incapacity), dependent on when it was paid (Example: Commission).

- If a payment is related to a period within an income year (1 April to 31 March) and the payment is also made within that same income year, we will consider the earnings in the period they relate to.

- If a payment is related to a period within an income year (1 April to 31 March) but is paid in a later income year, the payment is considered earnings in the period in which it was paid. However, in some special cases backdated payments relating to a previous tax year may be considered as earnings in the period that they relate to if the employer had mistakenly underpaid the employee due to an oversight or an error in law.

- If a payment is related to a period across income years (Example: relating to 01 March to 30 April) and paid in that later income year, the payment that relates to the previous income year (in this Example: 01 March to 31 March) will be considered earnings in the period in which it was paid, and the payment that relates to the current income year in which it was paid (in this Example: 01 April to 30 April), will be considered earnings in the period it relates to.

This is because subject to the income tax legislation, the Accident Compensation Act 2001, section 9 specifically defines 'earnings as an employee' in relation to each income year, which is 1 April to 31 March.

 Add collection point information for a non-permanent employee or Non-PAYE shareholder

NOTE What if there is Previous Employee income in the last 52 weeks?

Then add the employer and earnings information for each previous employment to the collection point ensuring that the earnings fits within the defined 52 week period from the 'current non-permanent' employment. You DO NOT need to add any hours or a work pattern for previous employments.


NOTE What if the RTE shows earnings from both the parent company and the subsidiary company in the 52 weeks?

When considering earnings to be loaded into the collection point you will need to add earnings from both employer filings under the most recently filed company unless it is clear there has been a pay out of any leave or a cease date is present on the RTE.

This is a change in the employers ACC number and not a change in the client's employment.

NOTE What if the client is non permanent and was solely self employed/Shareholder for a period of time in the 52 weeks?

Add an exclusion period using Solely Self Employed/Shareholder

 Add collection point information for a PAYE shareholder

NOTE What if the client earned less than the minimum full-time earner rate?

Clients are eligible for the minimum full-time earner rate if they earn less than the minimum rate and work full time (30+ hours per week).


Confirm the client worked an average of 30 hours per week or more over the short term and they would have continued to work 30 hours or more per week over the long term. Confirm in Eos they are eligible for the full-time minimum earner rate.

If the client is a permanent or non-permanent employee, Eos will automatically calculate the full-time earner rate.

NOTE What if the client will cease full time employment (30+ hours per week) during the period of incapacity?


Add a full time cease date from the date where the client is no longer contracted to work guaranteed full time hours.

If employment would not have been full-time beyond a certain date, reduce the long-term weekly earnings figure to its base weekly earnings rate, updated for any applicable indexation. See 12.0 and 13.0 of the Calculate weekly compensation Policy

 Calculate weekly compensation Policy


NOTE What if the permanent employee or shareholder employee took unpaid leave or parental leave in the 52 weeks prior to date of incapacity?


Determine the periods and add as unpaid leave to the collection point.

 Edit collection point information for a permanent employee or PAYE Shareholder

NOTE What if the non-permanent employee took unpaid sick leave?

Periods over seven days of continuous unpaid sick leave should be excluded from the calculation.

 Unpaid leave Policy

 Weekly earnings calculations for non-permanent employee Policy

NOTE What if the permanent or non-permanent employee had previous weekly compensation (ACC earnings) within 52 weeks prior to the DOFI date?

Review ACC earnings on the collection point in Eos. Check the previous weekly compensation claim for the eligible period(s) which may need to be excluded, and manually adjust the dates.

 Gather information for employees

NOTE What if the client was Previously Part Time (worked less than 30 hours) in the 52 Weeks?

If the client is full time (averaged 30+ hours per week) at DOFI or DOSI but was part time (worked less than 30 hours per week) for ANY period in the last 52 weeks (for a reason other than unpaid leave) then they are entitled to a comparison between a permanent and non permanent calculation.

Ensure you check the "Part-Time employment during the 52 weeks prior" box on the collection point to allow this calculation to take place. This step is important, even if there are no other employee earnings because the rounding protocols for Permanent and Non-Permanent calculations are different and this can still result in a better result for the client.

NOTE What if the client has a Section 60 permanent incapacity weekly comp payment?

These payment types need to be administered by Experienced Payments Assessors. If you're not an Experienced Payments Assessor you will need to have this set up task re-allocated.

The S60 payment is an eligible earnings source for the weekly compensation calculation.

Before you add collection point information, on the Section 60 claim check that payable periods extend to the cessation date. Then remove incapacity periods so that they don't overlap with the incapacity period on the new claim. This action can only be performed by the Recovery Team Member managing this claim or certain Experienced Payments Assessors.

After you've edited the incapacity period on the Section 60 claim, return to the current claim and add collection point data for the Section 60 earnings by selecting 'Section 60' as the earnings source for both short and long term earnings type. Ensure the payment periods align and the amount is the same rate as paid to the client on the Section 60 claim.

Once you have completed the collection point data add the claim number of the Section 60 payment in the 'Additional Notes' so this can easily be referred to throughout the eligibility period. The system will prompt you if this section is left empty.

NOTE What if the wrong subcase has been added in error?

Once a subcase has been added in Eos it is unable to be removed. Place a contact on the correct subcase noting the other has been added in error.

- ☞ Add collection point information for a Section 60 permanent incapacity payment

NOTE What if the client's incapacity commenced during a period of parental leave and they were back at work or engaging in other employment at the time?

You will have set up the client's parental leave weekly compensation entitlement as normal.

You will need to manually calculate and pay the client's short and long term weekly compensation entitlement based on the 4/52 weeks prior to the actual DOFI/DOSI using a manual override adjustment. Go to Apply a Top Up or Override Payment procedure for guidance.

- Capture a record of this calculation in a contact on the claim
- End the override period for this entitlement on the parental leave end date + 7 days. If the parental leave weekly comp is for DOSI, end the override the day prior to the parental leave end date.
- You need to update the entitlement start date on the entitlement details tab to DOFI + 7 days (rather than Parental Leave + 7 days).

Note, if the interim weekly comp rate is more than the parental leave weekly comp rate you will need to ensure this rate continues after the parental leave end date (the 'greater of' calculation applies to both short-term and long-term rates i.e. you will either be paying via your parental leave earnings set, or if DOFI/DOSI earnings are higher, continue to pay via the manual override adjustment).

For further guidance, see Activity 6.0 of the 'Unpaid parental leave' policy linked below.

- ☞ **PROCESS** Apply a Top Up or Override Payment

- ☞ Unpaid parental leave policy
- ☞ Weekly compensation rate for a client on unpaid parental leave who resumes employment before their expected RTW date
- e Using the IR number for the employer check the employer party record to determine whether they are an ERA (Employer Reimbursement Agreement) employer.
 - NOTE What if the employer is an ERA employer?**
Go to the Set Up an ERA Payment Process.
 - ☞ **PROCESS** Set Up an ERA Payment
- f Set up the weekly compensation subcase.
 - ☞ Set up a Weekly Compensation entitlement subcase

☞ **PROCESS** **Weekly Earnings Calculations for Permanent Employee**
UNASSIGNED

☞ **PROCESS** **Weekly earnings calculations for non-permanent employee**
UNASSIGNED

3.0 Review client payment

Experienced Payments Assessor, Payments Assessor

- a Check if any deductions need to be applied to the weekly compensation.

NOTE What if abatement needs to be applied?

Go to the Manage Abatement process before returning to Task b.

 **PROCESS** Manage Abatement in Eos

NOTE What if client is receiving a Section 60 Permanent Incapacity weekly compensation payment?

You will need to compare the 2 rates to ensure we pay the client the higher of the 2 amounts. If:

- the Section 60 rate is higher than the weekly compensation rate edit the payment period on the new wc sub-case and select period type 'Do Not Pay' and status reason 'overlapping WC period' for all periods. Record the reason in the 'Notes' field. This process ends.

- the weekly compensation rate is higher, you will need to open the Section 60 payment claim and for each overlapping period (post 1 week stand down), edit the payment and select period type 'Do Not Pay' and status reason 'overlapping WC period'. Record the reason in the 'Notes' field.


If Section 60 payments have been paid during the new weekly compensation inclusion period, for each period that has paid, calculate the difference between the new rate and the Section 60 payment amount. On the subsequent injury claim apply a manual override payment for the difference for each period - Go to Apply a Top Up or Override Payment procedure for guidance.

You will need to suppress the automatic payment notification and send the client a manual payment notification letter explaining the outcome of this decision on their weekly compensation entitlement. See Update the payment notification method system steps linked below for guidance on how to update the notification method. Use the 'None – ACC applied' option from the Notification Method drop down box. You will need to set a task for the next day to remind yourself to change back to the original method so that notifications will send in future.

 Update the payment notification method


NOTE What if a Third party Deduction needs to be applied?

Go to the Manage Client Third Party Deductions process before returning to Task c.

 **PROCESS** Manage Client Third Party Deductions

NOTE What if a reimbursement to Ministry of Social Development (MSD) needs to be applied?

Go to the Reimburse Ministry of Social Development process before returning to Task c.

 **PROCESS** Reimburse Ministry of Social Development

b Review employer details on the script.

NOTE What if the employer on the script is noted as Default Proxy?

Add the current employer from the RTE request to the list of participants on the claim.

If there is a subsidiary employer account, please load this rather than the prime employer.

NOTE What if the incorrect employer has been loaded as a participant to a non-work injury claim?

Add the correct employer from the RTE request to the list of participants on the claim and remove the incorrect employer

If there is a subsidiary employer account, please load this rather than the prime employer.

NOTE What if the incorrect employer has been loaded as a participant to a work injury claim?

Contact the case owner (task creator, or team) to ask them to update the employer's details. If not contactable, create a high priority task and send it to the relevant recovery queue (assisted, enabled, supported, partnered).

If there is a subsidiary employer account, please load this rather than the prime employer.

 Add an employer participant

c Check that the system derived NZSQA date is correct. This date will need to be modified in the situations detailed in the notes below.

NOTE What if you are calculating a further injury period where the weekly compensation is still in the first week of the further injury claim?

Then you will need to adjust the entitlement end date (NZSQA) so that it is correctly calculated from the date of first entitlement (DOFE) on the further injury claim.


NOTE What if the client was not paid an entitlement on EOS's preset DOFI +7days entitlement start date?

Then the entitlement end date (NZSQA) will need to be adjusted from the date of subsequent incapacity (DOSI), now being the DOFE, so that the entitlement end date is correct.

NOTE What if you are setting up a parental leave, or leave related to organ donation, weekly comp for DOSI?

You need to update the entitlement start date so that it is DOFI + 7 days (rather than Parental Leave + 7 days).

 Edit Entitlement Start Date

 Weekly Compensation and New Zealand Superannuation (pre-1 July 2019) policy

d Review and modify the client's Pay Period End Day as appropriate.

NOTE What Pay Period End Day should you choose?


- Pay Period End will default to Sunday – no change necessary unless the client requests an alternative day.

- ERA claims will default to the employers selected Pay Period End Day - no change necessary

e Review and modify the client's Pay Day if required.


 Set a preferred pay day

f Review the calculation for completeness and accuracy.

 Calculate weekly compensation Policy

g Update the payment period's status from Pending to Approved so that a payment schedule of due events can be created and initiate approval.


 Edit a payment period

 Initiate payments for approval

- h** Send the Setup Weekly Compensation task for Approval and Release. Add any notes or instruction to the task description that the approver may require, such as whether the payment should be fast-tracked.

NOTE What if there's no Setup Weekly Compensation task?

Create an Approve Weekly Compensation Entitlements task and send to the Centralised Weekly Compensation Approval queue.

 Add an approval task

- i** Check if the client is being notified through MyACC, after the task has been approved.

NOTE How do you check if the client is being notified through MyACC?

Check whether it says the client has registered for MYACC at the clients Party Record, under Additional Information – Party Flags section.

NOTE What if they haven't signed up for MyACC?

Use the template below to send the client an etxt advising that their payment has been made. ACC payment is set up, \$*amount* (*start date of payment period* - *end date of payment period*) is due in your bank on *banking date*. We've sent you more information by post.

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Add an Eform

Published 27/04/2023

Introduction

Use these procedures to add a stand alone Eform to a party record.

How to

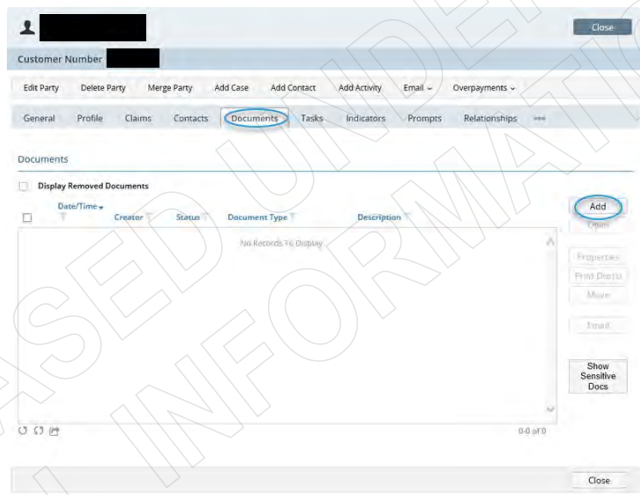
- [Add a non standard WC setup Eform](#)

Add a Non standard WC set up Eform

Step 1

Open the party record then select the Documents tab. Click **Add**

Add a document to a party record



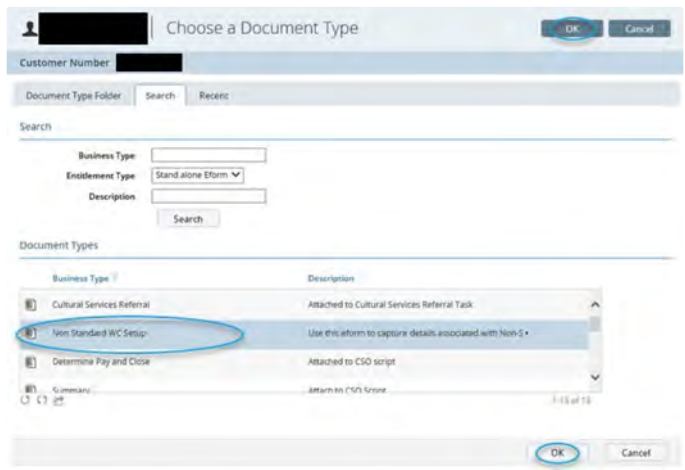
Step 2

Select 'Stand alone Eform' from the Entitlement Type dropdown. Click Search.

Step 3

Select a document type from the list of Document Types. Click OK.

Select an Eform type TS165360



Step 4

Select the Non Standard WC setup purpose then complete the relevant details. Click OK.

Customer Number [REDACTED] OK Cancel

Non Standard WC Setup

Request for Transfer of Weekly Compensation?
 Accredited Employer Transfer?
 Loss of Potential Earnings?
 Reinstatement of Weekly Compensation?

Incapacity Details

Medical Certificates Loaded in Eos?
 Medical Certificate Number [REDACTED]
 DOFI [DD/MM/YYYY] [calendar icon]
 DDSI [DD/MM/YYYY] [calendar icon]

Pre-Incapacity Earnings

Pre-Incapacity Earnings Certificate on File?
 Employment Status (If Applicable) [Not Selected] [dropdown]
 Days Worked Per Week (If Applicable) [Not Selected] [dropdown]
 If Special Please Specify Details [REDACTED]
 Date Last Pay Period Ended [REDACTED]

Post-Incapacity Earnings

Post-Incapacity Earnings Information in Eos?
 Has Claimant Been on a DWI Benefit?
 Will Post-Incapacity Earnings Continue?
 Multiple Abatement Details Attached?

Payee Information

IRD Number [REDACTED]
 Tax Code [Please Select] [dropdown]
 Bank Account [REDACTED]
 Has Bank Account Been Verified?

Transfer of Weekly Compensation Information

WC to be Transferred From Claim (1) [REDACTED]
 WC to be Transferred To Claim (2) [REDACTED]
 Date WC to be Transferred From [DD/MM/YYYY] [calendar icon]

Loss of Potential Earnings Information

In Paid Employment Prior to DOF/DOS?
 Periods of Eligibility [REDACTED]

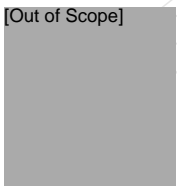
Reinstatement Information

If Reinstatement - Date From [DD/MM/YYYY] [calendar icon]
 Weekly Compensation to be Paid To [Not Selected] [dropdown]
 Details of Payee if not Claimant (Name, Address, Bank Acc, etc) [REDACTED]
 Interest Payable?
 Interest Request Attached to Task?
 Comments [REDACTED]

Security Level [Not Selected] [dropdown] OK Cancel

Step 5

The Eform has been added to a list of documents for the party record.



Claims

EOS Online Topic

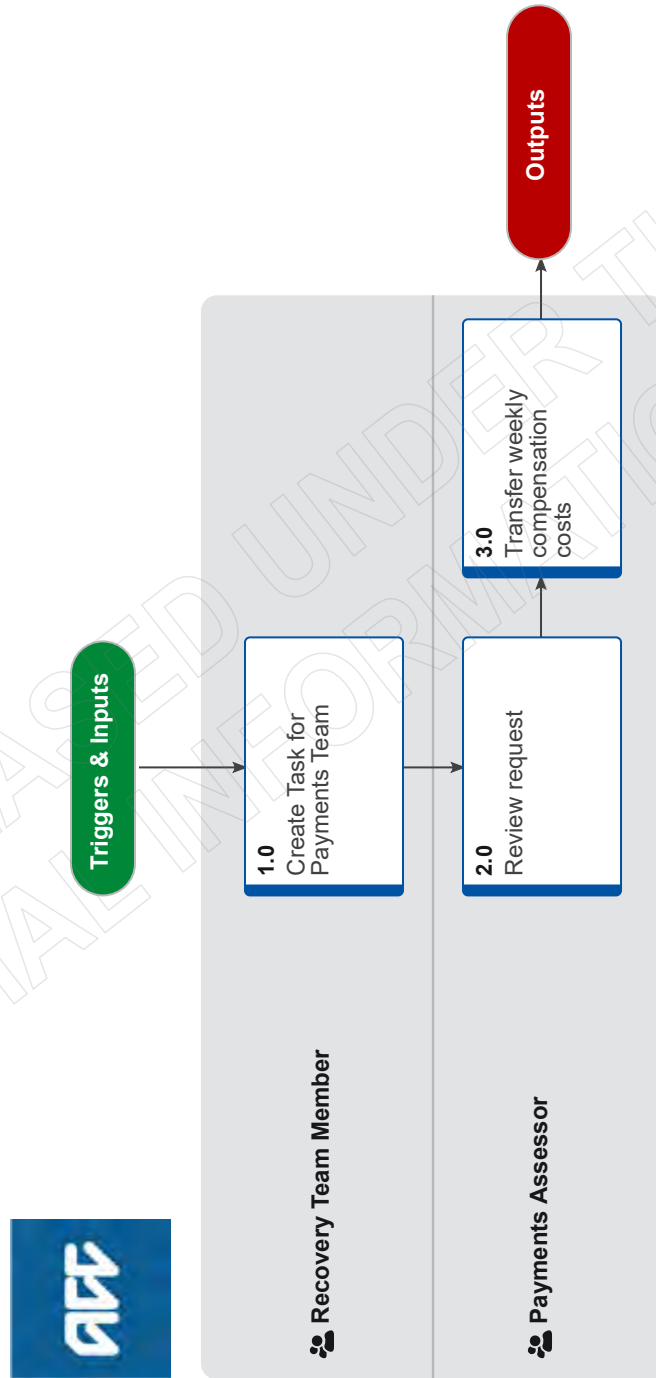
Documents

Information Type

System Steps

Relates To

Claim



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

Use this process when you receive a request to transfer weekly compensation costs from one claim to another claim for the same client.

NOTE - THIS PROCESS HAS NOTHING TO DO WITH THE FURTHER PERSONAL INJURY PROCESS.

If you need to consider transferring weekly compensation from one claim to another due to a further injury, refer to the process "Determine Transfer of Weekly Compensation to a new claim due to Further Injury".

Background

Claim costs for weekly compensation can be transferred to another claim where they have been allocated to the incorrect claim. The action to transfer costs is completed so that the costs can be correctly calculated and attributed for Experience Rating purposes.

Owner

[Out of Scope]

Expert

Procedure

1.0 Create Task for Payments Team

Recovery Team Member

- a Confirm you have included all the information the payments team requires to action the transfer

NOTE What information does the payments team require?

- The claim number that you are going to transfer costs from (original claim)
- The claim number that you are going to transfer costs to (target claim)
- The amount of the costs that you want to transfer if this is different from the default, which is the full amount
- The reason and description why you are transferring costs between claims

- b Create Task and Send Request to Payments Team

NOTE What task should I create?

Create a [Follow up Entitlement] task, ensuring you have included all the necessary information in the task.

- c Assign the task to the Centralised Weekly Compensation Queue

2.0 Review request

Payments Assessor

- a Confirm you have the relevant information to transfer the weekly compensation claim costs.

NOTE What information will I need to complete the transfer?

- The claim number that you are going to transfer costs from (original claim)
- The claim number that you are going to transfer costs to (target claim)
- Details of the weekly compensation records that you want to transfer
- The amount of the costs that you want to transfer if this is different from the default, which is the full amount
- The reason and description why you are transferring costs between claims

3.0 Transfer weekly compensation costs

Payments Assessor

- a Transfer the weekly compensation costs from the original claim to the target claim.

Transfer the cost to another claim

NOTE What if I've made an error and have transferred the costs to the incorrect claim?

Then using the same steps, transfer the costs back to the original claim and complete this step again to transfer to the correct claim

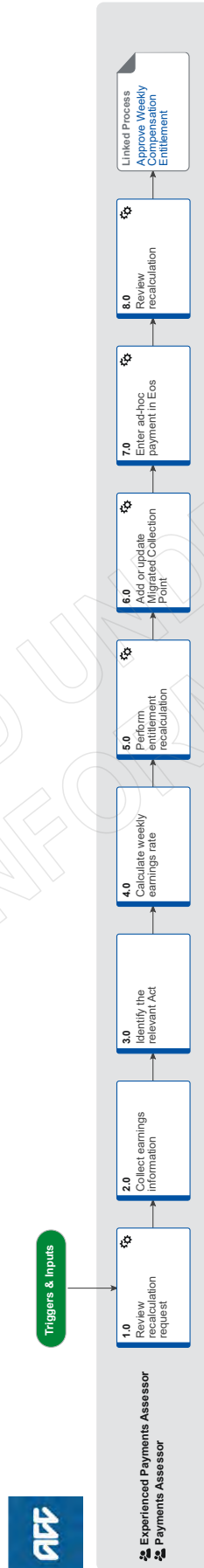
- b Update the Weekly Compensation Entitlement (WCE) subcase from the original claim to Inactive.

Make the Weekly Compensation sub case inactive

Recalculate Weekly Compensation Claims paid from Pathway v20.0

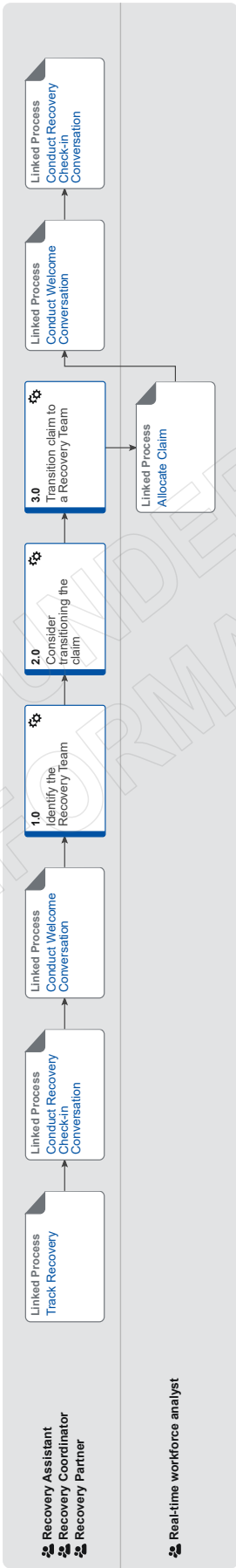


RELEASED UNDER THE OFFICIAL INFORMATION ACT





RELEASED UNDER THE OFFICIAL INFORMATION ACT



Recovery Assistant
Recovery Coordinator
Recovery Partner

Real-time workforce analyst

Summary

Objective

To review and consider transitioning a clients to another recovery team so that they receive the right level of support for their needs, at the right time.

Background

Clients will transition between recovery teams throughout the life of their claim. This might happen when:

- they progress with their recovery
- their situation changes
- new information becomes available.

Transitioning a client to a new recovery team takes place when the current team is no longer the best option for supporting their needs. Recovery team members should use their discretion when making this decision, drawing on Promapp guidance, provider feedback, and recovery support as required.

Owner

[Out of Scope]

Expert

Procedure

PROCESS **Track Recovery**
Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS **Conduct Recovery Check-in Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

PROCESS **Conduct Welcome Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Identify the Recovery Team

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the claim for information about a change in the client's circumstances and support needs.

NOTE **What if the claim is due to be closed within the next week?**

The claim does not need to be transitioned. This process ends.

NOTE **What if the client has another open claim with Escalated Care Pathways?**

If the claim is not a musculoskeletal injury then the claim should continue to be managed by a Recovery Team Member. If it is for a musculoskeletal injury, contact the ECP Team on 77097 to discuss.



The ECP Team will review with you, and may contact the ECP Provider managing the other claim to see if they also need to manage the additional claim. If they are going to do this, they will create a general task in EOS to track the progress and outcome. While you are waiting for an outcome, you should refrain from transitioning the claim unless there is an urgent request that needs assessment by a particular Recovery Team Member skillset.

If the ECP Provider needs to manage the additional claim, the ECP Team will update and transfer the claim to the ECP queue in EOS. If the Provider does not need to manage the additional claim, the ECP Team will update the task description to reflect this and close the general task. The claim can be transitioned if the ECP Provider is not going to take on the claim.

NOTE **What if you are in Assisted Recovery and need to determine which Assisted Recovery cohort should manage the claim?**

This is for claim transitions between Assisted Recovery cohorts only. For transitions into Assisted Recovery, see step 1.0 b.

- b** To enable you to make an informed decision on which is the correct Recovery Team review GUIDELINES Choosing the Right NG Recovery Team and NG GUIDELINES Whole of Person Guidelines and Allocations Rules.

-  GUIDELINES Choosing the right Recovery Team
-  Whole of Person Guidelines

NOTE **What if your client is newly injured?**

Hold off on considering a transition until more information is available, sometimes injuries are not as significant as first thought or clients make faster recoveries and may not need to transition to a different recovery team.

NOTE What if a treatment injury claim is accepted for cover for a mesh injury?

- If the Engagement Model Decision results state to send to Partnered, this claim will be transferred to Te Ara Tika.
- If the Engagement Model Decision results state to send to Assisted, Enabled or Supported, this claim will be transferred to Supported Recovery.
- For existing clients in Assisted Recovery - unless it is determined the client needs a higher level of support, these claims can remain in Assisted Recovery. If the client does require 1:1 support then normal transition guidelines should be followed.
- For existing clients in Supported Recovery or Partnered Recovery - if it is determined that the client needs some specialised support then the Recovery Team Member can discuss this with their Team Leader before the claim is transitioned to:
 - if transitioning to Supported Recovery, the claim will be assigned to a Recovery Coordinator who has been identified to manage mesh injury claims.
 - if transitioning to Partnered Recovery, the claim will go to Te Ara Tika.


NOTE What if there are claims managed by Third Party Administrators either through the Accredited Employer Programme or TPA Non-Work Service?

ACC should not be proactively offer to manage these alongside other ACC claims:

- For work related injuries managed under the Accredited Employer Programme, these claims will continue to be managed by the Accredited Employer or their nominated Third Party Administrator.
- For non-work related injuries managed by Third Party Administrators, these claims will continue to be managed by the nominated Third Party Administrator, however clients can opt out of this at any point and ACC can assume management of the claim if the clients wishes to opt out contact tpasupport@acc.co.nz or DDI 45394 they will facilitate the opt out and claim return.


NOTE What if it is a Work-Related injury and claimant is employed by an Accredited Employer

Go to the Identify and Transfer Work-Related Injury Claim to Accredited Employer (AE) Process.

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

NOTE What if it is a Non-Work-Related injury and the claimant is employed by an Accredited Employer

Go to the Identify and Transfer Non-Work-Related Injury Claim to Third-Party Administrator (TPA) process.

-  **PROCESS** Identify and Transfer Non-Work-Related Injury Claim to Third-Party Administrator (TPA)

NOTE What if the client has an actively managed Physical Injury claim and Complex Mental Injury claim in Assisted?

- If the client's needs are stable or require minimal support, both claims can be effectively managed by Assisted Recovery. The client does not need to be transitioned. For further information refer to the Whole of Person Guidelines and Allocation Rules.

- If the client's mental health deteriorates and their needs change and they require one on one support, this claim could be considered for transition and Whole of Person may apply. Refer to the Whole of Person Guidelines and Allocation Rules below.

NOTE What if the client has an actively managed Complex Mental Injury claim and Complex Physical Injury claim?

Both claims need to be managed by the Recovery team member managing the Complex Physical Injury.

NOTE What if the client has multiple claims requiring management?

All claims need to be managed by the individual or team that can best support their needs. For further information refer to the Whole of Person Guidelines and Allocation Rules.

NOTE What if the client is to remain with the same team but has a request related to their Recovery Team member's location?

For CMI claims: if at any time (including migration) the client identifies that they do not wish to be managed by their geographically located team record the conversation in a future dated contact. As this is customer engagement also record it in the Cultural area of the Recovery Plan with the client's preferred method of communication. The client can also be transferred to their local region if they move and request local management. Send an email to WFM@acc.co.nz requesting a change of Recovery Team member in addition to completing this process.

For Physical Claims - These will only be transferred if it will result in the best possible outcome for the client. The decision to transfer a client is based on their need and is made by Recovery Team Members with team leader approval. On the agreement that a claim can be allocated locally, rationale is noted on the claim and the Team Leader should agree on the named Recovery Team Member to receive the allocation, they then complete the Submit Claim Movement survey located in the WFM-Supported sharepoint this will ensure that claims go via the capability streaming tool.

NOTE What if the client has an active Care Indicator?

Recovery Team Member to review the Care Indicator prior to transition and discuss with their Team Leader as required to ensure any risks are identified and appropriate action taken.

NOTE What if the client has an active Vulnerable indicator?

Recovery Team Member to review the Vulnerable indicator and discuss with their Team Leader as required to ensure any risks are identified and appropriate action taken. Clients with Vulnerable indicators cannot be managed in Assisted or Enabled.

NOTE What if you are a Recovery Partner considering transitioning a client into or out of a capability stream?




Transition to the engaging in work team, will happen after the Recovery Team member has had a conversation with their Team Leader. Transitions are required to have Team leader agreement and this be noted on the claim.

See page 10 of GUIDELINES Choosing the right Recovery Team for points to be discussed with Team Leader.

NOTE What if you are a Recovery Partner considering transitioning a client into or out of Hāpai?

Notify your Team Leader if you believe your Māori clients will be best supported in Hāpai. Your Team Leader will contact the Hāpai Team leader to discuss capacity and potential transition to a Kaihāpai.

If a decision is made to transition into Hāpai, See page Transition a claim into or out of Hāpai for more information and ensure that you add the Hāpai indicator.

-  Hāpai - Transition Claims
-  Add a Hāpai Indicator
-  Transition Guidelines Between Assisted Recovery Cohorts

2.0 Consider transitioning the claim




Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Contact the client to discuss moving their claim to another team and understand the clients preference.

For guidance on how to conduct this conversation refer to NG SUPPORTING INFORMATION Having Recovery Team Transition Conversation and NG FAQ Transitioning a Client to Another Recovery Team.

NOTE What if there is another claim being managed by another team/person?

Consider Whole of Person management and follow the process as set out in the Whole of Person Guidelines.

-  Whole of Person Guidelines
-  NG FAQ Transitioning a Client to Another Recovery Team
-  NG SUPPORTING INFORMATION Having Recovery Team Transition Conversations

NOTE What if you are unsure a transition is needed?

Make sure you have a conversation with your team leader to clarify if a transition is needed BEFORE you discuss with the client.

NOTE What if the client doesn't agree to be transitioned?

- Record your conversation with the client as a contact on the claim.
- Discuss with your leader how to approach the transition conversation at the next Recovery Check In.
- Add a note in the description field to the next Recovery Check In to remind you to if appropriate considering revisiting transitioning the client.

This process ends.

NOTE What if you are a Recovery Coordinator or Partner and are unable to contact the client?

- Attempt a maximum of 2 contacts over 2 full working days before leaving a voicemail or sending a notification to request client contact.
- If you are unable to reach the client, extend the task for additional 2 working days and note in the task description that this is the 2nd attempt to contact the client.
- On the task due date and if there is been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach then by phone letter.
- Extend the task date as appropriate to take into account postal delivery and note in the task description this is the 3rd attempt to contact the client and the CM04 letter has been sent.
- On the task due date and if there is no contact from the client and they are continuing to receive support, discuss with your team leader to determine next steps. You may also consider seeking internal guidance.
- If you're in Partnered and no contact is made with the client after three attempts, you must contact the provider, GP or other verified contact on the claim.

NOTE What if you are a Recovery Assistant and are unable to contact the client?

Recovery Assistants must make at least one attempt to contact the client to discuss the transition. If contact is unsuccessful this needs to be documented in the reminder action created in the steps 2.0b

NOTE What if the client has a Complex Mental Injury and is being transitioned from Partnered to Assisted Recovery?

- Client has an accepted claim
- The client does not have an active vulnerable indicator
- There are no risks noted in the report or by the provider
- The client is actively engaged in their therapy and well supported
- The client is receiving non complex supports and not financial support i.e. weekly compensation
- The client is not under 18 years of age

The decision to transition the claim is done collaboratively and must be discussed with the client and/or provider prior to transition.

- b** Based on the discussion you have had with the client, determine if they should be transitioned to a different Recovery Team which can better support their needs.

NOTE What if the client is in Supported or Partnered Physical Injury and is 16 years or younger?

Team Leader approval for the transition must be obtained prior to the transition to Assisted Recovery. Email your Team Leader the claim number, summary of the client situation and rationale for transition, with clear evidence that you have considered:

- The client's whole situation including ease of communication with parents/guardians, current living situation and other indicators described in Note 1a of Referring children in potentially vulnerable situations.
- The stability of the current injury must be clear, with Clinical Services hotline input if the injury is not clearly progressing / resolving Seek Internal Guidance.

Team Leaders will consider the clinical needs, social needs and likelihood of a stable and sustainable return to independence for the child. Team Leader will respond by email with Approval or Declinature and recommended next steps.

If approved, update Life Areas in Salesforce with the date of the approval noting "Transition to Assisted Recovery Approved". File the email away to the claim.

If declined, update the Recovery Plan to include recommended next steps.

 Referring children in potentially vulnerable situations

 Seek Internal Guidance

NOTE What if you have determined the doesn't need to be transitioned?

The client remains with the current Recovery Team. This process ends.

NOTE What if there is an unmanaged Mental injury claim that is impacting the current managed claim?

If recommendations have been made for support to be provided or considered on a claim with a sensitive indicator, follow the below steps:

- 1) The Recovery Team Member managing the physical injury claim should contact the client and discuss the recommendations.
- 2) Offer the client an opportunity to speak with a Recovery Partner to discuss what ACC support could be considered under the sensitive claim.
- 3) If the client agrees to having this conversation with the Recovery Partner, create an NGCM call back request task on the client's party record with the follow details
 - a. What has prompted this contact request
 - b. Brief summary of the client's situation
 - c. Contact to be made with client to discuss supports under sensitive claim and re-opening this.
4. Link the claim number to the task and transfer to the Partnered Recovery Department queue for allocation.

For the Recovery Partner:

- 5) Contact the client to discuss support and re-engaging under the sensitive claim.
- 6) If the client agrees to engage in support or wishes to continue with agreed next steps under the sensitive claim, the Recovery Partner should then consider whether whole of person conversation is appropriate now or once an engagement form has been received.


See Whole of Person Guidelines below.

- 7) Ensure the claim is open and assign to you if the client has agreed to engage in support.

If the client does not wish to engage with support under the sensitive claim, advise the Recovery Coordinator or Recovery Assistant of this outcome. Record your contact and close the task. Claim can be transfer into Actioned cases.


NOTE What if you consider the claim should transferred to the Remote Claims Unit (RCU)?

Go to (NGCM) Transition claim into Remote Claims Unit (RCU) process.

-  **PROCESS** Transition client into Remote Claims Unit (RCU)

NOTE What if you consider the claim should be transferred to the Wellington Central Branch/ Te Ara Tika team?

Go to (NGCM) Transition Claim to Te Ara Tika.

-  **PROCESS** Transition Claim to Te Ara Tika

 Whole of Person Guidelines

NOTE What if you have received a 'General' task requesting a claim be transferred to Escalated Care Pathway (ECP)?

Close open tasks on the Recovery Plan. Transition the claim and the 'General' task received from ECP to 'Escalated Care Pathway' department queue for the ECP team to manage using the following system steps.

If you need to contact or transfer a call to the ECP team you can call [s 9(2)(a)] or email ECPTeam@acc.co.nz

3.0 Transition claim to a Recovery Team

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Prepare the claim for transition. Follow the below appropriate note, these steps must be completed:


NOTE What if you are preparing the claim to transition to Supported or Partnered?

- Check shared inbox and file away any emails (see system steps below)
- Ensure no outstanding emails on the claim
- Ensure filing away is completed and document list is tidy
- Complete all actions due
- Complete all urgent or overdue work required (Including referrals and emails)
- Life Areas updated
- Recovery goal updated
- Client is aware of and happy to transition (if not successfully able to contact this is noted in the task)

NOTE What if you are preparing the claim to transition to Assisted?

- Filing away completed and documents are tidy (see system steps for filing away below)
- All actions completed.
- All urgent or overdue work required is complete (including referrals and emails).
- Life areas updated.
- Recovery goal updated.
- No tasks overdue or due within 48 hours.
- Stakeholders (employer, provider etc) informed and information is updated i.e. participants.
- Remove any unnecessary Reminder tasks (i.e. waiting for report to arrive).
- Client is aware of and happy to transition.


If the client requires no further rehabilitation go to the Identify a Client for No Further Rehabilitation process.

 **PROCESS** Identify a Client for No Further Rehabilitation

 NGCM Filing Away - System Steps

NOTE What if the Recovery Plan requires updating?

Go to the Create or Update Recovery Plan process

 **PROCESS** Create or Update Recovery Plan

- b** Complete transition by following the below appropriate note:

NOTE What if you are transitioning a claim to Supported or Partnered


From the Salesforce Recovery Plan, add a Reminder Action and set the action due date to today then enter the following information into the description field:

- Send a notification to the client advising them of your contact details (Management team change notification).
 - Provide your rationale for transitioning the claim.
 - If applicable, state next actions.
 - In Eos, transfer the claim to the appropriate department queue. See Transfer a claim system steps below.
- *If the information exceeds the reminder character limit of 1500 characters then record the rationale for the transition in the 'Engagement' life area and note this in the reminder action.

If you are transitioning the claim to Partnered Recovery and need to advise if the claim needs to be allocated to the Mental Injury or Physical Injury team please email WFM@acc.co.nz

NOTE What if you are transitioning a claim to Assisted

- Notify provider/employer (if appropriate) of the transition and provide Assisted Recovery's details.
- In Salesforce, in the engagement life area record the transition rationale.
- In Eos, transfer the claim to Assisted Recovery.
- Ensure you have provided the client with Assisted Recovery's contact details either via phone, email or text notification.

 Transfer a claim (Eos Online Help)

 Create a Notification - System Steps

NOTE What if the client is continuing to receive one to one management but being transitioned to a new Recovery Coordinator/Partner?

Prepare the claim for transition as per the above preparation note.

From the Salesforce Recovery Plan, add a Reminder Action and set the action due date to today then enter the following information in the description field:

- Send 'Management team change' notification to the client
- Provide your rationale for transitioning the claim
- If applicable, state next actions.
- Email WFM@acc.co.nz if there are any allocation requirements (eg. location, gender, cultural capability)

NOTE What if your client is transitioning from Supported or Partnered Recovery and receives Medical Consumables through Community Client/Onelink?

Ensure any 'work items' awaiting approval are processed prior to transitioning the claim and that relevant Providers/Assessors are aware of the change of Recovery Team to ensure they select the correct approver for future requests.


NOTE What if the client is being transitioned from Enabled to Assisted?

I am a Recovery Administrator:

- In Eos, transfer the claim to the Assisted Recovery Department queue.
- Send 'Management team change' notification to the client with Assisted's contact details.
- If the claim has been incorrectly put in Enabled Recovery and a Welcome Conversation is required to complete the initial set up, create a NGCM Welcome Conversation task in Eos. Note in the description the reason for the transition.
- If the claim needs to be transitioned due to no longer meeting Enabled criteria (refer to Choosing the right Recovery Team), create the Recovery Plan in Salesforce. Add a Recovery Check In action (see create or update Recovery plan) and note in the description the reason for the transition.


I am a Recovery Assistant:

- In Eos, transfer the claim to the Assisted Recovery Department queue.
- Send 'Management team change' notification to the client with Assisted's contact details.
- If the claim has been incorrectly put in Enabled Recovery and a Welcome Conversation is required to complete the initial set up, attempt Welcome Conversation and set up the Recovery Plan accordingly.
- If the claim needs to be transitioned due to no longer meeting Enabled criteria (refer to Choosing the right Recovery Team), attempt a full Recovery Check in, if the client is an earner collect all Employment information e.g. Job title, job tasks and contact details for Manager and update the Recovery Plan accordingly.
- If the client is an earner attempt Employer Welcome Conversation and update life areas with relevant information.

 **PROCESS** Create or Update Recovery Plan


NOTE What if the client is being transitioned to Enabled?


- In Salesforce, complete all actions on the Recovery Plan timeline and mark as 'complete' or 'no longer relevant' (it is preferred that there are No open tasks for on-going claims management for clients with claims in Enabled Recovery).
- In Eos, transfer the claim to Enabled Recovery Department queue.
- Send 'Management team change' notification to the client.

 Transfer a claim (Eos Online Help)

NOTE What if you're transferring a claim from BAU to a Recovery Team?


In Eos, transfer the claim.

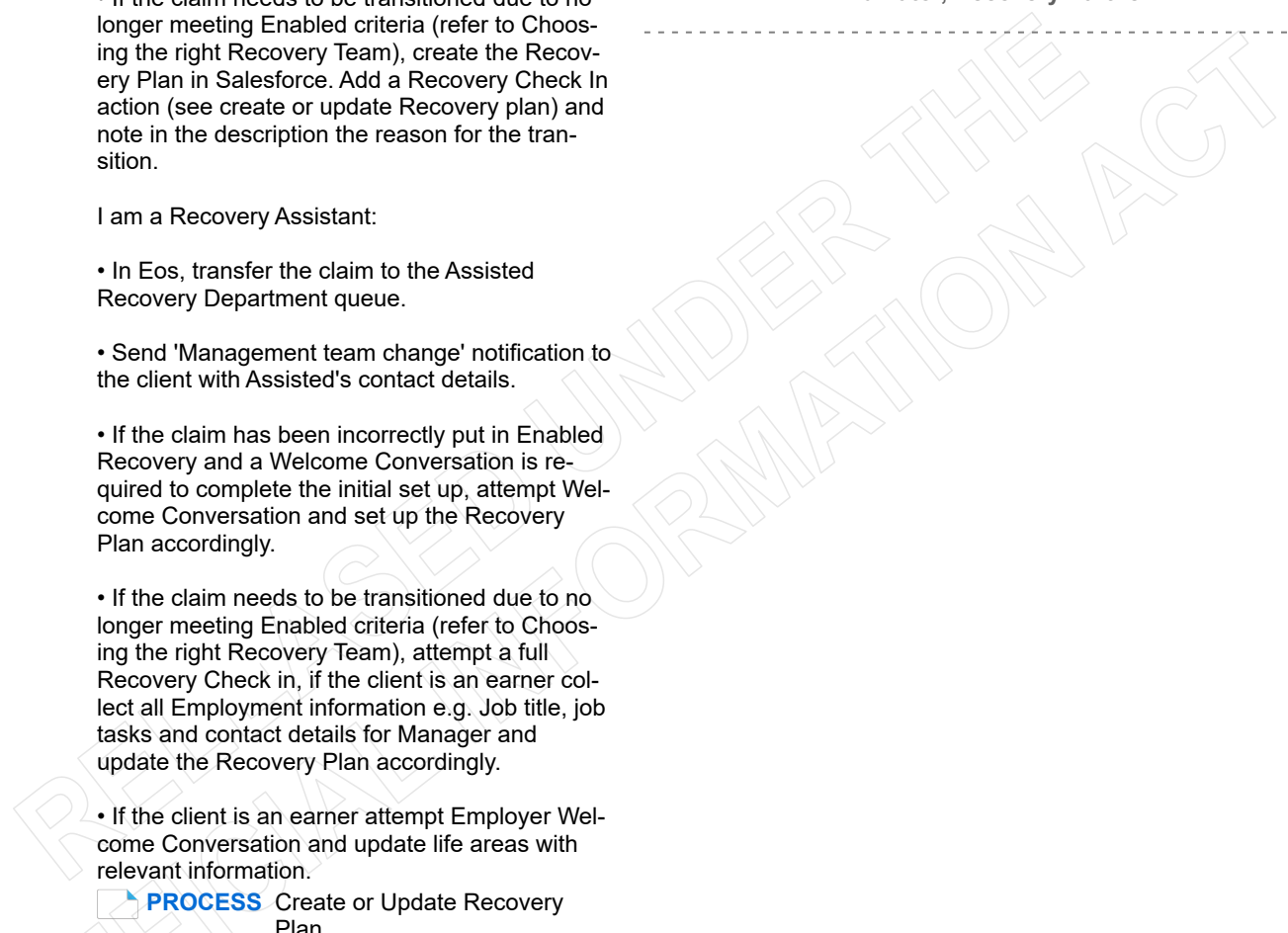
 Move a claim from BAU to NGCM

 Run or Edit Engagement Model Decision (EMD)

 **PROCESS** **Allocate Claim**
Real-time workforce analyst

 **PROCESS** **Conduct Welcome Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Conduct Recovery Check-in Conversation**
Recovery Assistant, Recovery Coordinator, Recovery Partner



Transfer a claim

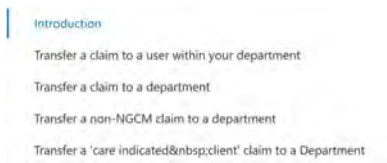
Published 1/11/2022

Introduction

Use these instructions to transfer a claim to another user or department.

Note: If you are completing a task for an actioned sensitive claim and you do not have access to sensitive claims, go to the party record and create a task. Once created transfer the task to the appropriate queue for processing.

How to:



Work in Eos is defined as claims and tasks related to claims. Claims assigned to an individual appear in the **My Claims** tab on the **Claims** screen, while tasks assigned to an individual appear in the **My Tasks** tab on the **Tasks** screen.

Claims can be opened, transferred to another user within the same department or transferred to another department. You can also open the claim list of another user within your department.

Users who work in more than one place, such as staff who relieve in other branches, can switch between the different departments they work in as required. Claims and tasks owned by a department and not yet assigned to an individual will show on the **Department Claims** tab and **Department Work** tab respectively. When a claim is transferred, only tasks that are open against the claim in the name of the current case owner are transferred to the new case owner.

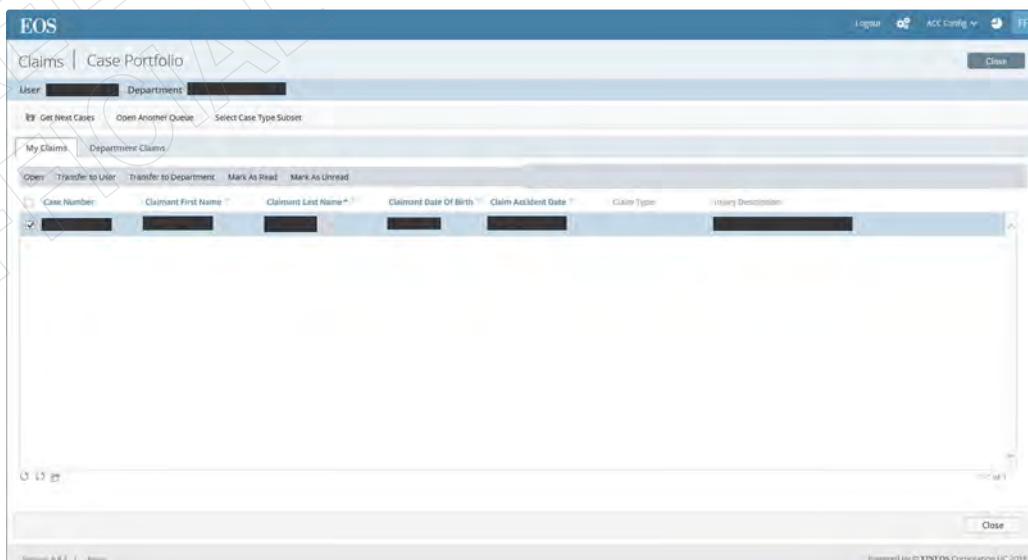
Note: When transferring a claim, 'Transfer all open child activities associated with this activity and owned by Username/Department' by default will be selected. This is to ensure that all these open child tasks will be automatically transferred from the current case owner to the new case owner.

Transfer a claim to a user within your department

Step 1

Go to the **My Claims** tab on the **Claims** screen.

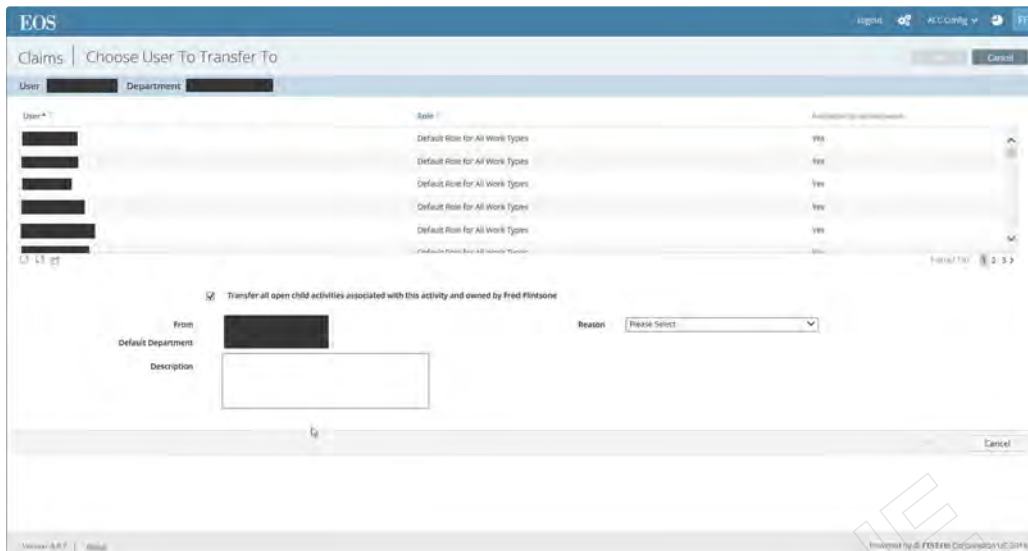
My Claims Tab TS100693



Step 2

Select the claim you wish to transfer and select **Transfer To User**.

Choose **User to Transfer To TS101156**



Step 3

Scroll through the list of users or click on the search icon and enter the user you wish to transfer the claim to. Click **Apply**.

Step 4

Select a reason for the transfer from the dropdown list.

Step 5

Enter an explanation informing the recipient of the reason for the transfer in the **Description** field. Click **OK**.

Note: Claims can only be transferred to staff members in the same department as the current case owner.

Transfer a claim to a department

Step 1

Go to the **General** tab on the **ACC45 Claim** screen.

Step 2

In the **Management Details** section, select the **To Department** field magnifying glass icon.

Step 3

Scroll through the department list to select the department name.

Step 4

Select a reason for the transfer from the dropdown list. Click **OK**.

Note: Any text entered in the **Description** field will not be viewable by the recipient of the claim. Rationale for transfer should be in a **Reminder Action** in the **Engagement Life** area of the **Recovery Plan**.

Do not transfer a claim to **Actioned Cases** if it belongs to another department. A request must be sent to that department requesting they close the case.

Transfer a non-NGCM claim to a department

Step1

From the **ACC45 Claim** select **Add Activity**.

Step2

Select the **Transfer to Next Gen** option.

Note: Some old claims in Eos don't have an ACC45 which means that an error will occur if you use the **Transfer to Next Gen** button. If this is the case the claim needs to be transferred manually as follows:

- Transfer the claim to the appropriate department
- Update the business model to NGCM
- Add Recovery Plan subcase
- Manually send the MyACC invite

Step3

Select the **Recovery Team** you want to move the claim to from the list. Click **OK**.

Transfer a 'care indicated client' claim to a Department

Note: Claims for risky clients should not be transferred to another branch without the agreement of that branch manager.

For more information on risky clients, see [Transferring care indicated clients to another branch](#)

Step 1

Go to **My Claims** tab on the **Claims** screen. Select the claim you wish to transfer and select **Transfer To Department**.

Step 2

Scroll through the department list to select the department you're transferring to.

Step 3

Select a reason for the transfer from the dropdown list.

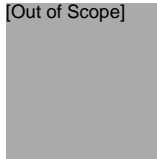
Step 4

Enter an explanation advising the recipient department of the reason for the transfer in the **Description** field.

Step 5

Enter additional information in the **Description** field to ensure details of the risky client status and the transfer are clearly recorded. Click **OK**.

[Out of Scope]



Claims

Information Type

System Steps

Relates To

Internal

RELEASED UNDER THE
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Determine Transfer of Weekly Compensation to a new claim due to Further Injury v20.0



Summary

Objective

Refer to this guidance when a client suffers a further personal injury. This information applies to claims where the client became unable to work from 1 July 2010.

Background

A client who is unable to work due to a personal injury and receiving weekly compensation from ACC may sustain a further personal injury, which is also covered by ACC.

For example, a client may be on weekly compensation for a knee injury sustained while playing sport then, also suffer a back injury lifting a heavy object in a separate accident. This second injury is regarded as a further personal injury. Also, a client may be on weekly compensation for a lumbar sprain. After further investigation, a surgery request is approved on an older claim with cover granted for a disc prolapse. Even though it's on an older claim, this is still considered a further injury.

In such cases, ACC needs to decide if and when weekly compensation payments should be transferred, from the prior personal injury claim, to the further personal injury claim. This is because a client cannot receive weekly compensation on more than one claim file at a time.

If there is a transfer, the existing weekly earnings calculation on the prior personal injury claim, continues to apply on the further personal injury claim. A recalculation of weekly earnings, based on earnings prior to the date of the further personal injury, is not required.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine whether weekly compensation should be paid on the further personal injury claim

- a Use the below two decision tables to determine if and when to transfer from the prior personal injury claim, to the further personal injury claim.

if, at the time the further personal injury occurs...	and...	then...
<ul style="list-style-type: none"> - the client is receiving abated weekly compensation payments - the amount of weekly compensation payable in the week after the further personal injury, is double (or more than double) the amount of abated weekly compensation payable, in the week prior to the further personal injury <p>Note: This doubling effect will be caused by any increase in the level of incapacity, due to the further injury and the corresponding reduction in earnings they were getting, through partial work</p>	<p>the expected duration of incapacity:</p> <ul style="list-style-type: none"> - for the further personal injury is likely to exceed or be equivalent to that of the prior personal injury <p>or</p> <ul style="list-style-type: none"> - for both the prior personal injury and further personal injury is likely to exceed two years 	<ul style="list-style-type: none"> - weekly compensation payments must transfer to the further personal injury claim, from the date that the further personal injury occurs <p>otherwise</p> <ul style="list-style-type: none"> - consider decision table two below

Decision table one - abated weekly compensation.PNG

NOTE Example

A client injures their right knee while at work, which causes a permanent inability to perform their work duties. ACC determines that they are eligible to receive a weekly compensation payment of \$400 per week.

The client gradually returns to a new job at near full capacity and is receiving \$100 abated weekly compensation per week when they have a motor vehicle accident and injure their left leg, which results in an amputation. Weekly compensation payable after the further personal injury is \$400, because the client is certified fully unfit for work from the date that the further personal injury occurs.

As weekly compensation payable in the week following the further personal injury (that is, \$400) is more than double the amount payable in the week prior to the further personal injury (that is, \$100), and medical evidence confirms that both the first and second injury are likely to cause inability to work of equivalent duration, weekly compensation is transferred to the further personal injury claim from the date that this further personal injury occurs.

if at the time of the further personal injury...	then...
<p>the client is receiving either</p> <ul style="list-style-type: none"> - full, unabated weekly compensation - abated weekly compensation and decision table one (above) does not apply 	<p>weekly compensation continues to be payable on the prior personal injury claim, until the date that the prior personal injury ceases to cause incapacity</p> <p>if, at this date, incapacity continues as a result of the further personal injury, weekly compensation payments transfer to the further personal injury claim</p>

Decision table two.PNG

NOTE What are the exceptions when considering whether to transfer from the prior personal injury claim, to the further personal injury claim?

1. If Earnings Related Compensation (ERC) was being paid on two claim files immediately before 1 July 1992 and these payments were carried over under the transitional provisions, of the Accident Rehabilitation and Compensation Insurance Act 1992 and subsequently carried forward under the transitional provision, of the Accident Insurance Act 1998 and the Accident Compensation Act 2001.

2. If a client is receiving compensation as a dependent, on an accidental death claim and is also receiving weekly compensation for loss of earnings, due to personal injury on another claim.

NOTE What if it is unclear whether incapacity is related to the new personal injury?

Contact the clients treating practitioner to establish the date on which the inability to work, due to the initial personal injury, will cease and the date on which the inability to work, due to the further personal injury, will cease, the following questions may be helpful:

- In your opinion, on what date would <client's name> have been fit for work, after their initial personal injury?
- If you are unable to provide this date, is it your view that the inability to work, due to <client's name> initial personal injury, will continue beyond that, due to their further (new) personal injury?
- Is <client's name> further personal injury contributing to their current inability to work?
- Has <client's name> further personal injury delayed recovery from their initial personal injury?
- Is it your view that <client's name> inability to work, due to their initial personal injury, would have stopped, before the inability to work due to their further personal injury stopped? That is, would they have received a clearance, had it not been for their further personal injury?
- In your opinion, on what date should <client's name> inability to work, due to their further personal injury stop?
- For what period will <client's name> be unable to work, solely as a result of their further personal injury?

- b** Determine if the client is eligible for weekly compensation on the further personal injury claim.

NOTE What if the further personal injury happens within 28 days of weekly compensation ceasing on a previous claim?

If a person suffers a new injury, that makes them unable to work within 28 days of ceasing weekly compensation on a prior personal injury claim, confirm whether the client is eligible for weekly compensation for the new injury.

That is, they are an earner in employment at the time the new injury occurred and have earnings immediately before they became unable to work due to the new injury.

Where a new inability to work applies, weekly earnings are always recalculated based on earnings before the client became unable to work for the new injury.

NOTE What if the further personal injury is Fatal?

If the further personal injury results in death, inability to work on the prior personal injury claim ceases at the date of death.

Weekly compensation ceases to be payable on the prior personal injury claim at the date of death. If the fatal claim is accepted, payment of weekly compensation based on the prior claims weekly earnings is payable to spouses, children and other dependants of the deceased from the date of death.

- c** Seek Internal guidance to confirm the transfer should be done.

Delegation to approve transfers of entitlements sits with Technical Services. You will need to obtain this through written guidance via Clinical and Technical Services.

NOTE Refer to the Seek Internal Guidance process.

 **PROCESS** Seek Internal Guidance

2.0 Notify the client


- a** Contact the client to advise of the decision to transfer Weekly Compensation to a further personal injury (new claim).

NOTE What if the client asks how their weekly compensation will be calculated?

Under the Accident Compensation Act 2001, Schedule 1 Clause 48 a client's eligibility for weekly compensation for the further personal injury is based on the client's weekly earnings from the prior personal injury claim.

This means that the weekly earnings, as calculated on the prior personal injury claim, updated for any applicable indexation, become the weekly earnings for the further personal injury claim.

Similarly, as the client's inability to work is continuous between the prior personal injury claim and the further personal injury claim, the inability to work regime of the prior personal injury claim is carried forward to the further personal injury claim. That is, the same first week, short-term and long-term periods that applied on the prior personal injury claim will also apply on the further personal injury claim. In other words the second claim 'picks up' the regime of inability to work, of the prior personal injury claim.

 Accident Compensation Act 2001, Schedule 1, Clause 48
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

NOTE What if the client has been paid for the first week?

If the further personal injury is a work injury and the employer has made a first week payment then those earnings will need to be considered for abatement.

3.0 Request the Transfer

- a** If required, wind back the incapacity on the originating claim to the last day of payment before the further injury date. Ensure any final abatement information has been provided on this claim if necessary.
- b** On the originating claim, in Salesforce add a note to the engagement life area in the Recovery Plan that entitlements have been transferred to claim no. xxx as at xx date.


NOTE See Close claim to determine if claim can now be closed.


 **PROCESS** Close claim

c Add and approve incapacity on the claim which weekly compensation will be paid on from the date weekly compensation is to be paid from. Add a note to the engagement life area in the Recovery plan that entitlements have been transferred from claim no. xxx as at xx date.

d c) On the claim that weekly compensation will be paid on, create a non standard e-form and provide the following information:

- Originating Claim number
- Further injury claim number
- DOFI and/or DOSI date of further injury
- Approved incapacity from DOFI and/or DOSI on further personal injury claim
- Confirmation of bank account, IRD number and tax code for further personal injury.

 Add an Eform

 Add approved incapacity

 Modify approved incapacity

e d) Create a 'Setup Weekly Compensation' task and link the non-standard E-form to the task.

 Link a document to a task in Eos

 **PROCESS**

Transfer Weekly Compensation from one claim to another

Weekly Compensation and New Zealand Superannuation (post-1 July 2019) Policy ^{v15.0}



Summary

Objective

Refer to this policy when a client reaches the New Zealand superannuation qualification age (NZSQA), and you need to determine when their eligibility to weekly compensation ends (including weekly compensation for loss of potential earnings).

- 1) NZSQA more than 24 months from first becoming eligible for weekly compensation
- 2) First becoming eligible for weekly compensation less than 24 months before NZSQA, OR after reaching NZSQA
- 3) Transitional clients - clients turning 66 after 1 July 2019 and first eligible for weekly compensation 12 months before NZSQA
- 4) Timeframes for making a NZ Super election
- 5) Client request to reverse their election
- 6) When reversals of elections can be considered
- 7) Table of NZ superannuation qualifying dates
- 8) Examples of NZ superannuation qualifying dates
- 9) Links

Background

NZ Superannuation is a government pension scheme available to people who reach NZSQA and who satisfy its eligibility criteria - see the link at the bottom of this page for further information.

This policy covers clients who become eligible for weekly compensation after reaching NZSQA, or who reach NZSQA whilst receiving weekly compensation.

Schedule 1 clause 52 of the Accident Compensation Act 2001 specifies that a person's entitlement to weekly compensation and loss

of potential earnings may end at the following periods when reach NZSQA:

- immediately at reaching NZSQA.
- two years after first entitled to the weekly compensation.

The Accident Compensation Amendment Act 2019 allows clients who turn 66 after 1 July 2019 and were first eligible for weekly compensation 12 months before reaching NZSQA to receive weekly compensation and New Zealand Superannuation (NZ Super) until they turn 66 and choose from the age of 66 either:

- receive either weekly compensation until they turn 67 (NZ Super will stop between 66 and 67 and from age 67 they'll only be eligible to receive NZ Super)

or

- receive only NZ Super from the age of 66 years (no further weekly compensation is payable on that claim from the age of 66)

or

- to receive weekly compensation for up to two years from the date they first became eligible for weekly compensation (eligibility to NZ Super is not affected under this option).

Owner

[Out of Scope]

Expert

Policy

1.0 Timeframes for receiving weekly compensation when a client reaches NZSQA

- a When a client is nearing or is over NZSQA (age 65), they can only receive weekly compensation for a specified timeframe.
- b The timeframes apply from when the client was first eligible for weekly compensation on their claim. New timeframes don't apply for any subsequent periods of eligibility on the claim.
- c The timeframes below apply for weekly compensation claims made on or after 1 July 2019.

NOTE What if a claim for weekly compensation is made after 1 July 2019 for periods prior to that date?

The timeframes set out in this policy will still apply.

NOTE What if a client has previously made decisions about their weekly compensation and NZ Superannuation prior to 1 July 2019?

Clients are bound by the decisions about their weekly compensation that they made prior to 1 July 2019.

 **PROCESS** Weekly Compensation and New Zealand Superannuation (pre-1 July 2019)

NOTE What if a client made an election about their weekly compensation before 1 July, but the effect of their election takes place after this?

Clients who were previously required to make an election between 1 June 2019 and 30 June 2019 (one month before the election came into effect) can be advised that the new rules apply to them and their election is not required. The following letter can be sent:


 WCO47 NZ Super Retracting Election Notice

- d A client will not lose their eligibility for NZ Superannuation if they are receiving weekly compensation.


- e When a client's weekly compensation is about to end due to these rules, send the following decision:


 WCO46 NZ Super Reminder WC Ending

 Ceasing weekly compensation for a client at NZSQA

 Ceasing accidental death weekly compensation for other dependant at NZSQA

 New Zealand Superannuation qualification age

 Ceasing weekly compensation post-NZSQA for clients not eligible for NZ super election

 Ceasing accidental death weekly compensation post-NZSQA for other dependant not eligible for NZ Super election

2.0 If the client was first eligible for weekly compensation more than 24 months before NZSQA

- a Clients first eligible more than 24 months before NZSQA (ie before the age of 63) will stop receiving weekly compensation at NZSQA.

3.0 If the client was first eligible for weekly compensation less than 24 months before NZSQA

- a A client who was first eligible for weekly compensation less than 24 months before NZSQA (ie between the ages of 63 and 65) can receive weekly compensation for up to 24 months. They can also receive any NZ Superannuation they may be eligible for from NZSQA.

4.0 If the client was first eligible for weekly compensation on or after reaching NZSQA

- a A client who is first eligible for weekly compensation on or after NZSQA (ie they are 65 or over) can receive weekly compensation along with NZ Superannuation for up to 24 months:

5.0 Transitional clients - clients turning 66 after 1 July 2019 and first entitled to weekly compensation 12 months before NZSQA

- a Clients who turn 66 on or after 1 Jul 2019 and were first eligible for weekly compensation:

- before 1 July 2019; and

- within 12 months of reaching NZSQA (ie between the ages of 64 and 65);









can receive weekly compensation and any NZ Superannuation that they may be eligible for until the day before they turn 66.

- b From age 66 these clients can elect to:





- receive either weekly compensation OR New Zealand Superannuation until they turn 67. From age 67, they will only receive NZ Superannuation;

or



- receive weekly compensation for up to two years from the date they first became eligible for weekly compensation. Their eligibility to receive New Zealand Superannuation will not be affected during this period. At the expiry of the two year period, only NZ Superannuation will be available.

-  Eligibility for a client to make NZ Super Election
-  Ceasing accidental weekly compensation post-NZSQA for other dependant who elect NZ Super
-  Ceasing weekly compensation post-NZSQA for clients who elect NZ Super
-  Eligibility for other dependants to make NZ Super election
-  Ceasing weekly compensation for a client at 67 years
-  Ceasing accidental weekly compensation for other dependant of deceased client at 67 years
-  Ceasing weekly compensation for a client electing NZ Super and weekly compensation
-  Ceasing weekly compensation for other dependants of a deceased client electing NZ Super and weekly compensation








5.1 Time limits for NZSQA elections

- a Clients who are eligible to elect the period of their weekly compensation and NZ Superannuation must make their election before the date it would have taken effect (ie before their 66th birthday).
- b Where the rate or the period of entitlement has been in dispute, or where the entitlement application is made retrospectively, the client must elect within one month after they have been advised of the amount of weekly compensation.
- c Below are the business rules specifying the timeframes for making an election:
 -  The standard timeframe for clients to make an NZ Super election
 -  The standard timeframe for other dependants of deceased clients to make an NZ Super election
 -  Timeframe for clients to make NZ Super election following a dispute or retrospective decision on a weekly compensation entitlement
 -  The timeframe for an other dependant of a deceased client to make an NZ Super election following a dispute or retrospective decision on an accidental death weekly compensation entitlement




5.2 Clients who fail to elect in time

- a Clients who don't make their election within the prescribed timeframes, will be deemed to have elected to receive weekly compensation for a period of 24 months from the date they first became eligible for it on their claim. The business rule below specifies this criteria:
 -  Ceasing weekly compensation post-NZSQA for clients with deemed NZ super election
 -  Ceasing accidental death weekly compensation post-NZSQA for other dependant with deemed NZ super election

5.3 Decision letters for transitional clients

- a We need to give eligible clients the opportunity to elect the period of weekly compensation they wish to receive.
- b The following letter can be sent to the client to notify them of their options. ACC will also discuss these with them:
 -  WCO48 NZ Super Transition Pre Discussion
- c Once the client has been advised of their options and they have verbally made their election, the following decision letter can be sent confirming this:
 -  WCO49 NZ Super Transition Confirmation Post Discussion
- d When weekly compensation entitlement is about to end, send the following decision:
 -  WCO46 NZ Super Reminder WC Ending
- e The following business rules specifying how ACC is to be notified of the client's choice. The rules also specifying our obligation to record and confirm the election with the client/other dependant.
 -  Method of notifying ACC of an NZ Super election
 -  Recording of an NZ Super election made by a client
 -  Recording of an NZ Super election made by an other dependant
 -  Confirming NZ Super election

6.0 Links

-  Manage Client NZ Super Qualifying Age (NZSQA)
 -  New Zealand Superannuation (NZ Super)
<https://www.workandincome.govt.nz/eligibility/seniors>
 -  Accident Compensation Act 2001, Schedule 1,
clause 52 Relationship between weekly compensation and New Zealand superannuation
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-

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Summary

Objective

Refer to this policy to help you determine when a client's eligibility for weekly compensation, including weekly compensation for loss of potential earnings (LOPE), ends when they reach New Zealand Superannuation qualification age (NZSQA). USE THIS POLICY FOR CLIENTS WHO REACHED NZSQA PRIOR TO 1 JULY 2019.

- 1) Note: the Accident Compensation Amendment Act 2019 (post-1 July 2019)
- 2) Reaching NZSQA on or after a client first becomes eligible for weekly compensation
- 3) NZSQA within 12 months of first becoming eligible for weekly compensation
- 4) NZSQA between 12 and 24 months from first becoming eligible for weekly compensation
- 5) NZSQA more than 24 months from first becoming eligible for weekly compensation
- 6) Time limits for NZSQA elections
- 7) Client request to reverse their election
- 8) When reversals of elections can be considered
- 9) Table of NZ superannuation qualifying dates
- 10) Examples of NZ superannuation qualifying dates
- 11) Links to legislation

Background

Superannuation is universally available to everyone who reaches the NZSQA.

Schedule 1 clause 52 of the Accident Compensation Act 2001 specifies that a person's eligibility for weekly compensation and loss of potential earnings ends when the person reaches the NZSQA.

After a year of receiving weekly compensation and superannuation, claimants who first become eligible for weekly compensation for a personal injury, at or past NZSQA must elect between receiving either weekly compensation or superannuation for the next year.

Owner

[Out of Scope]

Expert

Procedure

1.0 Note: the Accident Compensation Amendment Act 2019 (post-1 July 2019)

- a On 1 July 2019, ACC's legislation changed to affect how long a person can receive both weekly compensation and New Zealand Superannuation at the same time.

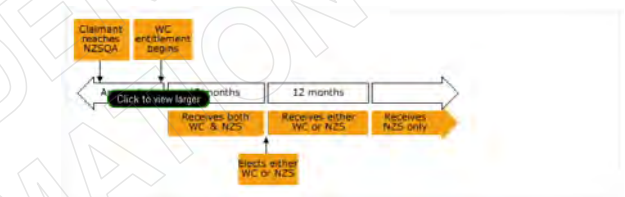
For clients who were first eligible for weekly compensation more than 24 months prior to reaching the New Zealand superannuation qualification age (NZSQA), they cannot receive further weekly compensation from 65 (after NZSQA).

For other clients who turn 65 after 1 July 2019, and who were eligible to elect between 1 June and 30 June (one month before the election came into effect), they do not need to make an election and can receive both weekly compensation and New Zealand superannuation under the amendment. Please see the link to the new Promapp page below.

2.0 NZSQA has already been reached when a client first becomes eligible for weekly compensation

- a If the client first becomes eligible for weekly compensation for a personal injury on or after reaching NZSQA, they are eligible to receive:

- weekly compensation and New Zealand Superannuation (NZ Super) for up to 12 months from the date they first became eligible for weekly compensation (i.e. the start of the short-term period)
- after the end of the 12 month period, the client is eligible to continue to receive weekly compensation for a further 12 months if they make an election to receive weekly compensation rather than NZ Super. If they elect to receive weekly compensation:
 - they will be eligible to receive weekly compensation for a further 12 months
 - at the end of this further 12-month period, the client's eligibility for weekly compensation will cease and they can start to receive NZ Super.

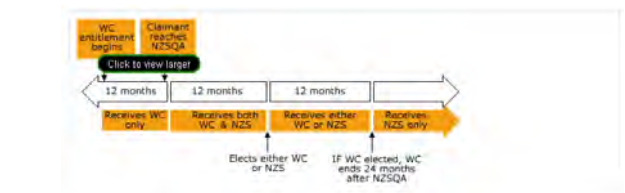


NZSQA on or after.PNG

3.0 NZSQA within 12 months of first becoming eligible for weekly compensation

- a If the client will reach NZSQA within 12 months of first becoming eligible for weekly compensation for a personal injury, they are eligible to receive:

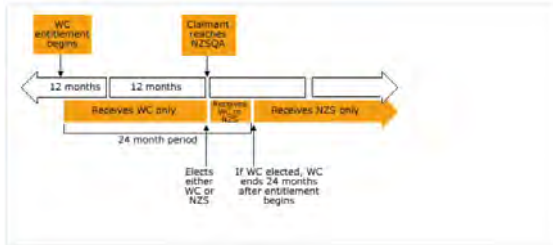
- weekly compensation and NZS for 12 months from their NZSQA date
- after the end of the 12-month period, the client is eligible to continue to receive weekly compensation for a further 12 months if they make an election to receive weekly compensation rather than NZ Super. If they elect to receive weekly compensation:
 - they will be eligible to receive weekly compensation for a further 12 months
 - at the end of this 12-month period, the client's eligibility for weekly compensation will cease and they can start to receive NZ Super.



NZSQA within 12 months.PNG

4.0 NZSQA between 12 and 24 months from first becoming eligible for weekly compensation

- a** If the client will reach NZSQA 12 months or more (but less than 24 months) from first becoming eligible for weekly compensation for a personal injury:
- they are eligible to continue receiving weekly compensation for this personal injury until they reach NZSQA
 - from the NZSQA date they may continue to receive weekly compensation for a total of 24 months from the date they first became eligible (i.e. the start of the short-term period) if they make an election to receive weekly compensation rather than NZ Super. At the expiration of the 24 month period, eligibility for weekly compensation ceases and they can start to receive NZ Super.



NZSQA between 12 and 24 months.PNG

5.0 NZSQA more than 24 months from first becoming eligible for weekly compensation

- a** If the client will reach NZSQA 24 months or more from first becoming eligible for weekly compensation for a personal injury, they are eligible to receive weekly compensation for this personal injury until they reach NZSQA, after which weekly compensation ceases and the client receives NZ Super.

Note: If a client, who has already received weekly compensation for a personal injury, reaches the upper age limit and then sustains a further inability to carry out work activities due to that injury, they are not eligible for further weekly compensation in respect of the subsequent incapacity.



NZSQA more than 24 months.PNG

6.0 Time limits for NZSQA elections

- a** The time limit for an election to receive either weekly compensation or NZ Super is the later of the following dates:
- within one month before the date the election takes effect
 - within one month after the client has been notified of their eligibility for weekly compensation.

Note: In the case of accidental death claims, the surviving spouse or other dependant must make this election within one month before they reach NZSQA.

- When to continue or cease weekly compensation to a spouse or partner
<https://go.promapp.com/accnz/Process/f7c4cd68-451>

When to continue or cease weekly compensation to an other dependant
<https://go.promapp.com/accnz/Process/f3e1102c-792>

7.0 Client request to reverse their election

- a** If the election is received outside the time limit, or if the client has made a request to reverse a previous election, the request may be approved if there has been a significant change in the client's circumstances since either the date of the original election or the expiry of the time limit.

8.0 When reversals of elections can be considered

- a** A request for reversal of an NZSQA election may be approved if there has been a significant change in the client's circumstances since either:
- the date of the original election
 - the expiry of the time limit for elections.

Significant changes may include changes in the client's financial circumstances or their living arrangements. A client's circumstances would not normally be considered to have changed significantly more than once in any 12 month period.

NOTE Examples

- When a person elected to receive NZ superannuation, they were single. Following their election they married, and their eligibility for weekly compensation now exceeds their NZ superannuation. This person could be considered to have had a significant change in their circumstances.
- A married person elected to receive weekly compensation. Following their election, their spouse died and their eligibility for NZ superannuation now exceeds their weekly compensation. They could be considered to have had a significant change in their circumstances.

9.0 Table of NZ superannuation qualifying dates

Born in the period	Age when qualifies	Period in which qualifies
Before 1/4/32	60 years	Up to 1/4/52
1/4/32 to 30/6/32	61 years	1/4/93 to 30/6/93
1/7/32 to 30/9/32	61 years 13 weeks	30/9/93 to 30/12/93
1/10/32 to 31/12/32	61 years 26 weeks	1/4/94 to 1/7/94
1/1/33 to 31/3/33	61 years 39 weeks	1/10/94 to 29/12/94
1/4/33 to 30/6/33	62 years	1/4/95 to 30/6/95
1/7/33 to 30/9/33	62 years 13 weeks	30/9/95 to 30/12/95
1/10/33 to 31/12/33	62 years 26 weeks	31/3/96 to 30/6/96
1/1/34 to 31/3/34	62 years 39 weeks	30/9/96 to 29/12/96
1/4/34 to 30/6/34	63 years	1/4/97 to 30/6/97
1/7/34 to 30/9/34	63 years 13 weeks	30/9/97 to 30/12/97
1/10/34 to 31/12/34	63 years 26 weeks	1/4/98 to 1/7/98
1/1/35 to 31/3/35	63 years 39 weeks	1/10/98 to 29/12/98
1/4/35 to 30/6/35	64 years	1/4/99 to 30/6/99
1/7/35 to 30/9/35	64 years 13 weeks	30/9/99 to 30/12/99
1/10/35 to 31/12/35	64 years 26 weeks	31/3/2000 to 30/6/2000
1/1/36 to 31/3/36	64 years 39 weeks	30/9/2000 to 29/12/2000
After 31/3/36	65 years	1/4/2001 onwards

Table of NZ superannuation qualifying dates.PNG

10.0 Examples of NZ superannuation qualifying dates

NOTE One month before effective date

The client is required to make the election within one month of the effective date.

If the effective date of the election is 22 October 2011, then the date one month before that is 22 September 2011.

The client would be required to make an election no later than 21 October 2011, but they must make the election during the period from 22 September 2011 to 21 October 2011 inclusive.

NOTE One month after notification



The time limit of the election date will be one month after the client has been notified of their eligibility for weekly compensation.

This means that the client is required to make the election within the one month period established.

If the client was notified on 22 October 2011, the time limit is one month after this date, which is 22 November 2011.

The client will be required to make an election during the period from 22 October 2011 to 21 November 2011 inclusive.

11.0 Links to legislation

-  Accident Compensation Act 2001, Schedule 1, clause 52 Relationship between weekly compensation and New Zealand superannuation.
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  Accident Compensation Act 2001, Schedule 1, clause 53 Election for purposes of clause 52
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

Summary

Objective

This guidance provides information on the Indexation tables under the Accident Compensation Act 2001.

- 1) Percentage increases
- 2) Minimum earner rate (full-time earners under 18)
- 3) Minimum earner rate (full-time earners aged 18 or over)
- 4) Maximum weekly compensation payment
- 5) Abatement
- 6) Potential earner rate (aged 18 or over)



Owner

[Out of Scope]

Expert

Policy


1.0 Percentage increases

- a** Apply the indexation amounts shown in the following table if the client was either eligible to receive weekly compensation:
- continuously since 31 December before the indexation date, or
 - for any 26 weeks or part weeks in the 52 weeks before the indexation date.
- b** The indexation rate does not apply to minimum weekly compensation under the IPRC (Indexation) Regulations 2002.
- c** Please follow the link below for details on the percentage increase, resulting from indexation, to weekly compensation payments.
-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)
 -  [Weekly Compensation Indexation 2001](#)


2.0 Minimum earner rate (full-time earners under 18)

- a** Follow the link below for the amount of weekly compensation payable to a client under the age of 18, who is eligible for the minimum payment on the basis they qualify either as:
- a fulltime earner
 - liable to pay the minimum earner premium.


NOTE An amendment to the Minimum Wage Act removed 'youth rates', followed by an amendment to the Accident Compensation Act: consequently, from 1 July 2008 there is no longer a different minimum earner rate for full-time earners under 18.

-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)


3.0 Minimum earner rate (full-time earners aged 18 or over)

- a** Follow the link below to find the amount of weekly compensation payable to a client aged 18 or over, who is eligible for the minimum payment on the basis that they qualify either as:
- a fulltime earner
 - liable to pay the minimum earner premium
 - a potential earner.
- b** These figures are based on the minimum wage rate.
-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)

4.0 Maximum weekly compensation payment

- a** Follow the link below for the maximum amount we can pay in weekly compensation to any client, as a weekly payment.
-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)

5.0 Abatement

- a** Follow the link below to find out the earnings thresholds, when calculating the level of abatement if the client has received earnings in a period they were unable to work due to their injury.
-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)


NOTE An amendment to the Accident Compensation Act changed the abatement calculation from 1 August 2008, so that the '24% and 56%' calculation no longer occurs, and only the 'total earnings excess' calculation is performed.

6.0 Potential earner rate (aged 18 or over)

- a** Follow the link below for the amount of weekly compensation payable to a client aged 18 or over, who qualifies as a potential earner. These figures are based on the minimum wage rate.

NOTE From 1 August 2008 until 30 June 2010, an amendment to the Accident Compensation Act provided for the potential earner weekly earnings rate to effectively be 100% of the minimum weekly earnings rate so, in effect, the client is paid weekly compensation equal to the minimum wage.

NOTE From 1 July 2010, a further amendment to the Accident Insurance Act changed this rate back to 80% of the minimum weekly earnings rate. Existing clients continue to be paid at their current rate, however they are not eligible for yearly adjustments until their weekly compensation equals 80% of the minimum weekly earnings rate.

-  [Weekly compensation indexation \(2001 Act\)](https://au.promapp.com/accnz/process/9e9b0a8b-df0)

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Summary

Objective

This section includes indexation tables for weekly compensation.

Note for MAXIMUM weekly compensation, the amount provided (2001) is the 80% Weekly compensation payment amount. Because Maximum Weekly Compensation is determined after the application of Abatement we do not include the 100% figures in the tables provided.

Owner


[Out of Scope]

Expert

Policy


1.0 Weekly compensation index 2001

- a Click the below link to view the weekly compensation indexation (2001 Act).

 [Weekly Compensation Indexation 2001](#)

2.0 Weekly compensation index 1998

- a Click the below link to view the weekly compensation indexation (1998 Act).

 [Weekly compensation indexation 1998](#)

3.0 Weekly compensation index 1992

- a Click the below link to view the weekly compensation indexation (1992 Act).

 [Weekly compensation indexation 1992.docx](#)



Summary

Objective

Refer to this guidance when assessing weekly compensation for a client who held permanent employment at the date of their incapacity. This guidance applies for incapacities that occurred from 1 July 2010.

- 1) Weekly earnings calculation
- 2) Short-term calculation
- 3) Long-term calculation
- 4) Establishing weekly earnings where there is a period of unpaid leave
- 5) Warren decision
6. Special case: full time at DOFI/DOSI but previously part-time
7. Special case: less than one week worked with set hours (Ryan Decision)

Owner

[Out of Scope]

Expert

Procedure

1.0 Weekly earnings calculation

- a The employee weekly earnings calculations are set out in Clauses 33 and 34 of Schedule 1 of the Accident Compensation Act 2001.
 - Schedule 1, Clause 33 Weekly earnings if earner had earnings as employee immediately before incapacity commenced
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 - Schedule 1, Clause 34 Weekly earnings if earner had earnings as an employee [in permanent employment] immediately before incapacity commenced: calculations
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- b A separate weekly earnings assessment is needed for each permanent employment held by the client at the date they first or subsequently became unable to work due to the injury (date of first incapacity 'DOFI' date of subsequent incapacity 'DOSI').
- c The calculations can be performed once ACC has:
 - established DOFI or DOSI
 - obtained the client's earnings details from the client's employment for the relevant periods in the 4/52 weeks prior to DOFI or DOSI, using the Real Time Earnings (RTE) portal or an ACC003 Employee earnings certificate
 - obtained any other necessary supporting documentation, such as a computer generated payroll print out, a copy of the wages book.
- d Earnings details are only required for periods in which the client received earnings from that employment.
- e Any periods, and any earnings in those periods, in which the client was eligible for weekly compensation for loss of earnings whether from ACC or an Accredited Employer (including abated weekly compensation but not payments for accidental death) are disregarded in the calculation.
- f See Information required for permanent & non-permanent employee weekly earnings calculation (link below)
 - Information required for permanent & non-permanent employee weekly earnings calculation

2.0 Short-term calculation

- a This calculation is used for the four weeks following the first week after DOFI.

$$A \div B$$

- A is the client's earnings as an employee (from that permanent employment) in the four weeks before they became unable to work due to the injury.
- B is the number of full or part weeks during which the client earned those earnings as an employee in those four weeks.

3.0 Long-term calculation

- a This calculation is used for any period after the first five weeks from DOFI.

$$A \div B$$

- A is the client's earnings as an employee (from that permanent employer/s) in the 52 weeks before they became unable to work due to the injury.
- B is the number of full or part weeks during which the client earned those earnings as an employee.

- b The following applies to any period after the first five weeks from DOFI.

- Consider all earnings from that employer in the 52 weeks prior to DOFI or DOSI, regardless of changes in job position, as an employee during that period.
- If an employer provides earnings for the full year immediately prior to DOFI or DOSI, accept this amount as being 52 weeks.
- See Information required for permanent & non-permanent employee weekly earnings calculation (link below).

- Information required for permanent & non-permanent employee weekly earnings calculation

- c When calculating long-term weekly earnings, use the attached decision table to establish the earnings period start date:

If the client has been in that employment for...	then count back...
52 weeks or more	52 weeks from DOFI/DOSI
less than 52 weeks	the number of weeks and days to the date that the client began that employment


- Earning period start date.JPG

- d If the client has unpaid periods or received weekly compensation for loss of earnings (including abated weekly compensation but not support for fatal accidents) in the 52 weeks prior to DOFI or DOSI, use either Complex long-term calculation or Simple long-term calculation.

4.0 Establishing weekly earnings where there is a period of unpaid leave

- a If the client has taken unpaid leave from their employment before they became unable to work due to the injury:

- the employer is required to confirm any periods of unpaid leave taken by the client in the short-term and long-term period
- when there are unpaid periods, the actual dates are entered into Eos as unpaid leave, this leads to a reduced divisor when calculating the weekly earnings.

- b If a client has had no earnings for a full working week or seven consecutive calendar days (given their particular work pattern), then a full week will need to be removed from the divisor, not just the individual dates of unpaid leave.
 - c See Examples of 'How to establish weekly earnings where period of unpaid leave'
-  Examples - How to establish weekly earnings where period of unpaid leave

5.0 Warren decision

- a The Warren High Court decision found that in situations where a person had earnings as a casual employee, ie non-permanent and permanent employee with the same employer over the relevant period, ACC is to use their earnings from permanent employment to calculate long-term weekly compensation for permanent employees.
- b If a client in permanent employment applies for weekly compensation and ACC is made aware that they have had a change in employment type, such as moving from a casual to permanent contract. The assessment of weekly compensation should only consider earnings from the client's permanent employment with that employer, ie disregard any non-permanent earnings from that employer.


NOTE Example

Amber had an accident on 10 January 2019 and is unfit for work. She has worked for Smith City for the past 52 weeks. From April 2018 until December 2018, Amber worked on a casual 'as and when needed' basis. From 1 January 2019 Amber was employed on a permanent basis.

For the purposes of calculating weekly compensation, earnings details would only be obtained from 1 January 2019, which is the date that Amber began permanent employment.



6.0 Special case: full time at DOFI or DOSI but previously part-time

If the client is...	and...	then...
full-time in this permanent employment, ie worked an average of 30 hours per week in the four weeks prior to the incapacity	was previously part-time, ie less than 30 hours per week, with that employer 52 weeks prior to DOFI/DOSI	<ul style="list-style-type: none"> • the client is eligible for whichever is the greater of the permanent or non-permanent employee weekly earnings calculation, ie where this employment is treated as a non-permanent employment • the greater applies to both the short and long-term periods

 Special Case Full time at DOFI-DOSI but previously part-time.PNG

- a Sometimes when ACC gets earnings details from a current employer it will become apparent that a person was previously working part-time. If this occurs, obtain earnings details from prior employers.

When determining the greater of the permanent or non-permanent employee weekly earnings calculations, gather earnings details for all employment held in the 4/52 weeks prior to DOFI or DOSI, taking into account any excluded periods.

-  Information required for permanent & non-permanent employee weekly earnings calculation
-  Examples - Full time at DOFI-DOSI but previously part-time - weekly earnings perm employee

7.0 Special case: less than one week worked with set hours (Ryan Decision)

- a If the client has worked less than one week in their employment before they became unable to work due to the injury:
 - ask the employer to confirm the client's normal working hours per week (advise them that you require this information to make a payment)
 - establish the earnings from that period of employment
 - establish the number of hours the client worked prior to their incapacity
 - use the following formula to calculate the weekly compensation rate

Actual earnings received ÷ actual hours worked x contracted normal weekly hours


- multiply this figure by 80% to get the weekly compensation rate.
- send out an ACC641 Weekly compensation advice form and add a Contact in Eos stating:

"The earnings rate on this file has been adjusted because the period included a part week. This adjustment is as a direct result of the Ryan v ACC District Court decision"

Example:

A client started a new job and had worked two and a half days before they were injured. To calculate their weekly compensation, ACC establishes that they had worked 21 hours in that job and will be paid \$310. They were contracted to work 45 hours per week.

Their weekly earnings rate is: $\$310 \div 21 \times 45 = \664.29 .

 ACC641 Weekly compensation advice

NOTE Where the client has no set hours, but has set days of work

If the employer cannot provide the contracted hours then consider the days that the client was expected to work for that week as follows:
 Actual earnings received ÷ actual days worked x number of days the client is expected to work in a seven day week = expected weekly earnings

Example:

A client starts work on a casual basis with a new employer on Monday 5 January. The client sustains an injury on Wednesday 7 January and is subsequently deemed unfit for work. The client worked 8 hours on both the Monday and Tuesday, their total gross earnings were \$240. The employer informs ACC that the client was expected to work a four day week, specifically Monday, Tuesday, Thursday and Friday.

The calculation in the example above would be:
 $\$240$ (actual earnings received) ÷ 2 (actual days worked) x 4 (days the client is expected to work in a 7 day week) = $\$480$ (expected weekly earnings).

NOTE Where the client is a casual employee with no set hours or days of work

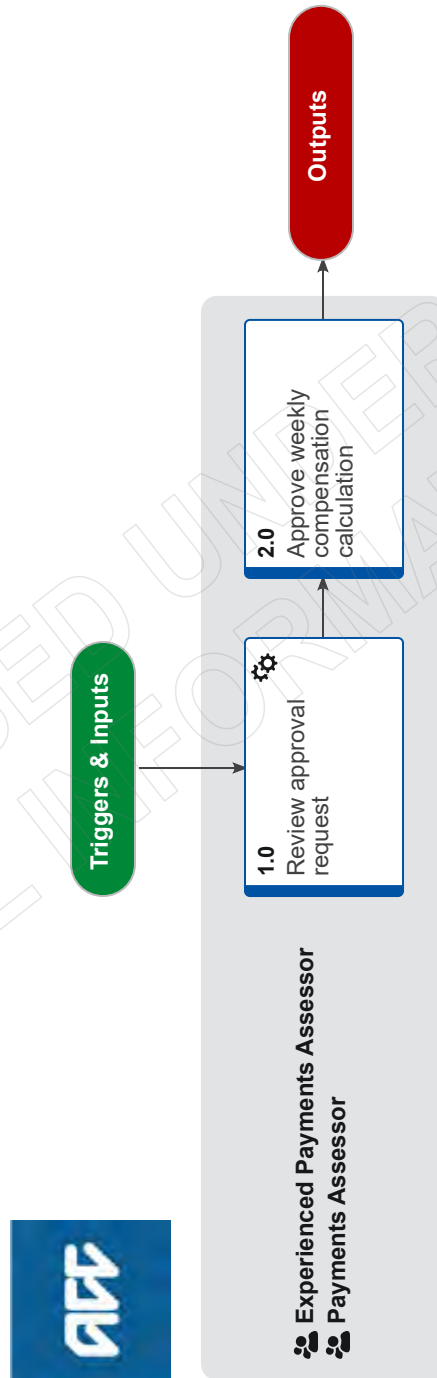
If you are unable to determine a client's usual work pattern because they have no set hours or work days, or they work on a piecemeal basis, then you must consider the number of hours/ days worked as a full week's work.

The section 'Special case: Less than one week worked' does not apply if the client and employer cannot confirm the client's contracted work hours or days of the week they would have worked.

This is because we have no firm evidence that they would have worked any more hours than they had already worked in that week.

In these cases you must enter the calculation into Pathway or Eos as a non permanent employee, as you would have done prior to the Ryan decision.

RELEASED UNDER THE
OFFICIAL INFORMATION ACT



RELEASED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

To approve an ERA weekly compensation entitlement so the employer can be notified of their payment and be paid.

Background

This process is required after you have completed the set up of the ERA entitlement. All ERA weekly compensation set ups require approval by a second staff member before the client can be paid.

Owner




[Out of Scope]

Expert

Procedure



1.0 Review approval request

Experienced Payments Assessor, Payments Assessor

- a** Review the request and the instructions in the Eos task to ascertain what you need to check to action the approval.
- b** Check the request and confirm that the payment calculation is correct.
- c** Check that the approved period the client was unable to work due to their injury matches the period payable and non-payable periods.
 -  View approved incapacity details
 -  View payment periods summary
- d** Review the Payment Calculation Summary and confirm that the payment calculations are correct.
 -  Review calculated Weekly Compensation payments



NOTE What if the payment calculations are incorrect?

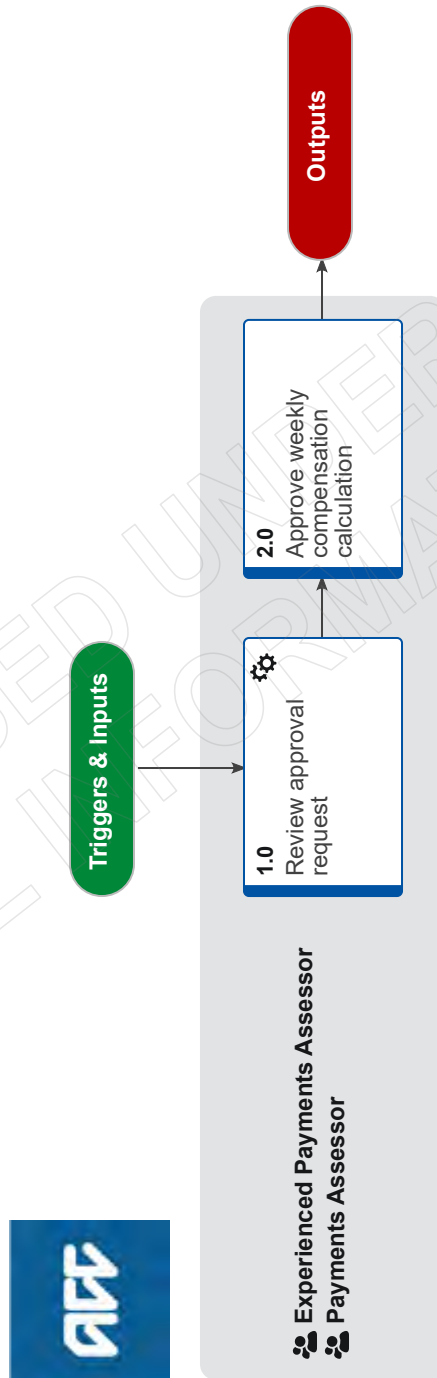
Transfer the task back to the Payments Assessor who sent the request and include instructions regarding the action required in the task Description field. This procedure ends.

- e** Check that the ERA Instruction has been added correctly to the Adjustments tab.
 -  Impediments to the manual approval of a payment
 -  Return requests where payment could not be approved

2.0 Approve weekly compensation calculation

Experienced Payments Assessor, Payments Assessor

- a** Approve the payment.
 -  Approve a Weekly Compensation payment
- NOTE** What if I can't approve the payment because it's outside my Delegated Financial Authority (DFA)?
- Then transfer the task to the Weekly Compensation Complex queue for approval.
-  Approver for payments
- b** Close the task.





Summary

Objective

To approve the weekly compensation entitlement (including fatal weekly compensation) so the client can be notified of their payment and be paid.

Background

This process is required after you have completed the set up of the entitlement. All weekly compensation set ups require approval by a second staff member before the client can be paid.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review approval request

Experienced Payments Assessor, Payments Assessor

- a Review the request and instructions in the Eos task to ascertain what you need to check to action the approval.
- b Check the request and confirm that the payment calculation is correct.
- c Check that the approved period the client was unable to work due to their injury matches the period payable and non-payable period(s).

NOTE What if it's a fatal claim?

This step is not required.
Go to task d Review the Payment Calculation Summary and confirm that the payment calculations are correct.

- View approved incapacity details
- View payment periods summary

- d Review the Payment Calculation Summary and confirm that the payment calculations are correct.

- Review calculated Weekly Compensation payments

NOTE What if the payment calculations are incorrect?

Transfer the task back to the Payments Assessor who sent the request and include instructions regarding the action required in the task Description field.

If the request was from a Recovery Team member, contact them via agreed process.

This procedure ends.

NOTE What if this is an accredited employer wc transfer?

Check that the AE management periods are correctly set to "Do Not Pay".

- Impediments to the manual approval of a payment
- Return requests where payment could not be approved

NOTE What if the payment is outside my delegation?

Then assign the task (with accompanying email notification) to a delegation holder for approval.

- Backdated Weekly Compensation \$100k gross - \$500k gross - Client Service Leader
- Backdated Weekly Compensation \$500k+ gross - Technical Services

- NGCM Delegations (Te Whāriki)

2.0 Approve weekly compensation calculation

Experienced Payments Assessor, Payments Assessor

- a Approve the payment.

- Approve a Weekly Compensation payment

NOTE What if there are instructions to fast track the payment?

Then fast track the payment using the system step linked below.

- Fast track a recurring payment
- Fast tracking only possible after approval
- Approver for payments

NOTE What if you receive an Alert "Can not approve payments on an Accredited Employer managed claim?"

- 1) Contact your Team Leader or the Recovery Team Member who was previously managing the claim, ask them to temporarily change the cover status back to "accept" so that you can action your task.
- 2) Once you have actioned your task, you will need to ask for the cover status to be changed back to "accredited employer".

NOTE What if you have approved the weekly compensation entitlement, and now need to make some changes?

If it is still the same day, the payment would not have been batched, and the payment notification would not have been sent to the client yet. This means you can go ahead and make your changes, and have these re-approved.

NOTE What if it is the next day and the outcome is the client will not be receiving any payment?

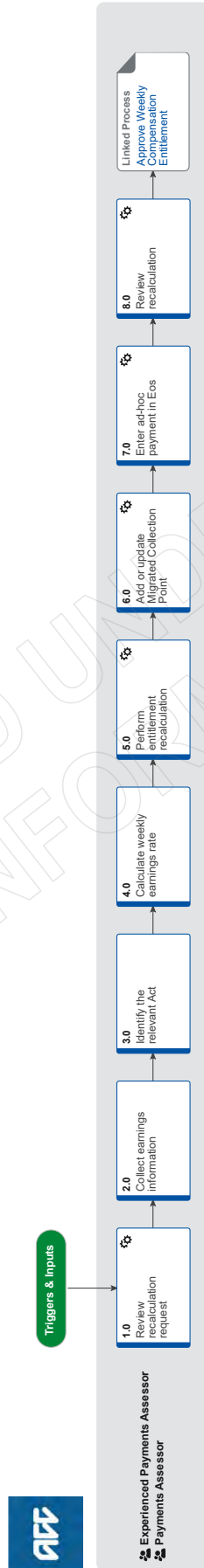
You must contact the client and inform them that the payment details have changed since the payment notification was sent to them and the reason why there is no payment.

- b Close the task.

NOTE What if it's a fatal claim?

Return the task to the Accidental Death queue so that a Cover Assessor can send the payment notification letter.

Recalculate Weekly Compensation Claims paid from Pathway v20.0



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Recalculate Weekly Compensation Claims paid from Pathway v20.0



Summary

Objective

This procedure states how to manage the recalculation of weekly compensation for claims that have been migrated from Pathway to Eos, specifically for recalculations that impact the period managed in Pathway before the claim was migrated to Eos, and new calculations pre-2010.

Background

This procedure covers the set up of weekly earnings base rate and calculation of entitlement for periods previously calculated outside of Eos and new calculations pre 2010. The process itself follows a similar path to standard weekly compensation (WC) set up, with complexity being found in the collection of historical earnings information, and the calculation of historical entitlements based on this information. The rate(s) determined through the Te Ara Hou calculator will need to be paid in Eos via an ad-hoc payment.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review recalculation request

Experienced Payments Assessor, Payments Assessor

- a** In Eos, confirm that the claim requiring recalculation was paid in Pathway and whether or not it was subsequently migrated to Eos.

NOTE **How do I know if the claim was paid from Pathway?**

Pathway Power BI reporting provides access to Pathway data, allowing access to Pathway information in a report format. To access Power BI reporting select the 'Launch PW' button in Eos.

- Power BI - Pathway Reports User Guide
- View a collection period

NOTE **What if the claim was only paid in Eos?**

Recalculation can be performed in Eos. Refer to 'Recalculate Weekly Compensation'.

This procedure ends.

- PROCESS** Recalculate Weekly Compensation

NOTE **What if the recalculation is only for a period after the claim was migrated from Pathway to Eos?**

Recalculation can be performed in Eos. Refer to 'Recalculate Weekly Compensation'

This procedure ends

- PROCESS** Recalculate Weekly Compensation

- b** Confirm whether or not Backdated Weekly Compensation is applicable.

NOTE **When should Backdated Weekly Compensation be applied?**

Backdated Weekly Compensation should be applied when there are arrears and/or a recalculated period greater than or equal to 90 days in duration. See the following business rules for more detail.

- Backdated weekly compensation eligibility

- Confirmation of a period of incapacity of 90 days or more

NOTE **What if Backdated Weekly Compensation is applicable?**

If Backdated Weekly Compensation is required, refer to 'Set Up Backdated Weekly Compensation'.

This procedure ends.

- PROCESS** Set Up Backdated Weekly Compensation

2.0 Collect earnings information

Experienced Payments Assessor, Payments Assessor

- a** Collect any earnings information required to proceed with the recalculation from Inland Revenue.

- Retrieve earnings from IR
- Use of Inland Revenue Real-Time Earnings Web-Service Policy

3.0 Identify the relevant Act

Experienced Payments Assessor, Payments Assessor

- a** Review the payment information to check that the Act has not already been determined.

NOTE **What if this claim has previously been paid from Pathway and the Act and Weekly Earnings rate(s) have already been established?**
Go to step 5.0 Perform entitlement recalculation.

NOTE **What if the request is for a reinstatement of Weekly Compensation and the claim was previously paid from Pathway?**

Use the original weekly compensation earnings rate calculation (after checking for accuracy). Go to step 5.0 Perform entitlement recalculation.

- b** Confirm the Date of First or Subsequent Incapacity (DOFI/DOSI).

- c** Use the Guide below to establish the correct Act(s) to assist with the calculation.

- Guide to establish the correct Act to calculate weekly compensation
- Transitional claims 1-7-99 to 31-3-02 (AI Act 98) Policy
- Transitional claims Policy

4.0 Calculate weekly earnings rate

Experienced Payments Assessor, Payments Assessor

- a** Check you have all the relevant information required to calculate the weekly compensation earnings rate.

NOTE **What relevant information do I need?**

- incapacity period(s).
- employment type
- earnings details
- earner status (if required)


- b** Manually calculate the weekly compensation earnings rate using the relevant guide based on the relevant Act.

NOTE What if the relevant Act is 1972 or 1982?

Refer to the Claims Manual for policy and instruction on calculating a client's weekly earnings rate.


NOTE What if the relevant Act is 1992?

Refer to the Payments Assessor guide to Weekly Compensation ARCI Act 1992.

 Payments Assessor guide to Weekly Compensation ARCI Act 1992


NOTE What if the relevant Act is 1998?

Refer to the Payments Assessor guide to Weekly Compensation AI Act 1998.

 Payments Assessor guide to Weekly Compensation AI Act 1998

NOTE What if the relevant Act is 2001?

Refer to the Payments Assessor guide to Weekly Compensation AC Act 2001.

 Payments Assessor guide to Weekly Compensation AC Act 2001

NOTE What if the relevant Act is 2010?

Refer to your current knowledge and Promapp procedures in regards to the Weekly Compensation AC Act 2001 (2010 Amendment).

NOTE What if you cannot determine the weekly earnings rate.

If the clarification is simple (less than 15 minutes estimated to clarify) contact Technical Services by phone. If clarification is likely to more complex, send a Complete Internal Referral task to the Operations Support queue requesting assistance.

- c** Upload details of the calculated weekly compensation earnings rate onto the claim.

NOTE What details do I need to include?

- relevant Act(s)
- earner type
- earnings details
- calculation breakdown
- weekly earnings rate/s

5.0 Perform entitlement recalculation

Experienced Payments Assessor, Payments Assessor

- a** Enter the appropriate information into the Te Ara Hou calculator as per the guide to calculate the weekly compensation entitlement.

 Te Ara Hou Calculator

 Te Ara Hou Calculator Guide.docx

NOTE What if the calculation is for a Fatal Weekly Compensation entitlement?


Use the Te Ara Hou calculator to calculate the Fatal Weekly Compensation entitlement. You will then need to manually apportion the entitlement based on the relevant Act and number of dependants.


- b** Save the excel Te Ara Hou calculation into the internal weekly compensation folder.
- c** Export the calculation from the Te Ara Hou calculator as a PDF and upload to the claim in Eos.

NOTE What if the recalculated entitlement result is an overpayment?

Overpayments in these circumstances are non-recoverable. No further action is required. Refer to 'Write-off of overpayments generated by entitlements paid from Pathway' and 'Overpayment recovery decision of for overpayments generated by entitlements paid from Pathway'.

This procedure Ends.

 Write-off of overpayments generated by entitlements paid from Pathway

 Overpayment recovery decision for overpayments generated by entitlements paid from Pathway

6.0 Add or update Migrated Collection Point
Experienced Payments Assessor, Payments Assessor

- a** In Eos, add or update the Migrated Collection Point

NOTE What if the recalculated weekly earnings rate at the migration date has changed?

Update the Migrated Collection Point with the new 100% weekly earnings rate as at the migration date.

NOTE What if this is a new calculation and I need to pay ongoing in Eos?

Add the DOFI and/or DOSI date as normal. Then add the Migrated Collection Point.

 Add Migrated Collection Point.pdf

7.0 Enter ad-hoc payment in Eos
Experienced Payments Assessor, Payments Assessor

- a** In Eos, enter the Te Ara Hou weekly compensation amount as an Ad-hoc taxable payment.

NOTE What if the recalculated pre-migration weekly compensation amount is an underpayment?

Add the Ad-hoc taxable payment on the Weekly Compensation Entitlement subcase in the 'Other Entitlements' tab as an underpayment.

 Ad-Hoc Payment Underpayment.pdf

NOTE What if the pre-migration weekly compensation amount is a new payment?

Add the Ad-hoc taxable payment on the Weekly Compensation Entitlement subcase in the 'Other Entitlements' as a new payment.

 Ad-Hoc Payment New Payment.pdf

NOTE What if deductions need to be applied?

Apply any deductions to the total recalculated pre-migration weekly compensation ad-hoc payment as required.

NOTE What if MSD reimbursement needs to be calculated?

Refer to 'Reimburse Ministry of Social Development'.

For the pre-migrated weekly compensation period, apply these deductions to the Ad-hoc taxable payment.

For the migrated period paid out of EOS, apply as per normal process

 **PROCESS** Reimburse Ministry of Social Development

NOTE What if you need to recalculate MSD reimbursements made on an Ad-hoc taxable entitlement?

Refer to 'Recalculate MSD reimbursements made on an Ad-hoc taxable entitlement'

- PROCESS** Recalculate MSD reimbursements made on an Ad-hoc taxable entitlement

8.0 Review recalculation

Experienced Payments Assessor, Payments Assessor

- a** Review that the recalculation request is complete and that both the Ad-hoc taxable payment for the pre-migrated weekly compensation amount, and the post-migration EOS entitlements are accurate.
- b** Send an Approve Weekly Compensation Entitlement task to the Weekly Compensation Approval Complex queue detailing the recalculation request and payments for approval.

- Add an approval task

NOTE What if this was a Backdated Weekly Compensation request?

Refer to 'Set Up Backdated Weekly Compensation' Process to be sure this has been followed.

- PROCESS** Set Up Backdated Weekly Compensation

-
- PROCESS** **Approve Weekly Compensation Entitlement**
Experienced Payments Assessor, Payments Assessor
-

Summary

Objective

Use this guidance if to determine whether a client who has suffered a mental injury following sexual abuse is able to seek civil damages.

Background

Under the Accident Compensation Act 2001, Section 21A, only people who first sought treatment between 1 July 1992 and 1 July 1999, and who suffered a mental injury following sexual abuse before 1 July 1992, are eligible to seek civil damages.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** The attached rules apply when a client seeks a claim for civil damages in the courts for mental injury.

If...	then...
a judgment was received in the client's favour before 11 May 2005	the client does not have cover under the AC Act 2001, Section 21A for the injury or injuries that relate to the civil action
the proceedings were filed but not heard before 11 May 2005	nothing prevents the proceedings from being heard or a court from awarding general damages



Rules for Civil damage for mental injury - Sensitive.PNG

- b**
- The client must declare any payments and entitlements received from ACC for the mental injury that they are seeking damages for. The court must take these payments into account if it decides to award any damages
 - The client ceases to have cover under Section 21A for the injuries on the date judgment is given on the proceedings and must advise ACC of the judgment.
- c** If the client loses cover due to seeking a claim for civil damages, we cannot recover any payments previously made to the client.



Escalate claim involving civil damages Policy



Summary

Objective

Section 123 of the AC Act 2001 confirms that entitlements are inalienable and cannot be paid to anyone else, such as a debt collection agency. However, ACC is able to make some deductions from any amounts payable, but only as specifically authorised under the AC Act 2001. Below are the relevant deductions that can be deducted from a client's weekly compensation payment. For deductions on other types of payment check with Customer Service Technical Support team.

Owner

[Out of Scope]

Expert




Policy

1.0 Rules

- a** Some deductions are subjected to 'protected earnings'. This means:

- we can only deduct a maximum of 40% of a client's net weekly compensation amount (after tax and ACC earner levy)
- once a client's total deductions reach 40%, no further deductions that are subject to the protected earnings can be deducted.


Deductions can be made by ACC in response to court-ordered repayment judgements, or to written requests made under relevant Acts:

-  Protected earning threshold
-  Order of priority in which third party deductions are applied to payments
-  [Deduction types - hierarchy list and legislation Policy.docx](#)

- b** Housing NZ deductions have previously been applied to a client's weekly compensation. However, this is no longer used as a new deduction on a client's weekly compensation. It can remain if it has already been applied to a client and can be changed if needed.

2.0 Deductions of which protected earnings do not apply

- a** The protected earnings threshold does not apply to some types of deductions. The business rule below specifies these.

-  Third party deduction of which protected earnings does not apply



Summary

Objective

We can make deductions from weekly compensation payments to recover outstanding costs for another agency. Authority for making deductions is governed by a range of legislation, including any part of the Accident Compensation Act 2001 (AC Act 2001) giving ACC the right to recover or deduct from weekly compensation payments.

Note: The relevant law relating to deductions is now contained in the Social Security Regulations 2018 (issued under s 444 of the 2018 Act).

If a deduction notice is issued to an employer of a debtor, the employer must not, in making deductions under the deduction notice, reduce the amount paid to the debtor by way of salary or wages in respect of any week to an amount that is less than 60% of the amount calculated as being the debtor's net ordinary weekly pay for a week.

This means that if a deduction request, such as MSD Supplementary debt (formally S86a), is requested for an amount greater than the 40% protected earnings threshold we cannot make the deduction. The System will enforce this rule.

Owner

[Out of Scope]

Expert

Policy

1.0 Relevant Legislation

- a** Deductions can be made under relevant legislation. Any deductions that do not come under the relevant legislation or requesting agency will not be applied. See Deductions type - Hierarchy list and legislation for more information.

- Deduction Types - Hierarchy List and Legislation Policy
- Definition of third party deduction requesting organisation

2.0 Making deductions

- a** Under the AC Act 2001, Section 123(2) Entitlements inalienable, we must not:
- pay a client's weekly compensation, or deduct from their weekly compensation, as part of a Summary Instalment Order authorised under the Insolvency Act 2006
 - assign or transfer weekly compensation to any person or organisation other than the client, except in special circumstances.

When an organisation requests the deduction of a client's weekly compensation, you must make sure:

- the client is eligible for or receiving weekly compensation
- the request is in writing and permitted under relevant legislation.

You may need to contact the requesting organisation to clarify the request details.

- AC Act 2001, Section 123(2) Entitlements inalienable <https://www.legislation.govt.nz/act/public/2001/0049/l/>

- Type of entitlement from which a third-party deduction can be made
- Type of amount owing to third party for which a third-party deduction can be made

3.0 Returning requests for deduction

- a** If there's no weekly compensation to complete the deduction request, you must write to the requesting organisation telling them we've declined their request under the AC Act 2001, Section 123(2).

- Notification of reason for decline
- b** ACC is to record some information when we decline a deduction. The business rule below specifies the information to be recorded.
- Information recorded for a declined request for third party deduction

4.0 Advising clients

- a** Once a deduction from a weekly compensation amount is applied or changed, clients will be sent payment advice outlining:

- the amount of the deduction
- the type of deduction being made

- that a new deduction has been applied or an existing deduction changed against their payment which may affect the amount they're paid

- that we will continue to make this deduction until the requesting agency informs us to change or stop it.

If we are unable to fully apply the amount requested, the payment advice will advise the client:

- that the full amount requested can't be deducted as it's more than the amount we're allowed to take
- to check in case a deduction has been removed
- to contact the requesting agency for more information about their deductions.

- Sending payment advice to client
- Information required on a payment advice for a full deducted third party deduction
- Information required on a payment advice for a third party deduction not deducted in full

5.0 Advising requesting agencies

- a** A remittance advice must be sent to the requesting agency to advise that the deduction is in place.

- Sending remittance advice
- Method for sending remittance advice

- b** We are also to advise the requesting agency where we do not deduct the full amount

- Notification to IR for reduced child support deductions

- c** Filing information with Inland Revenue

- Recording reduced child support deductions due to protected earnings

6.0 Stopping deductions

- a You must stop making deductions on a client's weekly compensation on the earliest of the following dates:
 - the date specified in the original request
 - the date the requesting organisation advises us to stop
 - the date the total amount has been recovered
 - the date the client's eligibility stops.

- Date to end third party deductions
- Ending third party deductions (discretionary)

7.0 Revalidating requests for deduction

- a We can revalidate a request to make a deduction when a period of time has passed between receiving the requests and approving or applying the deduction. The business rule below specifies the limitation in the time gap required for revalidating to occur.

- Revalidating a third party deduction
- Older deductions to start when revalidated

8.0 Tax code changes

- a ACC must change a client's tax code when requested by Inland Revenue under the Tax Administration Act 1994.

If a client asks to change their tax code, follow the instructions in the Manage Client Tax Code procedure linked below.

PROCESS **Manage Client Tax Code**

9.0 Recommencing deductions with weekly compensation payments

- a Where ACC had stopped paying weekly compensation payments to a client and then recommenced to make the payments, third party deductions can also recommence to being deducted.

- Third party deductions for recommenced weekly compensation entitlement

PROCESS **Manage Client Third Party Deductions**

Decline Entitlement when Client is Non-compliant Policy v18.0



Summary

Objective

Use this guidance to determine whether a client has unreasonably failed or refuses to comply with a reasonable request from ACC. The purpose of this guidance is to help ensure that we meet legislative requirements when issuing non-compliance decisions, and that our decision is fair and reasonable.

This entry also provides policy guidance on declining to provide entitlements, and resuming or backdating payments once the client complies with ACC's requests.

1. The difference between declining to provide entitlements and suspending entitlements
2. Fair and reasonable process
3. Example: Clients travelling overseas
4. Declined entitlements
5. Resuming payments and reinstatement
6. Backdating entitlement payments
7. Links to legislation

Background

Under section 117(3)(a) of the Accident Compensation Act 2001, ACC may decline to provide any entitlement for as long as the claimant unreasonably refuses or unreasonably fails to comply with any requirement of the Act.

Owner

[Out of Scope]

Expert

Policy

1.0 The difference between declining to provide entitlements and suspending entitlements

- a** If a client is no longer eligible for assistance, we suspend their entitlements rather than decline them.

See Suspend entitlement when client no longer eligible .

Suspend Support When Client is No Longer Eligible Policy

- b** We may decline to provide entitlements when the client unreasonably fails to comply with a reasonable request, including:
- complying with any requirement of the Accident Compensation Act 2001 relating to their claim
 - undergoing medical or surgical treatment for their personal injury that they are eligible to receive
 - agreeing to or complying with their individual rehabilitation plan (IRP).

See Managing non-compliance

Managing non-compliance

2.0 Fair and reasonable process

- a** We must follow a process to ensure that we meet legislative requirements and are seen to be fair and reasonable. The following points will help determine whether non-compliance is fair:
- our request must be reasonable
 - we must give the client reasonable notice and the opportunity to comply, and advise them about the implications of not complying
 - we must consider the reason(s) the client gives us for their non-compliance.

NOTE Example - Reasonable request

We ask a client to attend a medical assessment in two weeks' time. The client does not have any particular preference for a provider, and we advise them by letter about the assessment and the implications of non-compliance.

NOTE Example - Unreasonable refusal or failure

The same client ignores the request to attend the assessment, saying they didn't have enough notice, or didn't choose the provider, or have not been told about non-compliance. Any of these responses is considered unreasonable.

- b** We must send the client at least one written warning before they are deemed to be acting unreasonably. We must give the client an opportunity to comply before we make a decision.

3.0 Example: Clients travelling overseas

- a** In some cases, a client's rehabilitation may be delayed or interrupted because of overseas travel.

It is important to consider the circumstances of each case before deciding whether section 117(3) of the Accident Compensation Act 2001 applies. The fact that a client is travelling overseas, whether for a holiday or to relocate, does not necessarily mean that they are unreasonably refusing to comply.

It is possible that a client can undertake rehabilitation while overseas. They may also be able to agree on a reasonable timetable for returning to New Zealand to undertake their rehabilitation or to undergo assessments.

Overseas Claim Policy

4.0 Declined entitlements

- a** We cannot decline entitlements retrospectively. We can only decline to pay future payments and cannot recover payments that we've already made.

We are able to decline to provide all entitlements or just some of them.

We can decline an entitlement indefinitely if the client continues to not comply.

A client forfeits payments for the period in which they fail to comply.

When we revoke a decision to decline to provide entitlements, or our decision is quashed on review or appeal, we must reinstate the client's entitlement from the date that it was first stopped.

- b** If ACC issues a non-compliance decision, then we can decline to provide entitlements, including: weekly compensation payments, independence allowance payments, and rehabilitation interventions, such as home help or attendant care.
- c** Once the client complies with our request then we can reinstate entitlements.

NOTE Example - Eligible but entitlements declined until compliant

After continued discussion, including advice about the implications of not complying, a client still refuses to sign the ACC165 form. The Recovery Partner approves the client's eligibility, but declines to provide any weekly compensation payments until they agree to sign the form.

NOTE Example - Decline some but not all entitlements

We decline to provide a client's weekly compensation and independence allowance entitlements, but continue the client's attendant care because stopping it would cause the client and their family serious hardship.

5.0 Resuming payments and reinstatement

- a** We resume payment from the date the client complies and/or attends a missed appointment.

We are not normally liable to make any payment to which the client would otherwise have been entitled for the period between the:

- date from which their payments were first withheld
- date payments resume, ie the date the client begins to comply.

6.0 Backdating entitlement payments

- a** We are not required to backdate a client's entitlement over the period we declined to provide it. However, we can backdate the entitlement if we believe that both:

- exceptional circumstances exist
- it would be unfair to refuse to backdate.






- b** Factors include, but are not limited to:

- the client providing a medical certificate for either a new ACC covered injury or a non ACC covered condition.
- death or illness in the family
- the client or their family have been affected by unforeseen circumstances or circumstances beyond their control that have caused significant financial hardship or emotional distress
- the impact for the client or their family of not having the entitlement backdated is out of all reasonable proportion to the reason why the client refused to comply
- the client's rehabilitation has not been affected or delayed by the period of non-compliance.

See Delegations Manual: Cessation and suspension for details.

 [Delegations manual](#)

7.0 Links to legislation

-  [Section 54: Responsibility of Corporation to make reasonable decisions in timely manner](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  [Section 70: Claimant's and Corporation's obligations in relation to rehabilitation](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  [Section 72: Responsibilities of claimant who receives entitlement](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  [Section 117: Corporation may suspend, cancel, or decline entitlements](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
-  [Injury Prevention, Rehabilitation, and Compensation \(Code of ACC Claimants' Rights\) Notice 2002](#)
<https://www.legislation.govt.nz/regulation/public/2002/>



Summary

Objective

Use this guidance to help you determine whether a client is eligible for weekly compensation from ACC under the Accident Compensation Act 2001. This policy applies to claims where the client became unable to work from 1 July 2010.

- 1) Eligibility criteria
- 2) Section 103 - Can the client do the job they were doing before they were injured?
- 3) Section 105
- 4) Extension of Earner Status
- 5) Eligibility
- 6) Review inability status periodically
- 7) Termination of an employment
- 8) Links to legislation

Owner

[Out of Scope]

Expert

Procedure

1.0 Eligibility criteria

- a** For a client to be eligible for weekly compensation from ACC, all the following criteria must be met:
- the claim for personal injury is accepted for cover under the Accident Compensation Act 2001, and
 - ACC is responsible for managing the claim (that is, it is not a work-related personal injury suffered by an employee of an accredited employer), and
 - the client has made a written or verbal application for weekly compensation, and
 - the client is unable to work because of the personal injury under either section 103 or section 105, or.
 - the client is in employment at the time they suffer their injury, and was an earner immediately before incapacity commenced, or has been assessed as being an earner under the Accident Compensation Act 2001. (see the 'Definition of an Earner' policy page to determine if the client is an earner).



Definition of an Earner



Weekly compensation for maternal birthing injury clients

2.0 Section 103 - can the client do the job they were doing before they were injured?

- a** Under section 103 of the Accident Compensation Act 2001, ACC must determine a client's inability to work – and therefore their eligibility to weekly compensation – by determining whether they could do the job they were doing before they were injured.

- b** The people who are eligible for weekly compensation include those who, at the time they suffered their personal injury, were:
- in employment and had earnings immediately prior to becoming unable to work as one or more of an employee, self-employed and shareholder employee; or
 - on unpaid parental leave; or
 - a recuperating organ donor and receiving payments under the Compensation for Live Organ Donors Act 2016; or
 - in consecutive periods of unpaid parental leave and a payment period under the Compensation for Live Organ Donors Act 2016.
- c** In all cases, the client must have earnings immediately prior to becoming unable to work as one or more of an employee, self-employed and shareholder employee.

NOTE What if they are on unpaid parental leave?

Clients on unpaid parental leave at the time of their injury are deemed to be in employment for the purposes of Section 103.

NOTE What if clients are receiving organ donor compensation?

Clients who are recuperating organ donors under the Live Organ Donors Act 2016 are deemed to be earners if they:

- are injured during a payment period under that Act which was immediately preceded by a period of employment in which they were receiving earnings. Their inability to work is tested under section 103; or
- are injured during consecutive periods of unpaid parental leave and a payment period under the Live Organ Donors Act 2016. Their inability to work is tested under section 103; or
- had no earnings immediately prior to the organ donor payment period, they meet the timeframes under clause 43 of Schedule 1 at the commencement of the payment period. Their inability to work is tested under section 105.

3.0 Section 105


- a** We can't determine inability to work under section 103 for those clients who:
- have an extension of earner status under clause 43 of Schedule 1
 - are a potential earner at the time they suffered their injury, they may be eligible for loss of potential earnings (LOPE)
 - have purchased weekly compensation under section 223.


4.0 Extension of earner status


a Clients may have an extension of earner status under clause 43 of Schedule 1 because:

- leave payments that are liable for earner levy on ceasing employment extend the period of employment up to or beyond the date they became unable to work, or
- they became unable to work within 28 days after ceasing employment as an employee and had an employee job to return to within 3 months, or
- they became unable to work within 28 days after ceasing seasonal employment as an employee where they had been employed in the two previous seasons and the employer confirms that the client could reasonably expect to have been employed again within 12 months, or
- they became unable to work during a payment period under the Live Organ Donor Compensation Act 2016 and they satisfy the timeframes under clause 43 of Schedule 1 at the start of that payment period (as if that was the date they were unable to work).

b Please ask the client to sign the ACC165 Declaration of rights and responsibilities form, as described in the method for the initial interview, declaring that they understand their responsibilities for receiving weekly compensation.

 [ACC165 Declaration of rights and responsibilities](#)

 [Accident Compensation Act 2001, Schedule 1, Clause 43, Weekly earnings if employment ended before commencement of incapacity](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

 [Compensation for Live Organ Donors Act 2016](#)
<http://www.legislation.govt.nz/act/public/2016/0096/lat>

PROCESS


Weekly Compensation and New Zealand Superannuation (post-1 July 2019) Policy

5.0 Eligibility

a The rules for determining the level and duration of support are driven by:

- the dates when a client initially and/or subsequently became unable to work in the employment they held at that date (date of first incapacity 'DOFI', or date of subsequent incapacity 'DOSI')
- confirmation of ongoing inability to work.


b Refer to links below for additional information.


 [Definition of Incapacity](#)

6.0 Review inability status periodically

a When a client is eligible for weekly compensation it is important to continue to periodically review their inability to work.

b See the link below for additional information.

 [Definition of Incapacity](#)


 [Establishing Date of First Incapacity \(DOFI\)](#)

7.0 Termination of an employment

a If the employment a client held at DOFI/DOSI is terminated during the period that they are unable to work, they are still eligible for weekly compensation so long as they continue to be unable to work.

8.0 Links to legislation

 [Accident Compensation Act 2001, section 103](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

 [Accident Compensation Act 2001, section 105](#)
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

Summary

Objective

We're responsible for paying for or contributing to treatment required as a result of an injury.

Criteria for deciding whether to pay for treatment are set out in the ACC Act 2001, Schedule 1, Clause 2.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a Prior approval is not always required before treatment is provided, especially in emergencies. See Acute treatment.

If you have concerns about any type of treatment, consult with the medical advisor or team manager about approving or declining the request.

Acute treatment
<https://go.promapp.com/accnz/Process/85c2f492-2e8>

2.0 Treatment criteria

Treatment must be...	Ask yourself...
for a covered injury	does the client have cover for the personal injury?
necessary and appropriate	<ul style="list-style-type: none"> • is the need for this treatment related to the level of functioning lost as a result of the covered mental or physical injury? • is there evidence to support the treatment's effectiveness?
of the quality required	will the treatment be of the quality required to contribute to restoring the client's health?
given at the appropriate time and place, with only the appropriate number of treatments necessary	<ul style="list-style-type: none"> • will the treatment contribute to restoring the client's mental or physical health to the maximum extent practicable, but not enhance it beyond the pre-injury level? • is the frequency of providing the treatment enough, and only enough, to contribute to restoring the client's health? • are the time and place of the treatment appropriate?
provided by an appropriately qualified treatment provider holding a current annual practising certificate	<ul style="list-style-type: none"> • is the treatment provider qualified in providing this type of treatment? Is this a type of treatment the provider normally provides? • is this a treatment recognised by ACC? • does the treatment need prior approval?

Eligibility criteria for treatment.PNG

- a When you're deciding if these criteria have been met, always take into account the:

- nature and severity of the injury
- generally accepted treatment for the injury in New Zealand
- other treatment options available in New Zealand for such an injury
- New Zealand cost of both the generally accepted treatment and the other options, compared with the likely benefit to the client of the treatment
- clinical guidelines and treatment profiles.

3.0 Eligibility checks

- a Our Medical Fees Processing (MFP) system is set up to show when the client's initial number of treatments allowed, ie treatment trigger number, has been reached and prior approval is needed for additional treatment. See Processing an ACC32 request for extra treatment funding.

The system also allows us to monitor provider performance against their peers and to inform service development.

Processing an ACC32 request for extra treatment funding

4.0 Treating non-injury needs

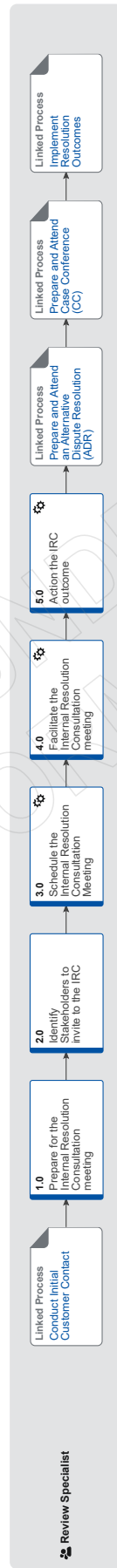
- a While we're responsible for contributing to injury-related treatment only, we must take into account non-injury factors, such as an underlying medical condition that might affect the client's recovery, when deciding eligibility for treatment.

However, we are not responsible for providing treatment required solely for an underlying condition.

NOTE Example

- A client with degenerative arthritis sprains a wrist. We're responsible for contributing to treatment for the sprain, eg physiotherapy costs, but not for any treatment that relates to the arthritis condition
- If the arthritis is so extensive that standard treatment is not effective, then we would take that into account when considering what alternative treatment to purchase. The existence of arthritis doesn't prevent the client from being entitled to the treatment, but the treatment must still relate to rehabilitation for the injury, not rehabilitation for the underlying condition

Prepare and Lead an Internal Resolution Consultation (IRC) v9.0



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Prepare and Lead an Internal Resolution Consultation (IRC) v9.0



Summary

Objective

The objective of this process is to use information and advice from relevant internal experts in an attempt to seek a resolution for the customer/representative. It will involve explaining the decision (and the reasons for the decision with the customer/representative), and provides them with an opportunity to hear from relevant internal experts.

Background

The Internal Resolution Consultation (IRC) is used to bring relevant parties together with the client to help clarify customer/representative understanding of a decision. The IRC is often used when a decision is robust, but not understood by the customer/representative. New information may be raised at this meeting by the customer/representative.

Owner

[Out of Scope]

Expert

Procedure

PROCESS Conduct Initial Customer Contact Review Specialist

1.0 Prepare for the Internal Resolution Consultation meeting

Review Specialist

- Identify the customer/representative's point/s of contention or grievance with the ACC decision.
- Gather documents or other evidence to support a discussion of the point/s of contention or grievance.
- Re-evaluate potential resolution options as an outcome of the IRC.

NOTE What potential options are available if the original decision was or appears correct?

- A resolution agreement
- Alternative Dispute Resolution
- A case conference

NOTE What potential options are available if the original decision was or appears incorrect?

- Overturning the original decision

2.0 Identify Stakeholders to invite to the IRC

Review Specialist

- Identify all relevant stakeholders who may be able to provide insight or technical advice on the decision at the IRC.

NOTE Who could be relevant stakeholders?

ACC staff who had input into the decision. This could include:

- Legal Services
- Clinical Services
- Technical Services
- Technical Accounting Services
- Weekly Compensation Team
- External medical practitioner/s
- Vocational Providers
- Allied health providers
- Levy Classification

Working together to find the right outcome

- Contact the potential stakeholder to determine attendance.

NOTE What if a member of the Levy Classification Team need to attend the IRC?

Email Levyclassification@acc.co.nz to request a colleague attend the IRC. The subject of the email should read "Resolution Services Attendance Request". The email should include:

- Review number
- Customer/representative name (if applicable)
- ACC number
- Date and time of the IRC
- Outline a request for attendance at the IRC

10 working days notice is required for Levys to attend the IRC.

3.0 Schedule the Internal Resolution Consultation Meeting

Review Specialist

- In Outlook, set up a teleconference by sending a meeting appointment to the customer/representative and identified relevant stakeholders.

NOTE What should be in the body of outlook meeting appointment?

- Information on the decision and why ACC made the decision
- The customer/representative's grievance with the decision and the specific points of contention
- Potential outcomes from the IRC
- A list of meeting attendees
- Contact details for the Review Specialist

4.0 Facilitate the Internal Resolution Consultation meeting

Review Specialist

- Using Skype for Business or Teams, initiate the meeting. Allow internal parties to join first and then dial in the customer/representative last.

NOTE What if one or more parties cannot be reached?

Reschedule the IRC for another time.

- Introduce all the participants to each other and explain the purpose of the internal resolution consultation.

- Facilitate the meeting ultimately steering/directing the conversation towards a resolution, or a clearly agreed outcome.

5.0 Action the IRC outcome

Review Specialist

- Using the IRC contact tool (this exists on the second tab of the CIR calculator tool) enter the outcome agreement.
 - If the review is about a decision on a claim copy and paste the information generated by the 'IRC contact calculator' into an Eos contact.
 - If the review is about a levy decision copy the IRC contact tool information into an interaction in Juno_CRM.

CIR Calculator Tool

Customer Resolution Hub - ACC SharePoint

NOTE What type of contact should be added in Eos?

- Reason: Dispute
- Direction: Internal
- Method of contact: Phone

b Action the IRC outcome agreed during the consultation.

NOTE What if no resolution was reached?


Decide whether to proceed to an ADR, or directly to case conference.


NOTE What if the agreed actions will take the review past 40 days from the lodgement date?

Set down a case conference date.

NOTE What if there was a successful resolution agreement, an agreement to withdraw the review, or overturn an incorrect decision?

Fulfil the resolution obligations.

 **PROCESS** **Prepare and Attend an Alternative Dispute Resolution (ADR)**
Review Specialist

 **PROCESS** **Prepare and Attend Case Conference (CC)**
Review Specialist

 **PROCESS** **Implement Resolution Outcomes**
Review Specialist



Summary

Objective

We sometimes make decisions based on legal opinion. When we do this we must notify the client, using the following rules.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** Although we don't have to release information subject to legal professional privilege, we:
 - must notify clients of the reasons for a decision
 - do not have to disclose that we've asked for or used any legal advice on any point.

We may include arguments from a legal opinion supporting the decision in a decision letter or explanatory letter to a client. However, if a letter states that we reached the decision using legal advice, ACC may be considered to have waived its right to legal professional privilege. For this reason you shouldn't state that the decision was based on legal advice. Instead of acknowledging legal advice you need to attribute the decision solely to ACC using expressions like ... "ACC believes that..." or "ACC considers that..." or "ACC has decided that..."

2.0 Accessing the reasons behind statutory decisions

- a** The reasons for our decisions must be apparent from the client's file. This is especially important when we've reached a decision using legal advice.

A copy of the decision letter or the explanatory letter must be included in the client's file.

Summary

Objective

Refer to this guidance to help you determine whether a client is eligible to receive weekly compensation while overseas, and how to manage ongoing eligibility for weekly compensation.

- 1) Personal injury within New Zealand
- 2) Personal injury outside New Zealand
- 3) Medical certification by overseas medical/nurse practitioner
- 4) Taxation of weekly compensation paid to Australian residents
- 5) Determine eligibility for weekly compensation if injured overseas
- 6) Overseas income and weekly compensation
- 7) Criteria for earner in receipt of New Zealand taxable earnings at DOFI

Owner

[Out of Scope]

Expert

Policy

1.0 Personal injury within New Zealand

- a** Both the following points apply for the period they are outside New Zealand:
- they must provide ACC with ongoing medical confirmation that they are unable to work due to the injury
 - ACC must approve the doctor/nurse practitioner providing that medical certificate.

If weekly earnings were based on earnings from illegal employment, eg working without a work permit, then:

- a reassessment is required, to remove the illegal earnings from the weekly compensation calculation.

This is effective for the period the client is outside New Zealand.

2.0 Personal injury outside New Zealand

- a** Section 127 of the Accident Compensation Act 2001 (AC Act 2001) outlines the criteria for the payment of weekly compensation to a client while they are overseas.

Section 127, AC Act 2001 - Payment of weekly compensation and lump sum compensation to claimant outside New Zealand
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

- b** Clients who have sustained personal injury while overseas, and who are living outside New Zealand, are eligible for weekly compensation in limited circumstances, which are described below:

- the general eligibility rules apply, i.e. they must be an earner with New Zealand taxable earnings at the date they became unable to work due to the injury
- a client may be eligible for consideration if they had earnings within the six-month period prior to leaving New Zealand, but they must still meet the first criterion, above
- they must provide ACC with satisfactory medical confirmation of their inability to work.

This also applies when establishing weekly compensation payable on a fatal claim, if the deceased client was overseas at the date of death.

Go to Accidental Death Support Policy.

Accidental Death Support Policy

3.0 Medical certification by overseas medical/nurse practitioner

- a** Special criteria apply for accepting medical certificates for the client becoming unable to work while overseas, in both the following instances:
- a client is injured in New Zealand and goes overseas
 - a client sustains an injury overseas that has cover

If the client is overseas and provides medical certificates for inability to work from an overseas doctor or nurse practitioner, these can be accepted if the:

- medical certificate clearly states the limitations the client is experiencing
- medical certificate states the period that the client is unable to work as a result of these limitations, up to a maximum of 13 weeks
- doctor or nurse practitioner has provided sufficient details of their qualifications and these qualifications are comparable to registered medical or nurse practitioners, who are able to practice in New Zealand
- medical certificate is written in English.

A decision on acceptability can then be made taking into consideration qualifications of the practitioner, the nature of the injury, and the limitations being experienced in relation to the client's pre-injury employment.

4.0 Taxation of weekly compensation paid to Australian residents

- a** A person is considered a tax-resident in Australia if they live there for more than six months a year. Any other clients who are about to move to Australia must be advised of these new tax rules, and instructed to contact the Inland Revenue Department (IRD) and the Australian Tax Office (ATO) about their tax liability.

It can be difficult to identify clients who are Australian residents as we do not explicitly identify clients by country. A report has been generated of all clients who are currently receiving weekly compensation, and searched for some derivative of 'Australia' in their postal, residential or case payee addresses.

- b** The IRD and the ATO have agreed that weekly compensation for Australian residents will no longer be taxed in New Zealand but in Australia.

- c These clients must approach IRD to obtain a special tax certificate which stipulates that ACC is to deduct their weekly compensation payments at 0% when the client is an Australian tax resident. They must also contact the ATO to seek information about their tax liability in Australia. For people who have been living there and receiving weekly compensation for a number of years, it is likely that the ATO will seek back-taxes from them for the entire period of their residency in Australia. These clients will also need to contact IRD to discuss any tax refunds for those years.

ACC has no jurisdiction in this matter, and is required by law to implement these changes. We cannot enter into any discussion about the tax treatment of these payments, and anyone enquiring about this needs to be directed to either the Australian Tax Office or the Inland Revenue Department.

The contact details for IRD and the ATO are:

- Inland Revenue Department (calling from overseas) on +64 4 978-0779
- Australian Tax Office (calling from Australia) on 13 28 61.

5.0 Determine eligibility for weekly compensation if injured overseas

- a A client may have cover through ACC for an injury that occurred overseas, because they were ordinarily resident in New Zealand at the time.

The following criteria must be met for a client to be eligible for weekly compensation in these circumstances:


- the client must be an earner receiving New Zealand taxable earnings as at start of the period they were unable to work due to the injury
- ACC must be satisfied that the client is unable to work due to the injury. See Determine if medical certificate completed overseas is acceptable.

 Determining if Medical Certificate Completed Overseas is Acceptable

6.0 Overseas income and weekly compensation

- a Overseas income and weekly compensation
When a person has earned overseas income before becoming unable to work due to the injury, it is possible that some or all of this income can be included in the calculation of their weekly compensation. The following should be considered:

- In all cases, they must be a New Zealand tax resident to have their income considered for ACC purposes
- If the person is employed overseas and paid PAYE deducted salary or wages by a New Zealand based employer, and the employer declares the wages to IRD, these will be considered 'earnings as an employee'.
- If the person works overseas for an overseas company, the earnings they receive may be classed as self-employed earnings, and would need to be declared on an IR3 as 'Overseas Income'. Regardless of whether the person is classed as an employee, the earnings would not meet the definition of 'earnings as an employee' as defined in section 9 of the Accident Compensation Act 2001.
- Earnings declared as 'overseas income' still may not have been billed ACC levies. Any claim with overseas income should be referred to the Technical Accounting Specialists to determine how much of the income is relevant for ACC's purposes.


 Accident Compensation Act 2001, section 9: Earnings as an employee
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

7.0 Criteria for earner in receipt of New Zealand taxable earnings at DOFI


- a ACC needs to determine whether the client can be classified as an earner, in receipt of New Zealand taxable earnings, at the start of the period they became unable to work.
- b The following categories of client could meet the criteria:
 - working overseas and receiving New Zealand taxable earnings
 - overseas on a brief period of unpaid leave (see the guidance 'Deciding eligibility and employment' linked below)
 - eligible under of AC Act 2001, Schedule 1 Clause 43, i.e. overseas on leave and received holiday pay before they left (see the guidance 'Extension of employee status' linked below)
 - eligible under AC Act 2001, Schedule 1 Clause 44, i.e. they are on a period of unpaid parental leave
 - eligible under AC Act 2001, Section 223 (see guidance 'Purchased TimeOut cover' linked below)
 - eligible under AC Act 2001, Schedule 1 Clause 47 and have received earnings in the six months before leaving NZ. Go to Loss of Potential Earnings (LOPE) to determine, gather information and calculate loss of potential earning capacity (LOPE)


 Purchased TimeOut Cover

 Loss of Potential Earnings (LOPE)

 Section 223 Persons eligible to purchase weekly compensation
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

 Schedule 1, Clause 43 Weekly earnings if employment ended before commencement of incapacity
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

 Schedule 1, Clause 44 Weekly earnings if employee on unpaid parental leave immediately before his or her incapacity commenced
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

 Schedule 1, Clause 47 Corporation to pay weekly compensation for loss of potential earnings capacity
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

PROCESS Setup Overseas Claim

Establish a Payment of Backdated Weekly Compensation for 90 Days or More

v14.0



Summary

Objective

Use this guidance to help establish whether a client is eligible for backdated weekly compensation (BDWC). This applies to clients who became unable to work due to their injuries from 1 July 2010.

- 1) Summary
- 2) Reasons to pay backdated weekly compensation
- 3) Determine retrospective inability to work
- 4) Evidence that is relevant to determining inability to work
- 5) Financial information
- 6) Work and Income reimbursement and deductions
- 7) Tax rate
- 8) Processing payments in Pathway
- 9) Processing payments from Eos

Background

We pay backdated weekly compensation to a client who is found to be eligible for this in an earlier period. We will consider backdating weekly compensation for various reasons, such as a late claim, a revoked decision, an overturned Vocational Independence decision, overturned suspension, a settlement or a decision quashed at review or in court.

A request for BDWC can come from a court decision, review decision, legal settlement, client or advocate. We will receive requests verbally or in writing. See Preparing and confirming a backdated weekly compensation request.

Owner

[Out of Scope]

Expert

Procedure

1.0 Summary

- a** Just as for ongoing weekly compensation, we must ensure that:
- the client has cover
 - the client was unable to work due to the injury for either:
 - their pre-injury role (see Accident Compensation Act 2001, Section 103), or
 - any other work they can do because of their experience, education, or training, or any combination of those things (see the Accident Compensation Act 2001, Section 105)
 - there is financial information that confirms their earner status and they had earnings before they became unable to work, and any earnings that may be liable for abatement.

We must determine if the client received a Work and Income benefit during this time, and deduct any reimbursement from the backdated payment.

Anything else that impacts the payment, such as a debt that arrears can be applied to, should also be identified and included in the calculation if appropriate.

- Backdated weekly compensation eligibility
- Confirmation of a period of incapacity of 90 days or more

- b** The Case & Claims Management Delegations set out who has the final decision making authority for making back dated payments. See the link below for further details.

- Definition of Incapacity
- Accident Compensation Act 2001, Section 103 <http://www.legislation.govt.nz/act/public/2001/0049/lat>
- Accident Compensation Act 2001, Section 105 <http://www.legislation.govt.nz/act/public/2001/0049/lat>
- Case and Claims Management Features Delegations

2.0 Reason to pay backdated weekly compensation

- a** Review the reason that backdated weekly compensation is requested, to determine what needs to be done.

If the request is complicated or medical evidence is unclear, you should request assistance from a Medical Advisor.

If the request is the result of a Court decision that quashed a decision we made to suspend weekly compensation, we must still make sure all the criteria are met to calculate and pay for the period or any part of it. If there are questions about the person's eligibility in the period, consult with Technical Services.

If the findings are that the client remained incapacitated, and weekly compensation should be reinstated, further confirmation of incapacity is not required.

3.0 Determine retrospective inability to work

- a** Determining a client's previous inability to work may be difficult, especially if it was over an extended period, and the period in question started a long time ago. It may even be before we had contact with the client.

Review any existing information we have including, other claims or information for other purposes that are on file which could be relevant, eg impairment assessments.

In cases requiring a determination under s 103, establish the nature of any previous pre-injury employment duties, tasks and hours and type of work.

If you are aware of existing information that is relevant but is not on the file, request this from the client or their provider:

- an independent specialist assessment, that would be used as the basis for a quashed decision
- GP or other medical notes, related to the injury or its effects, eg physiotherapy visits or operation notes.

4.0 Evidence that is relevant to determining inability to work

- a** Evidence includes but is not limited to:

NOTE Medical certificates

Contemporaneous medical certificates for 90 days or less, which clearly describe how the client is unable to work because of the injury, and are signed within 3 months of the period, are acceptable proof of inability to work. Otherwise, additional proof of inability to work should be sought such as the GP's notes for the period. If the GP did not see the client during the period of the certificate, ACC may not accept it as evidence of inability to work.

NOTE Specialist assessments or opinions

Consider the specialist's qualifications and the evidence they have provided in support of their opinion, especially in relation to pain and the effect on the client's ability to work or sustain work.

NOTE Impairment assessments

While impairment assessments are done for a different purpose, they can provide information about the client's functional ability which is relevant in assessing their inability to work due to the injury.


NOTE Other support

If a client requires treatment (eg surgery or rehabilitation) for their injury during the backdated period, this can be relevant to the assessment of their inability to work. If a client's pre-injury employment requires driving, and the client was approved to receive transport for independence during the backdated period, this could be a factor in showing they had an inability to work. A social rehabilitation assessment outlining client's injury-related need for social rehabilitation support may also be relevant.

NOTE Other evidence of inability to work

This could include an employer's account of the client's condition ie to what extent they could perform duties that they were able to do before the injury, like heavy lifting or prolonged sitting or the ability of the client to work their normal pre-injury hours or maintain those hours. In the absence of other evidence, ACC can consider WINZ medical certificates as evidence if they are for the same condition as the inability to work, and accompanied by contemporaneous medical notes.

- b** It is important that a clinical opinion is obtained to review the medical information to support and validate any subsequent recommendation in regard to a client's inability to work.
- c** If there is still uncertainty about the client's inability to work due to the injury, after gathering and reviewing existing information, and a specialist assessment is recommended, it is essential that all required information relating to the issue or time period that is uncertain, is assembled before initiating the process of Arranging a Medical Case Review.

 Arranging an additional medical assessment referral







5.0 Financial information

- a** If the client was receiving weekly compensation immediately prior to the backdated period, it may be possible for them to be reinstated at that original rate, once their inability to work is confirmed.

Otherwise the following must also be confirmed to calculate and pay weekly compensation:

- earner status
- type of employment before they became unable to work, eg:
 - permanent or non-permanent employment
 - self-employment
 - shareholder employment
- earnings before they became unable to work (see Gather earnings information)
- validation of earnings from Inland Revenue for backdated weekly compensation



Abate weekly compensation in respect of earnings after they become unable to work.

-  Definition of an Earner
-  Definition – Permanent and Non-Permanent Employment
-  Earnings as a self-employed person
-  Earnings as a shareholder employee
-  Validation of Earnings from Inland Revenue for Backdated Weekly Compensation
-  Determine Earnings Liable for Abatement

6.0 Work and Income reimbursement and deductions

- a** Once the client's eligibility for weekly compensation is confirmed, a request is made to Work and Income to determine if the client received a reimbursable benefit during the backdated period. If so, ACC provides Work and Income the gross amounts due the client, and Work and Income responds with reimbursement details which are included in the pre-tax calculation.

Other deductions can include other ACC debt, court fines, and child support. See: Hierarchy of deductions schedule for more information.

-  Reimbursements to Ministry of Social Development from ACC
-  Deduction Types - Hierarchy List and Legislation Policy

7.0 Tax rate


- a** The last step in the process is to advise the client of the payment, and to confirm the tax code. If the client does not advise the tax code within 10 working days, ACC can pay using the default tax code. Note that the client can subsequently request a change to their tax rate for this payment directly from Inland Revenue.

 Different Methods of Taxation

8.0 Processing payments in Pathway

 Backdated Weekly Compensation

9.0 Processing payments from Eos

 Manage Client Payments

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Summary

Objective

Use this guidance to help determine when interest is payable on backdated weekly compensation. This applies to claims where the client became unable to work due to their injury from 1 July 2010.

1. When interest is payable
2. Reasons for paying interest
3. Other reasons
4. Who makes the decision
5. Calculating interest
6. Reimbursements to the Ministry of Social Development

Background

Sometimes we're required to pay interest on weekly compensation when we're late in making a weekly compensation payment. In these cases, we may pay interest on all or some of the backdated payment.






Interest is not payable on any other types of support. For compensatory payments related to potential service issues or ACC error, see Payments Outside the Scope of Statutory Entitlements.

Owner [Out of Scope]

Expert


Policy

1.0 When interest is payable

- a** Under the Accident Compensation Act (AC Act) 2001, Section 114 we must pay interest to a client for the late payment of weekly compensation if we did not make the payment within one month of receiving all the necessary information required to process the claim.
 -  Accident Compensation Act (AC Act) 2001, Section 114
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
 -  Interest payment for backdated weekly compensation
- b** The date that interest is payable from, ie the 'all information date', is determined in part by the reason for the delay.
 -  Interest calculation start date for backdated weekly compensation when due from the date the WC stopped
 -  Interest calculation start date for backdated weekly compensation when due from the information received date
 -  Interest calculation end date for backdated weekly compensation


2.0 Reasons for paying interest

- a** Consider paying interest whenever weekly compensation is stopped, the decision is later overturned and weekly compensation is reinstated. Weekly compensation could have been stopped, for example, when:
 - a client is found to no longer be unable to work because of 'incapacity' under the AC Act, Section 103
 - weekly compensation is suspended on the grounds that the client's condition is not due to a covered injury
 - a client has achieved vocational independence.

 Accident Compensation (AC) Act, section 103
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

- b** Decision overturned: If our decision to stop weekly compensation is overturned, we must pay interest on backdated weekly compensation from the date payment stopped when:
 - ACC made an error in applying the law
 - ACC misinterpreted clear, unambiguous evidence about eligibility
 - ACC carried out insufficient inquiries, or had insufficient evidence to support our decision
 - ACC's decision to suspend was reasonable, but this decision is overturned on the same evidence.

See Court of Appeal decision in Accident Compensation Corporation v Miller ([2013] NZCA141).

 Court of Appeal decision in Accident Compensation Corporation v Miller ([2013] NZCA141).
<https://www.westlaw.co.nz/maf/wlnz/app/document?d>

NOTE Example

A client's weekly compensation is stopped because they're found to be vocationally independent in three roles. At review, ACC's decision is quashed because the reviewer found that ACC did not adequately consider the effect of the client's covered chronic pain syndrome on their ability to work.

- c** New evidence: We must pay interest, but not back to the date of suspension, when our decision to stop weekly compensation was correct at the time but later new evidence is relied on to overturn that decision in the client's favour. We'll only pay interest from the date at which we held all of the necessary information to make the same decision that is later made at review or appeal.

NOTE Example

Weekly compensation is stopped based on specialist reports and radiological findings that show the client's covered injury did not cause their ongoing condition. However, subsequent evidence establishes that the injury did cause the condition.

In this scenario, the 'all necessary information' date would be the date ACC received the information showing the cause of the condition.

3.0 Other reasons

NOTE Decisions declining eligibility

Interest may also apply if payment of weekly compensation is delayed because a decision declining eligibility is overturned. Examples include declined cover/earner status.

Scenarios 1 - 4 under 'Reasons for paying interest' apply to determine the 'all necessary information' date.

NOTE Service issues

If there is a serious service failure on our part, such as a delay in obtaining the necessary information, interest may be payable from an earlier date, ie the date on which we should have obtained the necessary information. This date will be decided on the facts of the case. Any payments will be made under section 114 of the AC Act 2001.

If we fail to act or respond to a client request causing a material delay in the management of their claim, this may also be a serious service failure.

NOTE What constitutes a serious service failure?

A serious service failure requires more than a simple omission or delay. It requires ACC to have fallen well below reasonable service standards, leading directly to a delay in weekly compensation being paid.

4.0 Who makes the decision

- a When determining eligibility to interest guidance should be sought from Technical Services in all cases.

You must send requests to Technical Services on an ACC6218 Referral for interest on late payment of weekly compensation form and leave the form as incomplete in Eos and send request via Salesforce written guidance. Eligibility that is later overturned, eg cover is declined because a client is found to be a non-earner.

- Technical Services
- ACC6218 Referral for interest on late payment of weekly compensation
- Seek Internal Guidance

- b The Weekly Compensation Panel makes recommendations on:
 - whether interest is payable in a non-suspension situation, where interest is claimed on the basis of a serious service failure
 - the point from which interest is payable.

You must send requests to Technical Services on an ACC6218 Referral for interest on late payment of weekly compensation form and leave them as incomplete in Eos. Technical Services will put a request through to the Weekly Compensation Panel.

- ACC6218 Referral for interest on late payment of weekly compensation

- c See the 'Make a Weekly Compensation Interest Payment' procedure linked below for instructions on how to request the decision and process an interest payment.

PROCESS Make a Weekly Compensation Interest Payment

5.0 Reimbursements to Ministry of Social Development

- a The weekly amount for interest calculation is the gross (pre-tax) weekly compensation rate, less the gross amount of any reimbursement paid to MSD.

The amount of the weekly compensation payment that replaces the benefit paid by MSD does not attract any interest because it is now deemed to have been paid by ACC on the date that the benefit was paid to the client by MSD. See Interest calculation for payments of backdated weekly compensation and Reimbursements to Ministry of Social Development, linked below.

- Interest calculation for payments of backdated weekly compensation
- Reimbursements to Ministry of Social Development from ACC

NOTE Example

A client receives a gross benefit from MSD for the 10-week period between 22 July 2002 and 27 September 2002, at the rate of \$200 per week. The total paid by MSD for the period is \$2000.

It is later found that the client was eligible for gross weekly compensation of \$300 per week - a total of \$3000 for the same period.

If interest is payable on the arrears for that period, the \$2000 reimbursed to MSD to replace the benefit paid for the period does not attract interest. Interest is only payable in respect of the \$1000 outstanding (\$100 per week), ie the difference between the two amounts.

NOTE Are MSD reimbursement details "necessary information" under s 114?

A District Court decision in 2016 held that a benefit that is to be reimbursed to MSD is deemed to be weekly compensation "for all purposes", under s 252 (6) of the AC Act 2001. ACC is therefore deemed to already know the details of that benefit. This means that the details provided by MSD to ACC is not "necessary information" under s 114.


6.0 Business rules for calculation of interest on backdated weekly compensation

- a The following business rules define how interest on backdated weekly compensation is calculated. These rules are used by the applicable backdated weekly compensation interest calculator.

- Calculating total interest payable for backdated weekly compensation
- Calculating the interest payable for a portion of a backdated weekly compensation liability period
- Apportioning liability period for backdated weekly compensation

- b The interest rate used for interest on backdated weekly compensation calculations is made up of the base rate plus the premium rate. See the following business rules for more information.

- Interest rate to be used for paying interest on backdated weekly compensation
- Premium rate to be used for paying interest on backdated weekly compensation

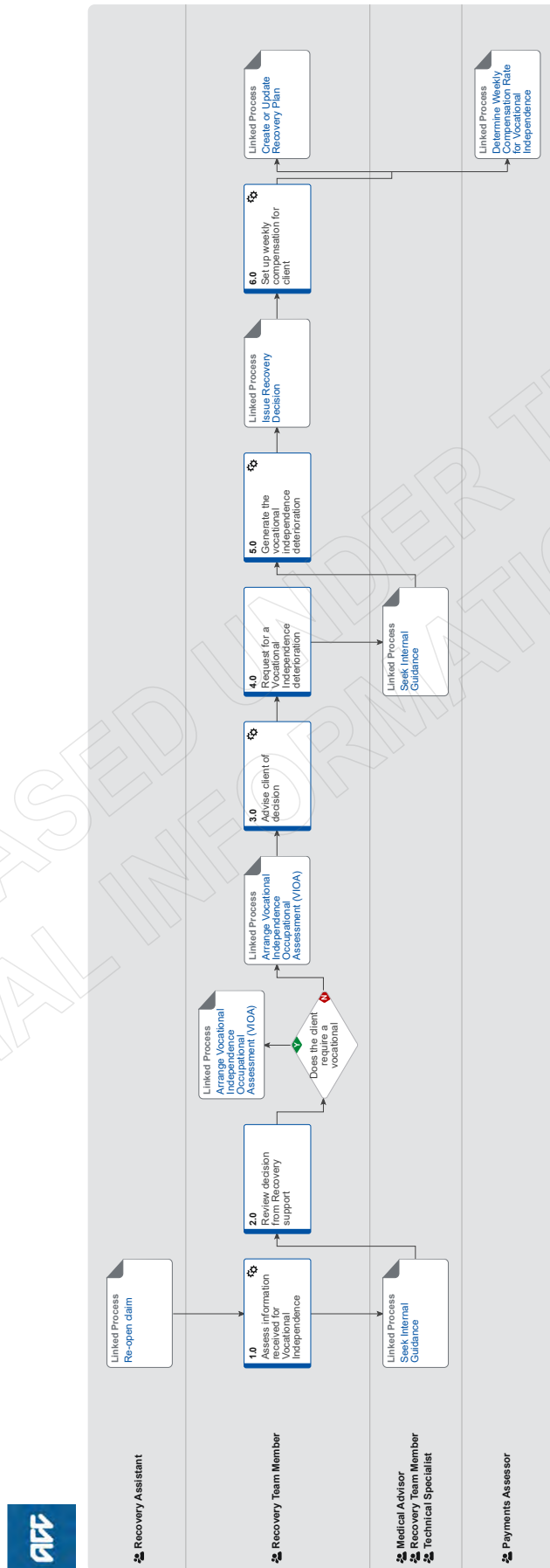
 Base rate to be used for paying interest on back-dated weekly compensation

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Make a Vocational Independence Deterioration Decision - Non Surgery v18.0



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Make a Vocational Independence Deterioration Decision - Non Surgery ^{v18.0}



Summary

Objective

To provide a standardised approach to the making of non-surgery vocational independence deterioration decisions.

Background

ACC is required to determine whether a client has lost their vocational independence (VI) due injuries related to the initial VI decision.

This process seeks to achieve this for non-surgery related deteriorations.

Owner

[Out of Scope]

Expert

Procedure



PROCESS

Re-open claim

Recovery Assistant

1.0 Assess information received for Vocational Independence deterioration

Recovery Team Member

- a Familiarise yourself with the vocational independence deterioration policy
 - About Vocational Independence Deterioration Policy
- b Confirm information received relates to the claim that has achieved VI.
- c Generate and send a VID01 Acknowledge application - claimant letter (34K) to the client acknowledging you received their ACC18 form.
 - VID01 Acknowledge application: claimant
- d Review the medical information or the request for weekly compensation received together with the client's case and claim history for related injuries to establish potential link between incapacity and the previous injury that achieved VI.
- e Request all the medical records of the client since the VI decision.

NOTE How do you request for medical records?

Use the VID03 GP report request - vendor letter. Generate this letter in Eos. Use the Request Clinical Records process.

PROCESS Request Clinical Records

VID03 GP report request - vendor

- f Once medical records have been received, request written guidance from a Technical Specialist and Medical Advisor for a confirmation that the client MAY have lost their vocational independence and, therefore, proceed to reassessment (VIOA and VIMA).

NOTE See 4.0 Request for Vocational Independence Deterioration Decision

NOTE If sensitive claim possible VI deterioration

1. Add an additional question in the request for written guidance asking whether a psychological/psychiatric functional assessment would be of benefit prior to any reassessment of VI.



PROCESS

Seek Internal Guidance

Medical Advisor, Recovery Team Member, Technical Specialist

2.0 Review decision from Recovery support

Recovery Team Member

- a Review the decision from Recovery Support in the Request for Written Guidance task.
- b Determine whether the client needs to proceed to a vocational independence re-assessment based on the decision from Recovery Support.

NOTE What if Vocational Independence needs to be reassessed?

First, contact the client and advise that we will progress to reassessing their VI to determine whether they still have capacity for work or not.

Then, go to 'Arrange Vocational Independence Occupational Assessment (VIOA)' and begin at Step 5.0 (Request assessment referral). The VI02, ACC191, ACC193 ACC691 documents are not required for reassessment. Be sure to inform this on the referral task to Recovery Administration.

Once the VIOA report is received, go to 'Arrange Vocational Independence Medical Assessment (VIMA)'. Complete the steps up to Step 6.0 (Review assessment report) and then continue the process below from Step 4.0.

PROCESS Arrange Vocational Independence Occupational Assessment (VIOA)

NOTE What If Vocational Independence Deterioration needs to be declined

Complete Step 3.0 below



Does the client require a vocational independence re-assessment?

Recovery Team Member

YES.... **PROCESS** Arrange Vocational Independence Occupational Assessment (VIOA)

NO.... Continue



PROCESS

Arrange Vocational Independence Occupational Assessment (VIOA)

Recovery Team Member

3.0 Advise client of decision

Recovery Team Member

- a In Eos, prepare the decision letter 'VI999 Deterioration of Vocational Independence Decline - client letter' to the client.

VI999 Deterioration of Vocational Independence decline - client

NOTE How do you issue a decision to a client?


Go to the NGCM Issue Recovery Decision process

PROCESS Issue Recovery Decision

- b** Go to the NGCM Issue Recovery Decision process to issue the decision to the client.
This process ends here.

NOTE How do you issue a decision to a client?

Go to the NGCM Issue Recovery Decision process

 **PROCESS** Issue Recovery Decision

NOTE What do you do with the VI claim after issuing the decision?

If client is eligible to other entitlements and assistance on the claim during and post surgery, proceed to Create or Update Recovery Plan process.


Otherwise, if client has no other entitlements on the claim or assistance required from ACC, proceed to closing the claim.

 **PROCESS** Close claim

4.0 Request for a Vocational Independence deterioration decision

Recovery Team Member

- a** Generate and attach the ACC198 to the Written guidance task and send it to Technical Specialists.

 ACC198 Vocational Independence Assessment - Final quality check and decision

- b** Seek written guidance from Recovery Support to confirm vocational independence deterioration for the client.

NOTE How do you request for a confirmation of vocational independence deterioration?

Use the (NGCM) Seek Internal Guidance process.

Go straight to step 3.1b Request Written Guidance (Tier 3)

 **PROCESS** **Seek Internal Guidance**
Medical Advisor, Recovery Team Member, Technical Specialist

5.0 Generate the vocational independence deterioration decision letter

Recovery Team Member

- a** Review the received Request for Written Guidance task and the attached ACC198.

- b** If you have any questions or concerns, discuss these directly with the Technical Specialist or Medical Advisor

NOTE Do you have the recommended next steps for the client?

Ensure that you have the recommended next steps for the client before getting in touch with the client.

You will need to agree with the client the new recovery pathway.


- c** In Eos, generate the appropriate decision letter.


NOTE Which decision letter should you generate?

Use the 'VI999 Deterioration of Vocational Independence Decline - client letter' for a decline VI deterioration decision.

NOTE - The letter will require amending to remove reference to 'beyond three months from the date of this letter' at the end of the paragraph for option 2a.

Use the 'VID06 Accept deterioration - claimant letter' for accepting VI deterioration for the client.

 VI999 Deterioration of Vocational Independence decline - client

 VID06 VI Accept deterioration - claimant

NOTE Please ensure date of acceptance for Vocational Independence deterioration is noted on the VID06 letter

NOTE Date of deterioration

Make sure you discuss with the client the date of deterioration as this could easily become a contentious issue.

The date should be provided by Recovery Support in the completed ACC198 form.

- d** Go to the NGCM Issue Recovery Decision process to issue the decision to the client and return to this process after issuing the decision.

 **PROCESS** **Issue Recovery Decision**
Recovery Team Member

6.0 Set up weekly compensation for client

Recovery Team Member

- a** In Eos, request for WC set up using the Setup Weekly Comp Entitlement task.

 Add a weekly compensation set up task


- b** Add the Non standard WC set up Eform.

 Add a Non standard WC set up Eform

- c** Ensure DOSI is the date of deterioration as specified in the ACC198.

NOTE When a client holds employment at the date VI deterioration is determined weekly compensation is paid at the higher of previous weekly compensation or current earnings. Please ensure the non standard weekly compensation set up task includes current work pattern and hours per week.

 **PROCESS** **Create or Update Recovery Plan**
Recovery Team Member

 **PROCESS** **Determine Weekly Compensation Rate for Vocational Independence Deterioration**
Payments Assessor

Complex Regional Pain Syndrome (CRPS)

Factors to consider when assessing Cover



Considerations when assessing cover for Complex Regional Pain Syndrome

This guideline is to assist Recovery Team Members, to make cover decisions for CRPS when all of the criteria below are met (see Guidelines for Recovery Team Members section), and to enable clinical advisors to consider the relevant factors before making cover recommendations.

The abbreviation 'CRPS' is sometimes used incorrectly to refer to 'Chronic Regional Pain Syndrome'.¹ There is no definitive test for the diagnosis of CRPS. It is a diagnosis of exclusion. Current best practice is to diagnose CRPS applying the Budapest Criteria. The Budapest Criteria is the tool ACC is using as part of the assessment of cover.

Guidelines for Recovery Team Members

- ✓ Check if a formal request for CRPS cover has been made, via usual mechanisms, such as:
 - (i) As a consequential injury/ies to an existing covered personal injury/ies (eg a fracture)
 - (ii) As a treatment injury following non-ACC related surgery
 - (iii) As an injury consequential to treatment (e.g. ACC-related surgery) for a covered personal injury

If the request is for CRPS NOS, seek internal guidance ([NGCM Seek Internal Guidance](#)) without checking any of the below steps. If the request is for 'CRPS Type I', 'CRPS Type II', or 'CRPS', proceed to the check points below.

- ✓ Confirm that the ACC18 or other formal request for cover was received after the date of the injury and after the expected timeframe for recovery from the covered injury but not more than three months after the expected timeframe for the recovery from the covered injury. Clear cases will present early. Complex Regional Pain Syndrome can be diagnosed after three months. If the request is beyond this period seek Clinical Advice.
- ✓ Confirm that the onset of CRPS occurred after the date of injury.
- ✓ Confirm that the CRPS is at the same site as the covered injury.
- ✓ Confirm that the medical records refer to a diagnosis of Complex Regional Pain Syndrome (CRPS), and not Chronic Regional Pain Syndrome. The first time the term is used in a document that is being used to support the request for cover, 'Complex Regional Pain Syndrome' must be spelled out in full. If there is any ambiguity in documentation where the abbreviation is used, there must be clarification of what this abbreviation means.
- ✓ If the notes refer to a diagnosis of Chronic Regional Pain Syndrome or if 'CRPS' is not defined in the notes seek clarification from the relevant provider. If the diagnosis of complex regional pain syndrome remains uncertain, seek internal clinical guidance.

¹ This document is not to be used when the diagnosis is Chronic Regional Pain (Syndrome). This is a different pain condition. Both Complex Regional Pain Syndrome and Chronic Regional Pain Syndrome can be abbreviated to CRPS.

- ✓ Confirm that there was no evidence of pain (for example a pain disorder, previous CRPS) prior to the relevant event.
- ✓ Confirm that a suitably qualified medical practitioner has made the diagnosis. The diagnosis can be accepted without Recovery Support input if diagnosed with reference to the Budapest criteria by a Fellow of the Faculty of Pain Medicine (ANZCA) or a medical specialist working in a tertiary pain service. If the diagnosing clinician is not a Fellow of the Faculty of Pain Medicine or a medical specialist working in a tertiary pain service, or you are not sure what the diagnosing clinician's specialty is, seek internal guidance. Also seek internal guidance if the request is made by a clinician who is not a medical practitioner.
- ✓ Confirm that the diagnosis of CRPS only applies to the affected limb.
- ✓ Confirm that there are clear recommendations for pain management moving forwards that involve an interdisciplinary approach. Appropriate treatment for CRPS should be initiated as soon as possible.
- ✓ If any of the steps above cannot be confirmed seek internal guidance.
- ✓ Check the medical tab on Eos for covered injuries. If Sudek's Atrophy or Reflex Sympathetic Dystrophy have already been covered for the same body site for this covered injury, cover for Complex Regional Pain Syndrome has essentially already been granted (these diagnoses are historical terms to describe CRPS). Consider updating the medical tab accordingly (the relevant ICD-10 code is 'CRPS-Other': G90.7), and then exit the current process.
- ✓ For CRPS cover decisions, if clinical advice is required advice should be sought from Clinical Advisors or Medical Advisors, including Treatment Injury Advisors, using the appropriate process. The Tier of guidance required will be dependent upon the number and complexity of unmet criteria discussed above.

Guidelines for clinical and medical advisors

- ✓ Review the available medical records and referral documentation and if insufficient to provide a clear recommendation request the necessary documentation
- ✓ Review criteria above and consider how these may apply to your advice.
- ✓ Establish if there is sufficient evidence from the available documentation that the diagnostic criteria for Complex Regional Pain Syndrome have been met. For example, if the treating clinician has stated that the current Budapest criteria have been met, this would be sufficient to confirm the diagnosis if the diagnosing clinician is a Fellow of the Faculty of Pain Medicine or a medical specialist working in a tertiary pain services. For CRPS diagnoses originating from any other clinician, a review of the medical records will be necessary.
- ✓ Refer to the CRPS Clinical Advisor Reference Tool Table 1 ([https://accnz.sharepoint.com/sites/ClinicalAdvisorReferenceTool/SitePages/Complex-regional-pain-syndrome-\(CRPS\).aspx](https://accnz.sharepoint.com/sites/ClinicalAdvisorReferenceTool/SitePages/Complex-regional-pain-syndrome-(CRPS).aspx)) for the relevant diagnostic criteria for CRPS. Note that the clinical diagnosis of CRPS requires that all four of the criteria listed in Table 1 should be met at the time of the diagnosis being confirmed. Ensure that the clinician making the diagnosis has documented the relevant differential diagnoses and that these have been considered and excluded.

- ✓ If the request is for CRPS-NOS, refer to a Principal Clinical Advisor.
- ✓ If recommending cover for CRPS, ensure that you also include an ICD-10 code (the recommended ICD-10 code for CRPS-Type I is G90.5, for CRPS- Type II it is G90.6, CRPS-Other is G90.7).

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Net Loss of Earnings Reimbursement - ACC Approved Appointments v15.0



Summary

Objective

When a client has to take time off work to attend ACC approved rehabilitation appointments, we can reimburse them for their net loss of earnings (NLOE). We'll only provide a reimbursement if the client requests it. The client's case owner is responsible for managing the request.

Different rules apply for assessment and treatment appointments.

- 1) Time off work should be a last resort
- 2) Assessment appointments
- 3) Treatment appointments
- 4) Links to legislation

Owner

[Out of Scope]

Expert

Procedure

1.0 Time off work should be a last resort

- a** The client is responsible for their own rehabilitation and should take all practical steps to minimise disruption to their employment and/or loss of earnings. See the Accident Compensation Act 2001 (AC Act), Section 70.

If we require a client to attend treatment or an ACC assessment, we must work with them to explore all options for them to attend the appointment either outside of their normal working hours or during their lunch break.

Some employers may have provisions for continuing wages for medical appointments.

NOTE To qualify a client must have been an earner at the date of injury and incapacity.

2.0 Assessment appointments

- a** The client can attend assessment appointments for the purpose of cover and entitlement decisions at ACC's expense. See the AC Act, Section 55. If they have to take time off work to attend, we can reimburse them for their Net Loss of Earnings (NLOE).

3.0 Treatment appointments

- a** Under the AC Act, time off work to attend treatment appointments is classified as incapacity and creates entitlement for weekly compensation. However, for discrete periods of time off work to attend treatment and rehabilitation appointments we'll reimburse the client using NLOE instead.

The normal stand down period for first incapacity applies. We're not able to pay the client if the appointment was within the first seven days of their date of first incapacity (DOFI).

If the client challenges their NLOE reimbursement or asks us to recalculate it, you must arrange for a full weekly compensation calculation.

- b** Confirmation of lost earnings is required from the employer. Contact the employer to request the nett amount of lost earnings. To make the payment see Manage Client Reimbursements (section 2.5)

- Definition of Incapacity
- Establishing Date of First Incapacity (DOFI)
- Manage Client Reimbursements
- Calculate Weekly Compensation

4.0 Links to legislation

- Accident Compensation Act 2001, section 70 - claimant's and Corporation's obligations in relation to rehabilitation
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- Accident Compensation Act 2001, section 55 - claimant responsibilities to assist in establishment of cover and entitlements
<http://www.legislation.govt.nz/act/public/2001/0049/lat>



Summary

Objective

Guidelines for Making Neuropsychological Assessment Referrals (NP104)

Owner

[Out of Scope]

Expert

Procedure

1.0 About referrals

- a** • There needs to be a clear and valid reason for referring for a neuropsychological assessment as these assessments are time consuming for clients and relatively costly for ACC.
 - Where case owners have established that a neuropsychological assessment is necessary and appropriate for a client with cover for traumatic brain injury, there is no need to refer for Psychology Advisor (PA) comment prior to making the referral. Standard questions/requests are suggested below, under 'Making the referral' (4.0). In practice, most experienced neuropsychological assessors are familiar with the areas that need to be assessed.
 - If cover for traumatic brain injury has not yet been established, and a neuropsychological assessment has been recommended as part of the cover investigations, psychology advice should be sought via the PA Hotline in the first instance.
 - For clients who have sustained moderate to severe traumatic brain injuries, referral for a neuropsychological assessment would usually occur no sooner than six months' post-injury. The aim is to identify those longer-term enduring cognitive, behavioural and emotional difficulties which need targeting in rehabilitation. However, there may be times when an assessment may occur earlier than six months' post-injury, such as when a client has made a rapid recovery and wants to return to employment.
 - While there is no need to involve a Psychology Advisor when considering a first neuropsychological assessment, Psychology Advisors should be consulted via the Hotline when case owners are considering a neuropsychological re-assessment, to ensure that the timing is appropriate.
 - If a referral is made directly to the service provider, ie not by the case owner, the provider must get the case owner's approval owner before starting any part of the assessment.
 - We do not pay a provider if they don't have prior approval.
 - All referrals must be in writing.
 - The assessment must be arranged and carried out within expected timeframes. Refer to Neuropsychological Assessment Overview Service Page (1.0 Who is this service for? and 4.0 Timeframes).

[Neuropsychological Assessment Overview Service Page](#)

[Psychology Advisors \(PAs\) Team Space](#)

[Neuropsychological Assessment Overview Service Page](#)

b Additional Considerations in Assessments of Children/ Adolescents:

Case owners can refer for neuropsychological assessment when clients (or parents/guardians) are concerned about cognitive, behavioural and/or emotional difficulties that are impacting on recovery and/or return to school and/or where the provider has recommended the assessment.

The neuropsychological assessment with children/ adolescents aims to:

- a) Confirm the existence of traumatic brain injury (TBI) and determine how the client is affected by the TBI.
- b) Clarify the possible role of brain injury related cognitive difficulties in presenting behavioural and/or emotional concerns.
- c) Provide a re-assessment to track recovery/ cognitive development
- d) Provide recommendations for intervention (or any changes in the existing rehabilitation plans), if appropriate.

2.0 Choosing a provider

- a** Approved neuropsychological assessment providers can be found on the list linked below.

[Contracted Suppliers by Geographic Area of Coverage](#)

3.0 Service location

- a** Assessment venues are specified in the individual provider's contract. Alternative venues may be used with the prior approval of the case owner.
 - If the case owner asks the provider to assess a client in a different location from the provider's usual place of practice, the provider may invoice ACC for travel time, kilometres travelled, and the cost of room hire, as set out in the contract in Part A, Clause 4
 - You must direct clients to the nearest approved provider location. If a client needs to travel to the appointment, see Non-emergency transport for guidelines on reimbursing for travel.

NOTE When can Telehealth be used to provide services?

- Services can be delivered by Telehealth, where clinically appropriate. Telehealth Services must:
- have client or authorised representative consent (recorded in the clinical notes), and with the option of an in-person meeting if the client prefers
 - be preceded by an initial risk assessment to ensure client safety
 - meet the same required standards of care provided through an in-person consultation
 - have clinical records that meet ACC and professional body requirements
 - meet the requirements outlined in the standards/guidelines of the New Zealand Psychologist's Board
 - If there is a difference between the regulatory body statements and what is stated in this contract, then the contract conditions take precedence
 - have both the client receiving the Telehealth service, and the provider delivering the Telehealth service, physically present in New Zealand and at the time the service is provided.

The 'Alias Code' for Telehealth Services is NP104T

4.0 Making the referral

- a** The case owner sends the referral document (ACC110) to the contracted service provider, along with all relevant information, such as GP notes, hospital records including: ambulance records, hospital admission report/s, any daily hospital progress notes (usually hand-written records) when available, hospital discharge report/s, imaging (CTI MRI scan) findings, rehabilitation progress reports, Concussion Clinic notes, counselling, psychological and psychiatric assessment and intervention/treatment reports, vocational and other medical reports. Relevant pre-injury GP/mental health notes for a period of 2 years pre-dating the head injury up to present should be accessed and included with the neuropsychology assessment referral.

Note: GP notes should include mental health concerns (e.g. symptoms of low mood, depression, anxiety, trauma, stress, and other non-specific symptoms such as headache, fatigue), head injuries/brain injuries, persistent/chronic pain and unexplained medical symptoms. Internal clinical guidance transcripts related to the head injury should also be sent, along with a summary of other head/brain injury/concussion, mental injury, and sensitive claims and relevant records for those claims. It is important to obtain client consent to share the sensitive claim information.

- Provide the reason for referral so that the provider knows exactly why the referral is being made. If there are complexities present, please outline what these are. It is important that the assessor has a comprehensive understanding of the client and any risks/complexities which are present. Risks include risk of harm to the client or other people (such as providers), such as aggressive behaviour. Complexities might include multiple head injury claims associated with persisting impairment, the presence of mental injury, or claims with a history of external reviews.


- There is one purchase order code – NP104. The maximum of 16 hours should be entered in the purchase order as the neuropsychologist only bills for the number of hours actually used.


- Please see below suggested questions and areas of focus for neuropsychological assessments for both adults and young people. It is important to look carefully at the areas of focus to determine whether they are relevant for the client in question and to establish whether any further information is required from the assessor.

- All neuropsychological assessment reports need to be reviewed by the Psychology Advisors.


NOTE What if you need to request medical or clinical records

Go to Request Clinical Records process

 **PROCESS** Request Clinical Records

-  ACC110 Neuropsychological assessment referral – vendor

- b** Send NPS01 to the client to advise that the provider will be in contact.

-  NPS01 Neuropsychological assessment request - claimant letter

C Areas of Focus to include in Neuropsychological Referrals:

Case owners can request that providers carry out a neuropsychological assessment incorporating the following requests:

- a) Provide a summary of injury and medical history as well as all other personal history of relevance
- b) Fully assess cognitive and psychological/affective functioning, incorporating named measures of performance and symptom validity
- c) Provide a detailed, balanced clinical opinion on causation of any cognitive or psychological symptoms/difficulties identified, including discussion of injury versus non-injury factors
- d) Opinion on whether or not there is/are any residual cognitive or other difficulty/ies related to the index event and the functional impact/s of those difficulties
- e) Provide your recommendations for any additional assessment/s required
- f) Provide your recommendations for ongoing input required and the appropriate avenues for accessing this

 **PROCESS**

Assess and Arrange Neuropsychological Assessment

RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

The Official Information Act (OIA) governs access to official information held by Ministers and specified government agencies. Almost all requests for non-personal information is to be handled under the OIA.

Summary

- The Official Information Act 1982 (OIA) governs access to official information held by Ministers and specified government agencies.
- Almost all requests for non-personal information is to be handled pursuant to the OIA. Complying with it isn't voluntary.
- The OIA Services Team are a group of OIA experts, there to provide advice and support.
- If you've received a request for information and you're not sure what to do, email the team at governmentservices@acc.co.nz or contact

[Out of Scope] Manager OIA Services

Owner

[Out of Scope]

Expert

Policy

1.0 Official Information Act

- a** The Official Information Act 1982 (OIA) allows people to request official information held by Ministers and specified government agencies (agencies). It contains rules for how such requests should be handled, and provides a right to complain to the Ombudsman Office in certain situations.
- 📄 Official Information Act 1982
<http://legislation.govt.nz/act/public/1982/0156/latest/D>
 - 📄 Ombudsman Office
<http://www.ombudsman.parliament.nz/make-a-compl>
- b** There is also a separate Act called the Local Government Official Information and Meetings Act 1987 (LGOIMA), which applies to local authorities.
- 📄 Local Government Official Information and Meetings Act 1987
<http://www.legislation.govt.nz/act/public/1987/0174/lat>

2.0 Purposes of the Act

- a** The key purpose of the OIA is to increase the availability of official information to the people of New Zealand to:
- enable more effective public participation in the making and administration of laws and policies; and
 - promote the accountability of Ministers and officials; and
 - enhance respect for the law and promote good government.

It is also to protect official information to the extent consistent with the public interest and the preservation of personal privacy.

3.0 What is official information?

- a** Official information means any information held by an agency subject to the OIA. It is not limited to documentary material, and includes material held in any format such as:
- written documents, reports, memoranda, letters, notes, emails and draft documents;
 - non-written documentary information, such as material stored on or generated by computers, including databases, video or tape recordings;
 - information which is known to an agency, but which has not yet been recorded in writing or otherwise (including knowledge of a particular matter held by an officer, employee or member of an agency in their official capacity);
 - documents and manuals which set out the policies, principles, rules or guidelines for decision making by an agency; and
 - the reasons for any decisions that have been made about a person.
- b** If a requester seeks information by asking a question, there is a distinction between:
- questions which can be answered by providing information already known to and held by the agency (official information); and
 - questions which require the agency to form an opinion or provide an explanation and so create new information to answer the request (not official information).

4.0 Practical examples within ACC

- a** Here is some example of information held by ACC:
- Internal policies and processes
 - Claims data
 - The names of staff
 - Materials from Injury Prevention
 - Internal correspondence or documents about a topic
 - Costs paid to Fairway or providers
- b** People before process - Some information is publicly available – for example 'legislation'. We encourage you when dealing with a client to provide them with the link to where the information is found. Under section 18(d) of the OIA, agencies may refuse a request if the information is or will soon be publicly available.

5.0 Personal Information

- a** People can ask for personal information about themselves. However, this type of information is covered by the Privacy Act 2020, not the OIA. Talk to the Privacy Team about this sort of request. You can contact them at privacy.officer@acc.co.nz.
- 📄 Privacy Act 2020
<http://www.legislation.govt.nz/act/public/1993/0028/lat>
- b** If someone is requesting personal information about someone other than themselves, this is considered under the OIA just like any other request for official information. The key thing to consider is the requester's relationship to the information they want – if it's about them, it's a Privacy Act request; everything else is an OIA request.

6.0 What happens after I receive a request?

- a** A request can be made in any form and communicated by any means, including orally. Please get in touch with us as soon as possible by emailing GovernmentServices@acc.co.nz. This is to ensure we meet the legal requirements for responding to requests of official information. This means no later than 20 working days after the request is received.

7.0 What if there are reasons for not releasing the information?

- a** An agency must make a decision and communicate it to the requester 'as soon as reasonably practicable' and no later than 20 working days after the day on which the request was received by the organisation.

When considering whether to grant the request, the agency must keep in mind the key principle that information must be made available unless there is good reason to withhold it.

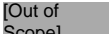
Requests made under the OIA can only be refused for one of the reasons set out in the following sections of the OIA:

- administrative reasons (section 18)
 - conclusive reasons (sections 6 and 7)
 - good reasons (section 9)
 - neither confirming nor denying the existence or non-existence of information (section 10).
- b** For further guidance on the reasons for refusing a request under sections 6, 7, 9, 10 and 18, the Office of the Ombudsman provides official information legislation guides.

 Official information legislation guides
<http://www.ombudsman.parliament.nz/resources-and->


8.0 How can the team help you?

- a** The OIA Services Team is a group of OIA experts. The team is jointly responsible for:
- drafting responses to OIAs
 - providing leadership and advice to the rest of the business
 - helping if you think there are good reasons for not releasing information under OIA
 - providing advice about releasing information proactively outside the OIA
 - providing training to teams on the OIA
 - providing cross government assistance in the OIA

The team can be reached by emailing governmentservices@acc.co.nz or by calling  the Manager OIA Services.

9.0 For more information

- a** The Office of the Ombudsman has a useful guide for more information about the OIA.

 The OIA for Ministers and agencies
<http://www.ombudsman.parliament.nz/resources-and->

Summary

Objective

ACC's Pain Management Services have been designed for Clients who have experienced pain for at least three months from the date of their injury or who have a Complex Regional Pain Syndrome (CRPS) diagnosis.

The purpose of Pain Management Services is to improve Client outcomes and experience by reducing the impact of persistent pain following an injury. Pain Management Services are provided by an experienced Interdisciplinary Team working collaboratively to provide tailored support to Clients.

Owner

[Out of Scope]

Expert

Procedure

1.0 What is pain?

- a** The International Association for the Study of Pain (IASP) provides this definition: 'Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.'
Persistent pain is defined as recurrent or chronic pain that continues beyond the expected injury healing time.
- b** Each person's pain experience is individual to them and varies in terms of frequency, intensity, and impact. Because pain is experienced, the quality of pain can only be defined by the person suffering from it. Pain can be a persisting symptom that affects a client daily, often for years, after the original injury.
- c** Many individual factors can affect the severity of pain a person feels and how much it impacts on their ability to participate in everyday life. A successful outcome for a client with pain may be that the person is able to manage their pain and lead a fulfilling life.
- d** Despite experiencing pain, most people manage a range of activities and, with optimal management, will also manage participation in the workplace, place of education and their usual activities.

2.0 Key principles of the service

- a** The Pain Management Service has been designed to improve clients' outcomes and experience by reducing the impact of pain following an injury

b Key principles of the service:

- Good communication between ACC, suppliers/providers, and the client is a cornerstone to working collaboratively towards the agreed goals
- Right service, right time, first time. Early recognition, acknowledgement, accurate assessment, and timely intervention can reduce the risk of pain-related disability, and significantly enhance the client's quality of life.
- Tailored Pain Management Programme plan for every client. The Pain Management Service is designed to offer a flexible interdisciplinary approach. Effective pain management services consider the whole person, not just their injury and is tailored to meet the individual needs of the client
- An interdisciplinary and collaborative approach that considers the client's overall health and wellbeing and encourages the client to actively participate in their rehabilitation plan.
- Services are "outcome based". It is vital that all treatment and rehabilitation efforts are targeted towards functional outcomes. Providers work alongside others involved in the clients rehabilitation to return clients to work or work readiness, education or independence

3.0 Who is this service for?

- a** The Pain Management Service is for clients who have:
 - Persistent pain that is preventing them from undertaking their usual activities, including work
 - Significant pain-related disability
 - Risk of developing pain-related disability following an injuryClients must also meet the entry criteria outlined on the Referrals and Entry Criteria Promapp page
[Referrals and Entry Criteria](#)
- b** This service is not suitable for:
 - Clients who require single discipline input, such as psychological support services or physiotherapy input which can be delivered by other contracts/services
 - Clients who require medical investigations to ensure they are suitable and ready to participate in a self-management pain programme.
 - Clients who do not have a pain related disability or risk factors for developing a pain related disability, and whose needs would be met by a single discipline approach.
 - Clients who do not meet ACC's Eligibility set out in the AC Act 2001, Schedule 1, Clause 2
- c** The Pain Management Service is a specialist service. If the client's pain can be managed within an existing programme (e.g. a Stay at Work programme), there is no need to refer the client to the Pain Management Service. However, if more intensive input from a specialist service is required and the client meets the referral criteria, the client may be referred to the Pain Management Service.

4.0 Types of Pain Management Services

- a** Group Education
 - A specialised, standalone programme for clients who would benefit from education about pain and learning self-management strategies, and who may not require more intensive Community or Tertiary Services. Group Programmes can run prior to engaging in Community Services, or run concurrently with Community Services, provided an integrated approach is taken.

- b** No prior approval is required for Group Programmes until 30 June 2023.
- c** Community Services - consists of two stages:
 - Community Service Level One is for those with less complex needs or barriers to rehabilitation.
 - Community Service Level Two is for those clients with persistent pain concerns and complex barriers to pain rehabilitation.
- d** Tertiary Services (Outpatient programme and/or Intensive programme)
 - Tailored, flexible, intensive interdisciplinary service for clients with long-standing persistent or clinically complex pain concerns.
- e** Tertiary Support Services
 - Provides advice and clinical leadership for Community Services by acting as a liaison and support.

5.0 The Interdisciplinary Team

- a** The Pain Management Service Interdisciplinary Team (IDT) works together to provide integrated, holistic support tailored to each Client's needs. It is essential the IDT collaborates and is guided by shared decision-making, where possible, as part of team meetings and/or discussions.

Members of the IDT must not deliver services in isolation or where there is limited discussion or collaboration between all members of the team, including interventional procedure providers.

- b** Key worker - a member of the core team will be designated as the client's keyworker, who is the key point of the contact and is responsible for:
 - Keeping the client, ACC and their GP updated on the client's treatment and rehabilitation.
 - Making sure the IDT works together in a coordinated way.
 - Coordinating and documenting the advice and support received from the Tertiary Support Service.

6.0 Delivery of the service

- a** The primary method of delivery of Pain Management Services Community Service Level One and Community Service Level Two is in-person. However, where access is an issue for the Client, a portion of the service may be offered via Telehealth, where clinically appropriate.

Pain Management Services Triage Assessments can also be completed via Telehealth where clinically appropriate and access is an issue for the Client.


7.0 Exclusions

- a** The Pain Management Service should be the primary method of supporting individuals with, or at risk of developing persistent pain. Other services or contracts should not be used to supplement this service where the ability exists to deliver this input under the Pain Management Service.

- b** The following services are not provided under the Pain Management Service:
 - Vocational Rehabilitation Services (VRS)
 - Training for Independence (TI)
 - Vocational Medical Services
 - Medical Case Review
 - Training for Independences Services
 - High-tech imaging
 - Clinical services
 - Gym based strengthening programmes.

8.0 Client Non-Attendance

- a** Clients have responsibilities to participate and co-operate in their rehabilitation. Clients should notify ACC or the provider if they are unable to keep their appointment or where there are unexpected changes in their circumstances. Clients must give at least 24 hours' notice if they wish to reschedule an appointment.
- b** Providers are expected to make all reasonable efforts to remind the client of the appointment, such as sending:
 - an appointment card or a reminder letter
 - a phone call or text the day before.
- c** Where clients appear unwilling to participate in the pain management services, providers must:
 - Complete the ACC7986 Did Not Attend Report when a Client fails to attend an appointment.
 - notify ACC within three days of the non-attendance via the completed ACC7986 form.
- d** On-going non-attendance or lack of engagement in pain management services is a flag that providers are expected to discuss with ACC.
- e** When a client is unwilling to engage in the Pain Management Service or chooses not to continue, it's expected that provider will use the resources of the interdisciplinary team to encourage the client to participate in the service. If, after repeated attempts to work with the client and after consulting ACC, the client remains unwilling to engage in the Pain Management Services, a provider will send a completion report via the ACC6272 Pain Management Plan, review, update and completion report.

 ACC6272 Pain management plan, review, update and completion report

 ACC7986 Pain Management - Did Not Attend Report

9.0 Did Not Attend Fee

- a** Did Not Attend (DNA) fees cannot be made for Pain Management Services purchase on a package basis.
- b** Did Not Attend (DNA) fees are payable on ACC initiated Triage referrals if the Client fails to attend their scheduled appointment and does not give at least 24 hours notice.
- c** Maximum of two DNA fees payable per claim.

10.0 Further information relating to Pain management Services

- a** For further information regarding the Pain Management Service, you can review the Operational Guidelines and Service Schedule

 Pain Management Service - Quick Reference Guide

 Pain Management Services - Service Schedule

 Pain Management Services - Operational Guidelines

 **PROCESS** **Set Up Pain Management Triage Assessment**

 **PROCESS** **Set Up Pain Management Service Support**

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Summary

Objective

A recent District Court decision *Bryan v Accident Compensation Corporation* [2013] NZACC 16 found that the client should have their chronic pain syndrome assessed under Chapter 15 of the American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition (AMA Guides).

In response to the Court decision, the Operational Policy Committee has approved a policy for assessing impairment where a client presents with injury-related pain. This is an interim policy until ACC can change the ACC User Handbook and/or adopt version 6 of the AMA Guides.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** When assessing a client's permanent impairment for support in the form of independence allowance and lump sums, assessors must ensure they assess the client's injury-related pain. How pain is assessed needs to be communicated to ACC in the assessment.
 - If a client suffers from pain related to a personal injury, the pain has to be assessed as part of the whole-person impairment, regardless of whether there is a covered mental injury
 - ACC will direct assessors to refer to the pain section of the ACC Handbook, (including consideration of Chapter 15 of the AMA Guides)

2.0 Changes to impairment ratings unlikely

- a** The interim policy is unlikely to result in any change to clients' impairment ratings and, therefore, independence allowance and lump sum payments. This is because Chapter 15 of the AMA Guides does not provide a separate impairment rating for the pain.

Further information on the guidance ACC is providing to assessors see *Assessing pain for independence allowance and lump sum payments*

Summary

Objective

This page identifies different types of payment errors and when an error can be considered as corrected.

See also Correcting a payment error for a step by-step guide to correcting errors.

1. Rules
2. Lost or missing files: certifying information is correct

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a** A payment error can be discovered in:
- an audit or review
 - the 'over 52-week file' reviews
 - general daily file maintenance.

When an error is identified in an audit or review, the branch representative must check the file and confirm whether or not an error exists.

Once a branch is aware of an error, it must be corrected as soon as possible.

- b** Below are examples of a payment error.

NOTE Payment errors include:


- incorrectly calculating entitlement payments
- making an incorrect cover decision
- duplicating a payment
- applying legislation incorrectly
- not paying a valid entitlement
- paying an invalid entitlement
- going over your delegation limit
- making a payment with insufficient information
- using an incorrect fund code
- having an incorrect date of first or subsequent injury
- having lost or missing files
- a deduction being incorrectly applied

- c** An error in payment can only be considered cleared after one of the following occurs:
- a debt is created on the claim, in the case of an over-payment
 - the client or vendor is correctly paid, in the case of an underpayment
 - the fund code is changed to the correct one
 - the correct delegated authority gives approval, where it previously had been incorrect
 - the 'Certifying lost client files' process has been completed
 - management have decided to take no further action with the error.

2.0 Lost or missing files: certifying information is correct

- a** When client files are missing or lost, we must confirm that the current entitlements being paid are correct. Without confirmation, an error may be raised during an audit or review that will affect the payment accuracy result for the branch managing the entitlement. See Certifying lost client files to ensure that the current payments to a client are correct.

If missing information can't be found, we must use any available information to make sure the client's entitlement is correct.

 [Certifying lost client files](#)

Summary

Objective

This policy defines the requirement for provision of vocational rehabilitation (VR) once an Initial Occupational Assessment (IOA) / Initial Medical Assessment (IMA) have been completed. Use this policy to understand:

1. Planning vocational rehabilitation
2. Vocational Rehabilitation Planning Tool
3. Meeting with the client to agree on vocational rehabilitation
4. Dual plan/pathways option
5. Changes to the agreed vocational rehabilitation
6. Completion of vocational rehabilitation

Background

Determining and planning vocational rehabilitation following the IOA/IMA is a crucial step for client's where regaining fitness for their pre-injury employment is unlikely.

Use this policy to guide you with planning vocational rehabilitation after receiving the IOA and IMA reports.

Owner

[Out of Scope]

Expert

Policy

1.0 Planning vocational rehabilitation

- a** ACC is required to provide vocational rehabilitation that meets the vocational rehabilitation needs of the client.


Planning vocational rehabilitation is about determining the most appropriate vocational options for a client and identifying the interventions or supports required to remove any barriers to enable the client to return to work or work readiness.

The information contained in the IOA and IMA reports will help determine which types of work to focus vocational rehabilitation towards. To help evaluate this information use the Vocational Rehabilitation Planning Tool (see below) to understand the vocational needs specific to each identified work type to help the client return to work or work readiness.

2.0 Vocational Rehabilitation Planning Tool

- a** This tool has been designed to assist you with vocational rehabilitation planning. It should highlight all the medically sustainable, or likely to be, work types for the client, as specified in the IMA report. It will summarise the rehabilitation recommendations and vocational needs specific to each work type.

Having an outline of the viable work types and vocational needs specific to each work type should give you an informed starting point for a discussion with the client.

 Vocational Rehabilitation Planning Tool

3.0 Meeting with the client to agree on vocational rehabilitation


- a** It is important to take the client's views into consideration when agreeing on what vocational rehabilitation to provide. The vocational rehabilitation needs to provide a sustainable outcome within the legislative framework.


When considering what vocational rehabilitation we might agree to provide, the following matters should be taken into consideration:

- whether the vocational rehabilitation is likely to achieve the goals in the client's Recovery Plan (RP) / Individual Rehabilitation Plan (IRP); and
- whether the vocational rehabilitation is likely to be cost-effective, having regard to the likelihood that costs of any entitlements the client is receiving will be reduced as a result of providing the vocational rehabilitation; and
- whether the vocational rehabilitation is appropriate in the circumstances.

- b** When you meet with the client, discuss:

- the IOA and IMA assessments and answer any questions they may have
- whether a return to, or regaining fitness for, their pre-injury employment is realistic and whether a change in VR goal is more appropriate (See 'Guidelines for managing the transition from maintain employment to obtain employment')
- the alternative work type options to focus vocational rehabilitation towards and the vocational needs to address to return to work / work readiness
- any other rehabilitation recommendations
- all of the likely services required to provide the agreed vocational rehabilitation (e.g. Back to Work programme)
- the VI rehabilitation pathway, if regaining fitness for the pre-injury employment is unlikely or not the focus of vocational rehabilitation (See 'About Vocational Independence (VI)' below)
- an RP/IRP with the outcome of the IOA and IMA, any new goals and the agreed vocational rehabilitation. It is also recommended that if it is agreed to not implement any of the recommended rehabilitation identified by the IMA assessor that this is recorded in the plan with the reason/s for not doing so.

 About Vocational Independence Policy

 Guidelines for managing the change in targeted vocational outcome

4.0 Dual plan/pathway option


- a** For some client's, the IMA might indicate that returning to, or regaining fitness for, their pre-injury employment might still be possible depending on their recovery progress. However, it might also be appropriate to concurrently focus vocational rehabilitation toward return to work / work readiness for alternative types of work.

In this circumstance, the client's RP/IRP might consist of a primary goal and secondary goal with agreed vocational rehabilitation focusing on achieving either outcome.

The primary goal might be the main focus for the client, however, having this dual focus will allow the client to seamlessly transition between goals if it later becomes more apparent that the primary goal is no longer suitable or achievable.

5.0 Changes to the agreed vocational rehabilitation

- a ACC is obligated to provide a client with all rehabilitation recorded in the RP/IRP. If, at a later date, it is mutually agreed to not undertake any vocational rehabilitation recorded in the plan, this agreement should be updated on the plan clearly documenting the rationale for no longer providing it.

 Individual Rehabilitation Plan Policy

PROCESS Create or Update Recovery Plan

6.0 Completion of vocational rehabilitation

- a Vocational rehabilitation is considered complete once all the agreed vocational rehabilitation recorded on the RP/IRP has been completed and has achieved its purpose (i.e. towards the vocational rehabilitation goal). This is measured not just by completion of the funded service or rehabilitation programme but also includes looking at whether the identified barriers have been addressed.

NOTE Example 1 - Pain Management

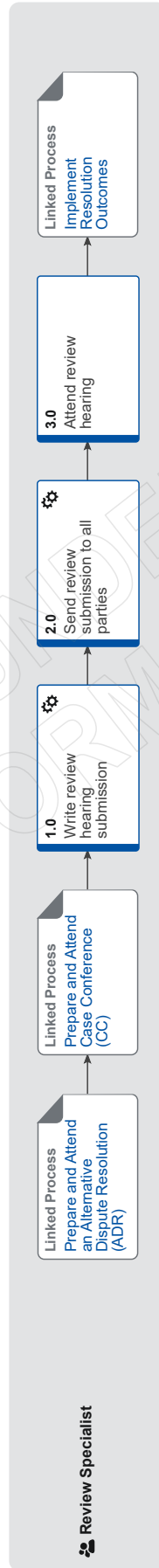
If a pain management programme was recommended in order to equip the client with the skills and understanding to self-manage their pain, consideration at the end of the programme should be given as to whether outcome this was achieved.

NOTE Example 2 - Computer Training

If it was agreed that ACC would provide computer training to acquire the computer skills typically required for a particular work type/s, consideration should be given at the end of the training as to whether the client has successfully acquired these skills.



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To attend a review hearing, on ACC's behalf, to provide submissions pertaining to the matter at review and the reasons for ACC's decision.

Background

A review hearing will provide ACC and the customer/representative with an outcome that is binding between the customer and ACC.

Owner

[Out of Scope]

Expert

Procedure

PROCESS **Prepare and Attend an Alternative Dispute Resolution (ADR) Review Specialist**

PROCESS **Prepare and Attend Case Conference (CC) Review Specialist**

1.0 Write review hearing submission Review Specialist

a Complete the review submissions.

NOTE **What information should be included?**


- Background of the issue
- Relevant legislation
- Relevant case law
- ACC's position

b If the review is about a decision on a claim, in Eos, upload the submissions and change the document code to 'REV - ACC2199 - ACC Submissions - Review Appeal' and the document description to the unique review identifier.

c If the review is about a levy, complete the submissions and save them to the customer folder.

d Use judgement to consider having the written submissions peer reviewed by a colleague, senior resolution specialist or a technical specialist.

e Read the review hearings rules policy to help understand more about review hearings.

 Review Hearing Rules Policy

2.0 Send review submission to all parties Review Specialist

a Check Eos and ensure that the client care indicator has not been activated since the ACC6239 was sent to the review provider.

NOTE **What if the client care indicator was already active but it hasn't been updated in the last six months?**

Contact the decision maker (DM) and their Team Manager (TM) using the Client Care Indicator Template to update the Care Indicator.

b If the review is about a decision on a claim, in Eos, use the email tool set to send the submissions document to all parties.

NOTE **What is the required timeframe for sending submissions?**

ACC has a contractual agreement that the submissions will be sent 14 days prior to the hearing taking place.

NOTE **What if you are expecting new information within 14 days of the hearing (therefore potentially changing your submissions)?**

ACC's expectation is that the submission will be sent 14 day prior to the hearing date. If new information is received after the submissions are sent the Review Specialist must provide either an amendment (if your position has changed) or an addendum (if the new information adds to ACC previously stated position).

Always ensure all new information (including revised submissions) are sent prior to the hearing for the client/representative to consider to minimise the likelihood of an adjournment.

NOTE **Who are all parties?**

- This includes:
- the review provider
 - the customer/representative
 - interested parties

NOTE **Who are interested parties?**

- Employers are interested parties where the client (employee) has put in a review to challenge the decline of cover for a work related PICBA and WRGPDI.
- Clients are interested parties where the employer has lodged a work injury dispute review.

NOTE **What if the customer/representative does not have an email address?**

Print the documents and send them to the necessary parties.

If you are working from home and this is not possible, please communicate with a colleague residing in the office or your Resolutions Manager to ensure this task can be completed within the required timeframe.

c If the review is about a levy, email the submissions to all parties, and save email as an interaction in Juno_CRM.

NOTE **What if the customer/representative does not have an email address?**

Post the submissions to the customer/representative and save a scanned copy in a Juno_CRM interaction.

d Ensure any new information (since the last bulk print) relevant to the review has been sent to all parties prior to the hearing (eg CAP comment, newly obtained medical notes).


3.0 Attend review hearing Review Specialist

a Consider who from ACC should attend the hearing.


NOTE Who from ACC should you consider?

Consider:

- decision maker
- TAS
- any other ACC expert (eg technical specialist, medical advisor, etc).

 Reference Guide for Review Specialists when deciding whether to refer a task to Technical Accounting Specialist (TAS)

b Dial into the tele/video conference or attend in person.

 Arrange Face to Face Client Meeting - Health and Safety Requirements

NOTE Where can face to face hearings be held?

- Whangarei
- Auckland
- Hawkes Bay (Hastings/Napier)
- Hamilton
- New Plymouth
- Wellington
- Blenheim/Nelson
- Christchurch
- Dunedin.

 Zoom Meeting Guide

c Answer any questions asked by the review provider.

NOTE What happens at the hearing?

- The customer/representative will outline their case.
- The reviewer will ask clarifying questions of the customer/representative.
- ACC will present their case and submissions.
- The reviewer will ask clarifying questions of ACC.
- ACC will be offered the opportunity to cross examine the customer/representative.
- The customer/representative will summarise their case and provide submissions.

NOTE What if you want to view the same file that was sent to the client/advocate and provider?

A copy of the file that was sent to all parties is available for you to view in the CIR Shared Portal

 Client Info Requests - Shared Portal

NOTE What happens if the reviewer adjourns the hearing?

The customer/representative and Resolution Services will agree on actions to be taken.

If the review is about a decision on a claim, update the Hearing Request task to provide the reasons for the adjournment. The review will remain allocated to the Review Specialist until the hearing is closed.

 Adjournments Policy

d Approve costs within the Review Specialist delegation when called upon by the Reviewer, using the delegation levels in 7.10 Mediation, review and appeal on Te Whāriki.

 7.10 Mediation, review and appeal (Te Whāriki)

NOTE What if the reviewer requests costs outside of the regulated amount?

This is outside of the Review Specialist delegation and must refer to a Senior Review Specialist or Resolution Manager for consideration.

This would most likely be in cases whereby travel costs to the hearing are outside of the regulated amounts.

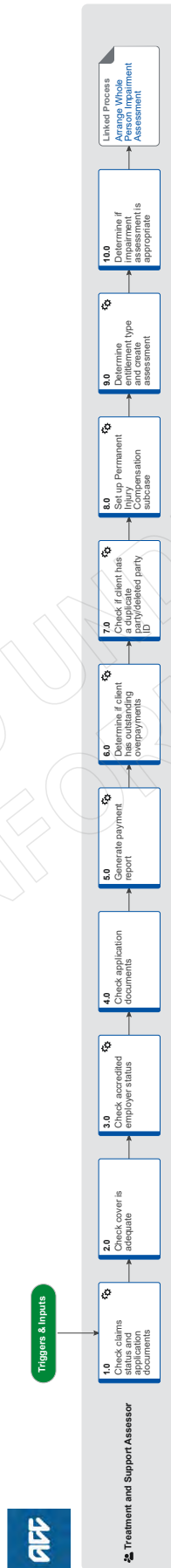
e Complete the [PRC REV Hearing Requested] e-form after the hearing is concluded, and close this task.

f Update the task information in the subsequent [PRC REV Record Review Outcome] to say "Awaiting Outcome" and note the date of the hearing. Update the target date to 28 days after the hearing date and transfer the task to the 'Hamilton SC - Quality Assurance' queue.

 **PROCESS** **Implement Resolution Outcomes**
Review Specialist



RELEASED UNDER THE OFFICIAL INFORMATION ACT





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 'Cover Assessment - General Cover' 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/I48e0ff>

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 sent 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/lee0ac>

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/I8b624>

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?

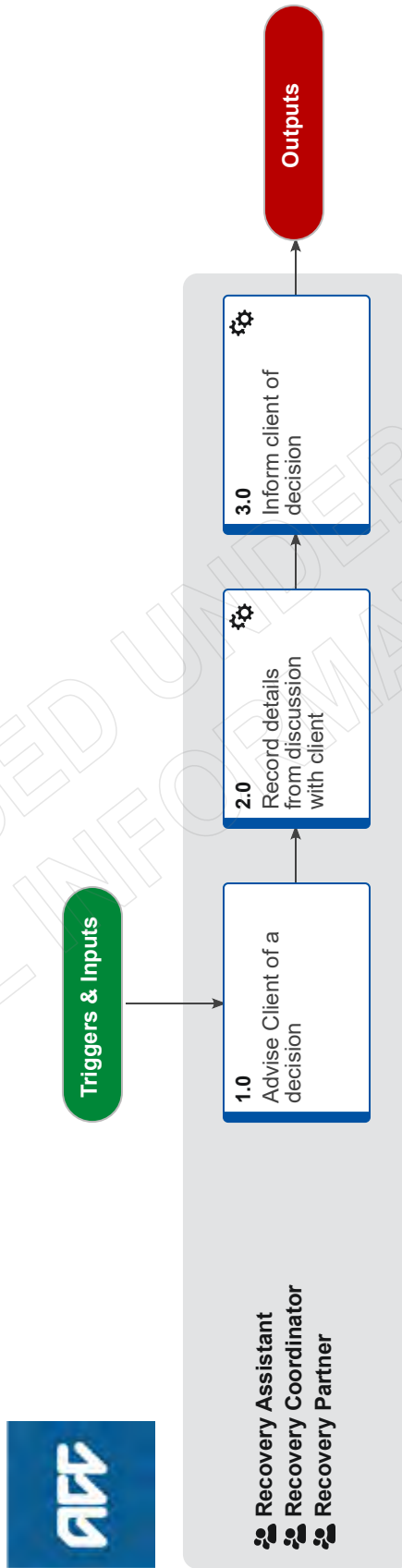
Proceed to 'Arrange Whole Person Impairment Assessment'

- 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



RELEASED UNDER THE OFFICIAL INFORMATION ACT





Summary

Objective

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

Background

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

Owner

[Out of Scope]

Expert

Procedure

1.0 Advise Client of a decision

Recovery Assistant, Recovery Coordinator, Recovery Partner

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

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

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

- Complex Mental Injury Decline and Disengagement Best Practice Guide

NOTE Does the provider need to receive a decision letter?

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

- PROCESS** Stop Supports

NOTE What if the client has already been contacted?

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

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

- Identity Check Policy
- Contacting sensitive claims clients Policy

NOTE What if you are unable to contact the client?

- If you are unable to reach the client on your first attempt, leave voicemail message and send a call back notification if appropriate. Create a Contact Action on the Recovery Plan to contact the client again in 3 days' time (unless urgent). Note in the task description that this is the first attempt to contact the client. If you are in Assisted Recovery also provide decision rationale in the task description field.

- 2nd attempt in 3 days: leave voicemail message and send another call back notification if appropriate. Consider contacting other stakeholders for an update and to confirm client contact details. Push out the task for another 5 days.

- 3rd attempt in 5 days: send the decision letter. If you are unsure about sending the decision letter, contact a Practice Mentor to discuss.

- Create a Notification - System Steps

- Recovery Plan - Create Contact Actions - System Steps

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

Refer to the process below

- PROCESS** Obtain Authority to Act (ATA)

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

2.0 Record details from discussion with client

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a In Salesforce, if relevant record the details of the discussion with the client on the claim.

- NG Principles Decision Making

- b Create a new contact. Record the following in the description field:

- Decision type [APPROVED/ADVERSE/DECLINED/PARTIALLY APPROVED] DECISION

- Provide in detail what was requested [eg. 6 hours home help per week over next 4 weeks]

- Who made the request and when

- The final decision

- Who was consulted [eg. Recovery Support hotline guidance from Practice Mentor received 10/03/19]

- Rationale for the final decision [(e.g. Partially approved home help of 2 hours per week to support Helen with cleaning bathroom, laundry, making beds and vacuuming. Did not approve 6 hours per week as agreed with PM that it is likely the agency could achieve the necessary support tasks within 2 hours)]

3.0 Inform client of decision

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Create and complete the relevant decision letter.

NOTE: The letter you use will depend on the decision to be made. What is important is that we add the below comment to the decision letter that we use to refer back to the decision that is being revoked.
= this letter revokes and replaces the previous letter of .././.....

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


Follow the Revoking Cover process below

 **PROCESS** Revoking Cover

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

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

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

 ACC Partnering with MSD Flowchart

 ACC Partnering with MSD

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

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

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

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

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

Amend the letter appropriately to reflect the individual situation.

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


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


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

[Add Mental Injury diagnosis]

NOTE What if the preferred option is email?

Follow the system steps for Emailing from Eos using a template and attach the 'ACC255 Working Together' document. Ensure that you use the letterhead from "Send letters from Client Recovery and Claims Assessment".

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

 Send letters from Client Recovery and Claims Assessment

NOTE What if the preferred communication is by post?

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

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

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

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

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

The reason for the decision should be sufficiently clear in the letter that providing supporting information will generally not be required.

However, if you have a case where you feel that providing supporting information may be appropriate, then you could check this with our Practice Mentor support.

NOTE What if a client requests information with a staff members name on it, e.g. Written guidance requests?

Please follow the Disclosure of staff names and the Privacy Act policy

 Disclosure of staff names and The Privacy Act

 Communicate Decisions about Client Supports

- b** Update the Recovery plan with the outcome.

- c** This process ends.

Summary

Objective

Use this high-level guidance to understand why and when we can revoke cover on a claim and to ensure that entitlements or payments are stopped correctly.

- 1) Rules for revoking cover
- 2) Rules for revoking deemed cover
- 3) When not to revoke cover
- 4) Stopping entitlements and payments
- 5) Relevant legislation for revoking cover
- 6) Link to process

Background

We can revoke cover on a claim when cover for the injury was initially granted and the decision issued, but we subsequently find that the original decision was wrong.

As revoking cover has significant implications for clients (they permanently lose all entitlements stemming from their injury) we must be certain the client should not have had cover granted in the first place.

Therefore, the threshold for revoking cover is high, requiring evidence that an error was clearly made in the original decision granting cover for the injury.

Owner

[Out of Scope]

Expert


Policy


1.0 Rules for revoking cover

- a** Cover can only be revoked if the original decision to grant cover was 'made in error'.

 When a cover decision can be revoked

- b** For the original decision to have been 'made in error' requires either:
- Identification of a significant mistake made by ACC when originally making the decision, which resulted in ACC accepting cover when it should not have; or
 - new external opinions based on new evidence, which was not in the possession of the original decision-maker, that clearly demonstrates the original decision to grant cover was wrong.

 Criteria for a cover decision to be considered made in error


 Criteria for determining that evidence is new

- c** Cover cannot be revoked if there are credible differences of opinion between experts, as differences in opinion do not clearly demonstrate the original decision was 'made in error.' Rather, ACC must be able to point to a clear error of fact made at the time of the decision or to some new factual evidence that shows the decision to have been wrong in hindsight.


 Reasons a cover decision cannot be revoked

2.0 Rules for revoking deemed cover

- a** Deemed Cover can be revoked without ACC needing to prove an error has been made. See 'Deemed Cover Decisions When Timeframes Not Met'.

 Deemed cover decisions when timeframes not met Policy




3.0 When not to revoke cover

- a** Do not revoke cover if you are satisfied that we originally granted cover correctly, or the criteria for revoking cover is not met.
- b** If there is evidence the client's current condition does not relate to the personal injury the client's entitlements can be stopped. Under these circumstances:
- decline the application if the client is applying for an entitlement
 - suspend the entitlement if we've already been providing it.
- c** Refer to the 'suspend support when client is no longer eligible policy' for more information on suspending entitlements
-  Suspend Support When Client is No Longer Eligible Policy


4.0 Stopping entitlements and payments

- a** If the client has been receiving entitlements for 52 weeks or more and we revoke cover, the client must be given up to four weeks' notice that their entitlements will stop. The four weeks' notice starts from the date we advise the client that they no longer have cover for their injury.

5.0 Relevant legislation for revoking cover

- a** If cover was granted under the Accident Compensation Act 2001, then revoke cover under the Accident Compensation 2001, section 65.
-  Accident Compensation Act 2001, section 65 Corporation may revise decisions
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- b** Under the Accident Compensation Act 2001, we must apply the cover provisions and policy rules of the earlier Act when considering whether to revoke cover granted under an earlier Act. If cover was granted under an earlier Act then revoke cover under the Accident Compensation Act 2001, section 390.
-  Accident Compensation Act 2001, section 390 Corporation may revise decisions
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- c** Deemed cover can be revised under section 65(2) of the Accident Compensation Act 2001.
-  Accident Compensation Act 2001, section 65 Corporation may revise decisions
<https://www.legislation.govt.nz/act/public/2001/0049/lat>

6.0 Link to process

- a** Refer to the following process for the procedure to use when revoking cover.
-  Revoking Cover



Summary

Objective

A Service Page that covers the services available for clients with tinnitus with or without hyperacusis

Background

Tinnitus is a condition where sufferers experience a ringing, buzzing, hissing, or pulsating noise in the absence of an external sound. It is a common complaint associated with hearing diseases, brain disorders and other causes such as ear infections, certain medications, general ill health, age-related hearing loss, head and neck conditions (such as cervical disc lesion or impacted molars) as well as noise-induced hearing loss. A client with a related covered injury, may ask ACC to help lessen the effects of tinnitus.

Hyperacusis is over-reaction to loud sounds, and is often found in people with tinnitus as a result of TBI. Many aspects of treatment are similar to treatment for tinnitus.

Owner

[Out of Scope]

Expert

Procedure

1.0 Tinnitus and personal injury

- a** Tinnitus isn't a personal injury so cover can't be approved for tinnitus alone. However, it may be a symptom of a covered personal injury, eg hearing loss or traumatic brain injury (TBI), which can result in significant difficulties for a client in their everyday life or employment activities. A client may be eligible for rehabilitation assistance if injury-related tinnitus significantly interferes with their ability to function in everyday life or employment activities.
- b** The first therapeutic option, if there's hearing loss, is to provide hearing aids. You should not normally consider alternative options for tinnitus before this option is trialled.
- c** Hearing devices with tinnitus programmes can also be provided for clients with tinnitus following TBI, whether or not there is hearing loss. These hearing devices would not normally be replaced in the normal way because tinnitus from TBI would be expected to have resolved over time.
- d** Funding for hearing devices is limited to the hearing regulations for those with hearing loss, and can be provided using the TBI codes: Hearing aids for clients with cover for traumatic brain injury (TBI) and insignificant pure tone hearing loss. Note that hearing devices provided for clients with tinnitus following TBI would not normally have these replaced ie the need for treatment of tinnitus as a consequence of TBI is not expected to persist over the time-frame for hearing aid replacement.
- e** Recommended interventions such as tinnitus counselling or tinnitus habituation devices or apps must be necessary, appropriate, cost-effective, and meet all other rehabilitation criteria. Not all Audiology providers are able to provide these services. MFP identifies audiologists with skills in tinnitus therapy, with tinnitus listed as a sub-specialty under audiologist classification.
- f** Clients suffering from hyperacusis may have ear plugs recommended for them for short-term use, while receiving tinnitus counselling support. Note that normal ear-plugs are counter-productive and may be harmful. Ear-plugs or electronic devices that suppress only high intensity sounds can be used.



Service types non-standard CoL adjustments.docx



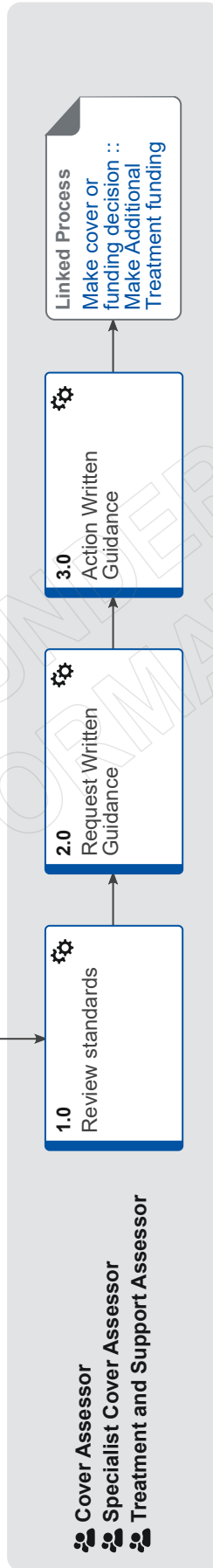
Auditory symptoms and mild TBI

2.0 Assessing the medical evidence

- a** A specialist medical opinion is required in order to establish the most likely cause of a client's complaint of tinnitus. The medical evidence must show that the most likely cause of the tinnitus is the injury-related covered condition (normally hearing loss but occasionally TBI). Specialists can only recommend that ACC fund an intervention for tinnitus based on the client's need if they can confidently relate the tinnitus symptoms to the covered injury (hearing loss or TBI).
- b** Acoustic shock disorder is a condition which may be associated with hyperacusis and tinnitus, and for which cover is available if the client has been exposed to intense sound which is threatening, unavoidable and uncontrollable.

3.0 Medical Advisor delegation

- a** Consult the medical advisor regarding any requests for assistance related to tinnitus.



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To request and receive hotline, rapid medical and/or written guidance from an internal advisor.

Background

During the course of making a cover or funding decision an Assessor may either choose to request guidance or must request guidance in accordance with the delegations framework or at Clinicals request.

Owner

[Out of Scope]

Expert

Procedure

1.0 Review standards

Cover Assessor, Specialist Cover Assessor, Treatment and Support Assessor

- a In Eos, create a 'Contact Internal Party' confirming the information requirements outlined in the 'Standards for Guidance' have been met.

NOTE What if you have not reviewed the standards?

Review the standards and make sure the information requirements have been met. Create a 'Contact with Internal Party' confirming this, otherwise request the necessary information. Once received return to this process.

Standards for Seeking Guidance

2.0 Request Written Guidance

Cover Assessor, Specialist Cover Assessor, Treatment and Support Assessor

- a In Eos, create a document group with the information that needs to be reviewed.

Manage document groups

- b In Salesforce, create a request for written guidance.

NOTE What if the claim is for MICPI or WRMI?

Refer to MICPI & WRMI | Guidance on complete Written Guidance e-form.

MICPI & WRMI | Guidance on Written Guidance e-form

NOTE What if the claim is for WRGP?

Send these questions in the written guidance e-form:

1) What, if any, physical injury is sufficiently confirmed in the evidence provided?

2) What are the occupational properties / characteristics recognised to cause this diagnosis/ diagnoses and are these sufficiently represented in the clients work to be considered as contributing to the cause of this diagnosis/diagnoses?

3) Is there any associated medical evidence that supports that persons working with the identified properties and characteristics (question 2) put them at a significantly greater risk of developing this condition over the general population that don't have those same properties and characteristics in their role?

Create a request for Written Guidance (CA)

NOTE What if the request is to fund surgery?

Copy and paste this text into the e-form:

Does the medical evidence support a causal link between the client's covered accidents and the condition/pathology requiring surgery? Please provide the reasons for your opinion.

PCA Surgery questions

NOTE What if you need guidance on invoice coding for surgery?

Email ClinicalAdvisorSurgery@acc.co.nz. If the query is considered complex an advisor will request you to submit a request for written guidance.

- c Confirm the priority of the task. Refer to High and Medium Priority Categories for Written Guidance Requests.

High and Medium Priority Categories for Written Guidance Requests

NOTE What if you have submitted a request, and you need to update the priority?

- 1) Click on the 'Recovery Support' tab, select the guidance
- 2) On the 'Details' page, select 'Update Guidance Priority'
- 3) Select 'Yes' under 'Is the request urgent?'
- 4) Select 'Other', specify either P1/P2 category code in 'Reason for urgent request' field.

- d Contact the client, ATA or whanau representative and advise you have requested Clinical and/or Technical advice to help inform your decision.

- e Add the action taken to the master task and update the target date to align with the service level agreement (SLA) for requesting guidance or or add the action taken and date to the assessment and decision e-form.

3.0 Action Written Guidance

Cover Assessor, Specialist Cover Assessor, Treatment and Support Assessor

- a In Salesforce, review the guidance.

Receive Written Guidance (Recovery Team Member)

NOTE What if clarification has been requested?

Respond to the clarification using the linked system steps.

 Respond to Clarification Request from Advisor (Recovery Team Member)

b Determine if you can accept the guidance.

NOTE What if you have received questions for the vendor for an Additional Treatment request?

Use the SIS40 template located in the Communication and guidance templates page in Te Whāriki.

NOTE What if you have been requested to refer a Silica case to the Multi-disciplinary panel for review?

Refer to the panel using the email 'Refer a Silica case to the Multi-disciplinary panel' template located on the WRGP Communication and guidance page.

 WRGP | Communication guidance and templates

NOTE What if you require clarification or there is missing information?

Request clarification.

c Accept guidance.

d Provide feedback, if applicable.

e Select the “bell” icon to review feedback provided to you, if applicable.

f Return to 'Make cover or funding decision' process and continue.

 **PROCESS**

**Make cover or funding decision ::
Make Additional Treatment funding
decision**

Cover Assessor, Specialist Cover Assessor, Treatment and Support Assessor

The Privacy Reporting Tool is used to manage information about privacy incidents. The purpose of reporting incidents is to enable ACC to ascertain root causes and capture data to view trends relating to privacy breaches, near misses, and other incidents.

Note, **DO NOT** record any personal information when you report an incident using this tool (i.e. no client names, customer names, staff names, provider names, or addresses etc).

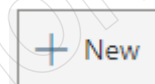
The new Privacy Reporting Tool can be found on the Privacy Hub SharePoint site here:

<https://accnz.sharepoint.com/sites/PrivacyHub/SitePages/Privacy-Reporting-Tool.aspx>

NOTE: Please use Google Chrome to open the new Privacy Reporting Tool on Sharepoint. It does not work on Internet Explorer or Microsoft Edge.

HOW TO CREATE A NEW INCIDENT

To create a new incident, click the New button on the left side of the page:



The first time you use the tool you will need to complete the Responsible fields at the top of the form. Any further incidents you report will default to the Responsible field values you added in your last reported incident. At a minimum you need to complete the Group and Location fields.

Responsible

Group *	Tier 1 Team
Governance	Privacy Team
Tier 2 Team	Location *
--Please Select--	Wellington

Update the Incident details with as much information as possible. Pop up messages will help you with what should be written in some fields. Fields with an * are mandatory to complete.

Incident details

Incident Type * Record sufficient details to fully describe the incident. Key points to include are What happened?, How it happened? and Why it happened? Please do not include personal information such as client/staff names or contact details.

--Please Select--

Description of Incident *

After completing all the fields with as much detail as possible click Submit at the bottom of the page.

Submit

The new incident will be saved with a status of Published and an incident ID will be created.

EDIT YOUR INCIDENTS

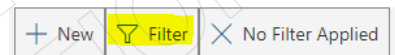
Incidents you created can be edited while at the status of Published. To edit your incident, click on the Title field and then click the Edit button. All fields can then be updated with further commentary or changes. To save your changes click Submit again. (Note, when an incidents status has been updated to Completed only members of the Privacy Team can edit it).

Incident 1039

Edit

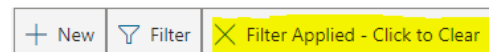
USING THE FILTERS TO VIEW INCIDENTS

A **Filter** option is available on the main page enabling the User to filter the view of incidents. The **No Filter Applied** button lets you know that currently you are viewing all incidents.



When the **Filter** button is selected a new form opens with filter options. There are several filter options available, select your criteria and click **Apply**. The incidents on the form will now only include those matching your filter criteria.

Note, that the **No Filter Applied** button has now been updated to **Filter Applied – Click to Clear**. Click this



button to clear the filter and have all reported incidents visible on the page.

If you have any questions regarding privacy reporting or the reporting tool itself, call the Privacy Team on ^{(s 9(2)} or email the team at privacy.officer@acc.co.nz

Transitional Provisions and Combining Whole Person Impairment to Determine Independence Allowance Policy v8.0



Summary

Objective

Refer to this guidance to determine a client's independence allowance (IA) when they have:

- a personal injury, where the date of injury is:
 - before 1 July 1999 (which falls under section 377 of the Accident Compensation Act 2001), and/or
 - on or after 1 July 1999 and before 1 April 2002 (which falls under section 378 of the Accident Compensation Act 2001)

and/or

- a mental injury, treatment injury, or work-related gradual process injury (under Clause 55 of the Accident Compensation Act 2001).

Use this guidance to help you determine whether the client should receive IA based on the combined whole-person impairment.

We will only combine IA if the outcome is beneficial for the client.

This approach only applies to claims from 4 April 2019.

We will not back-date or reconsider combining IA for claims prior to this date.

Background

The District Court decision, *U v Accident Compensation Corporation* [2018] NZACC 28 (U), overturned ACC's decision not to combine the whole person impairment ratings from independence allowance (IA) assessments for two injuries:

- a physical injury where the date of injury was prior to 1 July 1999, and
- a mental injury claim lodged under the Accident Compensation Act 2001 (the 2001 Act) where the criminal act last occurred before 1 April 2002.

The type and date of the injury meant that different transitional provisions applied to their IA calculations. This means that there are two statutory paths for determining IA.

ACC's approach to the transitional provisions in the 2001 Act was to assess the two injuries separately, with the impairment rating for each injury meeting the threshold of ten percent before IA was payable.

The Judge in this case concluded that instead of referring to the transitional provisions in legislation to assess IA, ACC should have referred to the assessment tools prescribed by Injury Prevention, Rehabilitation, and Compensation (Lump Sum and Independence Allowance) Regulations 2002.

The guidelines provide for a combined whole-person impairment (i.e. combining the impairment resulting from separate injuries). This meant that the client would now receive a slightly greater IA based on the combined impairment rating from both claims.

Owner

[Out of Scope]

Expert

Policy

1.0 Applying 'U': determining independence allowance (IA) by combining impairment ratings resulting from separate injuries

- a** From April 4 2019, we will determine a client's IA by combining impairment ratings resulting from separate injuries in cases where there is:

- a personal injury, where the date of injury is:
 - before 1 July 1999 (where section 377 of the 2001 Act applies - known as combined IA), and/or
 - on or after 1 July 1999 and before 1 April 2002 (where section 378 of the 2001 Act applies - known as single IA)

- and/or a mental injury, treatment injury, or work-related gradual process injury with a date of injury on or after 1 April 2002 but where clause 55 of Schedule 1 to the 2001 Act applies.

- b** We will not recalculate IA support that has been calculated prior to 4 April 2019.

- c** If the combined Whole Person Impairment (WPI) does not meet the ten percent threshold, then the client would not be eligible for IA.

NOTE Clients do not require a claim under clause 55 to be considered for an IA based on a combined WPI

This approach means that:

- we can combine impairment ratings for a personal injury (where section 377 of the 2001 Act applies) WITH impairment rating for personal injury (where section 378 applies)

- we can combine impairment ratings for two or more single IA claims (where section 378 applies). As a result, clients whose impairment for each single IA is assessed under the ten percent threshold (but ten or more percent combined) may now be able to receive IA based on a combined whole-person impairment.

U v ACC independence allowance eligibility requirements

Calculating a combined U v ACC whole person impairment rating

Criteria for combined independence allowance eligibility

Criteria for combined independence allowance eligibility for a person who has received an old lump sum

Calculation of a whole person impairment rating [current minus old lump sum]

2.0 In cases where the client will not benefit from an IA based on a combined WPI, we will base IA on the impairment rating for each injury

- a** Not all clients will benefit from an IA based on combined whole-person impairment.

- b** For example, a client has two injuries covered under different Acts (i.e. one under the Accident Rehabilitation and Compensation Insurance Act 1992 and one under the Accident Insurance Act 1998) that are over the ten per cent threshold (e.g. impairment from each injury is 25 per cent). Kept separate, the client would receive compensation for a total of 50 percent impairment. Applying a combined whole-person impairment to determine IA would result in the client receiving around 44 percent impairment.
- c** There will also be some cases where clients have received a lump sum payment under Acts prior to the 1998 Act, and who are also eligible for a combined IA. In these cases, ACC are required to deduct the lump sum impairment percentage from the combined IA.
- d** In cases where the client will not benefit from an IA based on a combined WPI, we will base IA on the impairment rating for each injury.

3.0 Scenario One

- a** Client has applied for two injuries:
 - 23/07/2000 for sprain right shoulder
 - 01/12/1997 for sprain lumbar spine

Client was assessed for whole person impairment of:

- 23/07/2000 for sprain right shoulder – 5%
- 01/12/1997 for sprain lumbar spine – 5%

Before the U decision, the client would not be eligible, as both injuries are under 10%.

Under the U decision, both impairment rating can now be combined: combining 5% and 5% gives 10%. The payment would start from date of lodgement of the second claim as that is when the >10% threshold was met.

4.0 Scenario Two

- a** Client has applied for two injuries:
 - 11/06/2000 contusion right knee
 - 01/04/2001 fracture left leg

Client was assessed for whole person impairment of:

- 11/06/2000 contusion right knee – 7%
- 01/04/2001 fracture left leg – 9%

Before the U decision, the client would not be eligible, as both injuries are under 10%.

Under the U decision, both impairment ratings can be combined: combining 7% and 9% gives 15%. The payment would start from date of lodgement of the second claim as that is when the >10% threshold was met.

5.0 Scenario Three

- a** Client has applied for three injuries:
 - 7/08/1999 for burns to both legs
 - 13/05/1992 for fractured vertebrae of lower back
 - 28/07/1998 for neck sprain

Client was assessed for whole person impairment of:

- 7/08/1999 for burns to both legs – 15%
- 13/05/1992 for fractured vertebrae of lower back – 12%
- 28/07/1998 for neck sprain – 5%

The impairment assessment would be:

- combined impairment: combining 12% and 5% gives 16%, with payment of \$283.14
- single impairment assessment of 15%, with payment of \$268.32
- total payment of \$551.46.

There would be no benefit to combining further: combining 16% and 15% gives 29%, with payment of \$465.92, which is less.

6.0 Scenario Four

- a** Client has applied for two injuries:
 - 12/03/2001 sensitive claim PTSD
 - 13/10/1991 lumbar injury, which has received an old lump sum (LS) of 10%.

Client was assessed for whole person impairment of:

- 12/03/2001 PTSD – 20%
- 13/10/1991 lumbar injury – 10%

Before the U decision, the client would not be eligible for combined IA, as the lumbar injury is under 10%: 10% impairment less 10% old LS equals 0%.

Under the U decision both impairments can be combined: combining 20% and 10% gives 28%, less 10% old LS equals 18%. There would be no benefit from combining the ratings.

7.0 Scenario Five

- a** Client has applied for three injuries:
 - 7/08/1999 contusion to right shoulder
 - 15/01/1992 strain/sprain left knee
 - 27/05/1981 strain/sprain right wrist/hand, which has received old lump sum (LS) of 5%.

Client was assessed for whole person impairment of:

- 7/08/1999 contusion to right shoulder – 8%
- 15/01/1992 strain/sprain left knee (cover updated to include osteo) – 15%
- 27/05/1981 strain/sprain right wrist/hand – 10%

Before the U decision, the client would not be eligible for single IA, as it was under 10% and would be eligible for combined IA: combining 15% and 10% gives 24%, less 5% old LS equals 19%.

Under the U decision, both impairment ratings can now be combined:

- combining 15% and 10% gives 24%
- combining 24% with 8% gives 30%
- 30% less 5% old LS equals 25%.

The IA would start from the date of application, as per criteria for old LS.

8.0 Scenario Six

- a Client has applied for three injuries:
- 9/12/1999 Amputation left finger
 - 15/01/1992 sprain/strain right wrist
 - 17/08/1991 left knee, which has received old lump sum (LS) of 10%

Client was assessed for whole person impairment of:

- 9/12/1999 Amputation left finger – 11%
- 15/01/1992 sprain/strain right wrist – 5%
- 17/08/1991 left knee – 8%

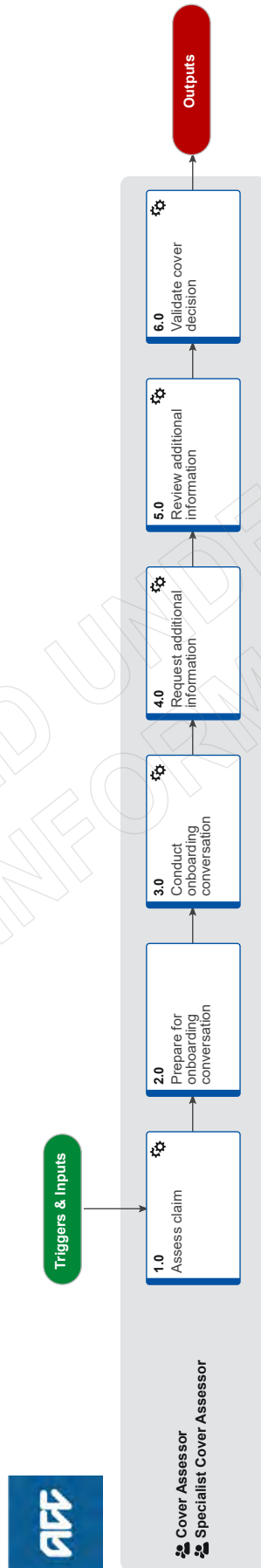
Before the U decision, the client would:

- not be eligible for combined IA: combining 8% and 5% gives 13%, less 10% old LS equals 3% (under 10%).
- be eligible for single IA, as 11% meets the >10% threshold.

Under the U decision, both impairment ratings can be combined: combining 13% and 11% gives 23%, less old LS 10% equals 13%. The IA would start from the date of lodgement of the 09/12/1999 injury, rather than combined impairment from the date of application, as per old LS criteria.

9.0 Links to legislation and district court decision

- 📄 Accident Compensation Act 2001, section 377 Independence allowance for personal injury suffered before 1 July 1999
<http://www.legislation.govt.nz/act/public/2001/0049/lal>
- 📄 Accident Compensation Act 2001, section 378 Personal injury suffered on or after 1 July 1999 and before 1 April 2002
<http://www.legislation.govt.nz/act/public/2001/0049/lal>
- 📄 Accident Compensation Act 2001, clause 55 Transitional limits on eligibility for lump sum entitlements
<http://www.legislation.govt.nz/act/public/2001/0049/lal>
- 📄 U v Accident Compensation Corporation [2018]
<http://www.nzlii.org/cgi-bin/sinodisp/nz/cases/NZACC>



Summary

Objective

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

Background

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

Owner

[Out of Scope]

Expert

Procedure

1.0 Assess claim

Cover Assessor, Specialist Cover Assessor

a Consider Risk of Harm questions.

Risk of Harm Guidance 1.0.pdf

NOTE What if I believe there is a risk of harm?

The risk of harm data will be entered when you update the Treatment injury tab in Eos and will be processed via the Create Report for Risk of Harm Review Group process linked below.

However, if at any time during the cover assessment process you believe there is an imminent risk of harm to the public and you believe you cannot wait until the cover decision is made, then send an email to clinicalquality@acc.co.nz outlining your reasons why you believe there is an imminent risk of harm to the public.

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

Identify Claims for Rapidly Deteriorating Clients

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

1. Ensure that an ENT05 Cover decision pending letter is sent out to the client. This letter advises the client that as cover is yet to be determined, we are not able to consider an application for entitlement, unless cover is awarded on their claim. Ensure that you forward date the task associated with the request to the legislative date on the claim.

2. Create 'Follow-up cover' task and add in the description [Complex claim, please assess].

3. Set priority on the task as 'high' if:
a) the client requires a critical decision,
b) the client needs more than a week off work,
c) there is an ARTP on file,
d) the claim is on the complex list,
e) we determine the client needs some sort of other urgent assistance

4. Change the target date of the task to the lodgment date

5. Transfer 'Follow-up cover' task to TIC-Case Ownership."

c Generate ACC2184 Cover decision tool if required.

NOTE When is ACC 2184 is required?

ACC 2184 is required if ANY or ALL of these criteria apply:

- It is a complex claim
- A detailed timeline of the events is required
- Any tier 3 internal or external opinion is required

If the claim does not meet the above criteria use the below template and place into a contact on Eos.

ACCEPT or DECLINE (delete one) - (state the injury being accepted)

DATE OF INJURY:

ACC 45

ACC 2152

BACKGROUND

ANALYSIS

ADVICE

RESEARCH

d Confirm this is a newly lodged claim.

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

- If there is no new information on file, and we did not re-open the claim, add a contact to note this. Call the client to advise. This process ends.
- If there is no new information on file, and we re-opened the claim, go to 'Issue Cover Decision' process.

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

1) If there is new information on file which would warrant re-assessment, and the claim was initially lodged under the Treatment Injury legislation (claim lodged with ACC after 1 July 2005), continue with this process - Assess Claim for Cover - Treatment Injury.

2) If there is new information on file which would warrant re-assessment, and the claim was initially lodged under the Medical Misadventure legislation (claim lodged with ACC prior to 1 July 2005), check if a personal injury was found during the initial investigation.

- If a personal injury WAS found during the initial investigation of the claim, re-assess the claim under the Medical Misadventure legislation. Refer to 'Cover criteria for medical misadventure Policy'.
- If a personal injury was NOT found, re-assess claim under the Treatment Injury legislation. Continue with this process.

If you are uncertain discuss the claim with a Specialist Cover Assessor, Practice Mentor or Technical Specialist.

Note, even though there are no timeframes on re-assessment, we must complete re-assessment in a timely manner.

 Cover criteria for medical misadventure Policy

NOTE What if the claim is a duplicate?

Go to Identify and link duplicate claims.

NOTE What if the claim is for surgical mesh?

If claim is for surgical mesh, select the Mesh Injury indicator under the General tab and transfer this claim to TIC-Management Queue for allocation to dedicated SCA who works on Mesh Claims.

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

Refer to Consequential Injury Claims Policy

NOTE What to do if claim was previously incorrectly accepted as PICBA?

If claim was previously accepted as PICBA in error, however, it was determined that this is a treatment injury claim and not a PICBA claim; transfer the claim to TIC - Admin Queue for triaging. In the confirm cover decision task - add the following description "claim accepted by system in error - please reassess this claim for Treatment Injury" and follow the Triage and Allocate Claim (Treatment Injury).

- e** Following an initial review of the claim, document your findings in Eos in a contact

NOTE What should be written in the contact?

Claim checked for PICBA, AE (accredited employer), consequential claims, reassessment, duplicate claims - nil found. No evidence of a mental injury on ACC45, ACC2152 or other lodging documents ie ACC18, ACC21.

If one of the above claim types is identified, document this clearly in the contact and if relevant the associated claim number.

- f** Determine whether the client has suffered a personal injury.

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


Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.


NOTE What if the claim is for a mental injury?


Asses whether there may be a physical injury that we can assess for cover (discuss this during the onboarding conversation):

- If there is a physical injury we can assess for cover, you will need to lodge a separate claim for the mental injury because of physical injury after completing the onboarding conversation (see activity 3(d)).
- The mental injury claim will be initially declined because of the specific legislative timeframes associated with the lodgement of a separate claim. Once you have approved or declined cover for physical injury, the mental injury claim will be re-opened to assess for cover either as MICPI (if physical injury is approved) or TIMI (if physical injury is declined).

Refer to the policy pages below for more information on mental injury policy and how to manage timeframes.

 Mental Injury Because of a Physical Injury Policy

 Statutory timeframes for mental injuries Policy

 Treatment injury mental injury Policy

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

 Context of Treatment Policy

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

Context of treatment refers to the registered profession of the health provider who gave, provided or directed the treatment either in New Zealand or overseas.

If the injury occurred within the context of accident, update the Treatment Injury tab to reflect PICBA status and ensure the fund code is not treatment injury. Then go to 'Assess Claim for Cover :: PICBA'. This process ends.

If the injury occurred within the context of work, eg work-related personal injury and work-related gradual personal injury, return the claim to the Hamilton Reg - Cover Assessment. This process ends.

NOTE What if the injury occurred as a result of treatment received overseas?

Any personal injury caused by treatment outside New Zealand is coverable Section 22(3) and (4), only if:

- the injured person is a New Zealand resident when they were treated, and
- the injury is suffered on or after 1 July 2005, and
- the treating practitioner is equivalent to a New Zealand Registered Health Professional (the 'equivalency standards'), and
- the injury is one they would get cover for in New Zealand

In simple terms there is cover for a Treatment Injury caused by treatment overseas but only for those who are ordinarily resident at the time of treatment.

Cover Assessor or Specialist Cover Assessor can discuss the criteria for treatment received overseas and if client meets the ordinarily resident criteria or not. If easier, please send the ACC 164 to client to determine the residency criteria.

📄 ACC164

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

- 📄 Context of treatment
- 📄 Cover Criteria for Treatment Injury Policy
- 📄 Request Clinical Records for Treatment Injury
- 📄 When to use an Interpreter Policy
- 📄 Criteria for injury occurring outside New Zealand Policy

NOTE What if the treatment received overseas by a health provider who did not meet the equivalency standards?

If there is does not meet the equivalency test noted in Context of Treatment policy, then consider the claim under the PICBA cover criteria.

📄 Assess claim for cover: PICBA

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

NOTE What if there is no direct causal link?

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

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

📄 Necessary Part or Ordinary Consequence of Treatment Policy

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

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

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

📄 Treatment Injury Exclusions from Cover Policy

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

Decline claim. Go to 'Issue Treatment Injury Cover Decision' process.

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

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

📄 Next Generation Case Management landing page

- n** Updating Eos with relevant information

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

As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

📄 Causal Link Policy

2.0 Prepare for onboarding conversation

Cover Assessor, Specialist Cover Assessor

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

Go to Activity 4.0 in 'Triage and Allocate Claim (Treatment Injury)' process.

📄 Identify Claims for Rapidly Deteriorating Clients

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

📄 ACC Guidelines to obtain verbal or written authority

NOTE When is a ACC6300 required?

An ACC6300 is required to request notes after 12 months of a claim being lodged, or when a provider has indicated that they will not provide notes based on the ACC45 consent and/or verbal consent.

- Verbal consent can be obtained during the onboarding conversation
- If you think you cannot rely on the verbal consent and the ACC45, as we need a significant amount of information from several providers, or we require external clinical advice - send the ACC6300 form to the client after conducting the onboarding conversation

NOTE What if the client is deceased?

- If the client is deceased contact the lodging provider to obtain contact details for the NOK (next of kin)
- Contact the NOK to determine if there is an executor of the estate, if there is an executor of the estate, obtain the relevant consent documents regarding this (copy of the will showing the named executor and send an ACC163, confirm with the executor of the estate that they wish to continue with the claim investigation
- If there is no executor of the estate, discuss with the Privacy team on Ext. 46464 that there is no executor of the estate and confirm that it is appropriate to then utilize the NOK as the authority on the claim
- Despite the multiple attempt (maximum 2 attempts) to contact the NOK or executor of the estate (EOE) (without success) - please issue the appropriate decision after discussing this with your Team Leader. However, do not send the decision (unless address is verified in last 2 months - though check with your Team Leader or Privacy Team) and in contacts add "unable to contact the NOK or executor of estate - decision not sent".
- If you receive the call after decision is issued, please confirm the authority with NOK or EOE, re-open the claim if it required or asked by the NOK/EOE and reassess the claim accordingly.
- If a client dies during the investigation of their claim, ensure that this is reflected in the party record by altering the 'Profile' tab and the 'Deceased Status' data field

NOTE What if verbal consent is appropriate?

In Skype, during the call with the client, play the pre-recorded consent message:
1. Select "Invite More People" in the top right hand corner of the active call window
2. Enter the extension for the Verbal Consent Recording: 50013 and press OK
3. You will appear in a Conference with the Verbal Consent Recording and the Client
4. Once the consent recording has finished playing, it will automatically leave the phone conference

Then verbally confirm that the client agrees, and note this down in a contact.

Refer to the process below for more information.

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

- obtain client's consent.
- inform the client they will receive a declined decision regarding the mental injury claim.
- advise we will reopen the claim to investigate once we have made a decision on their physical injury.

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

NOTE What if the client requires an Authority to Act?

Refer to the process below prior to conducting the onboarding conversation.

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

NOTE When should you request ACC2152?

The ACC2152 can be beneficial when filled out by the provider who gave the treatment or a provider who has given subsequent treatment on the injury with a similar qualification and/or scope of practice. Consider if ACC2152 would be helpful. If not, request clinical records.

NOTE What if you require an audiology assessment?





- Check with the client whether they have already undergone audiometry assessment during the onboarding conversation, ACC will not require a client to undergo a further test if the audiometry has been undertaken in the last three months.
- If the client hasn't completed this assessment, let them know during the onboarding conversation that we will send the letter and purchase order for them to complete the assessment. Advise the client that they will need to organise an appointment with the most convenient audiometry provider, who will send the report directly to ACC. Advise them that ACC will fund this.

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

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

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

To find resources to support a client with language and cultural needs, refer to the following documents.

-  NG GUIDELINES Supporting the Diverse Needs of our Clients
-  When to use an Interpreter Policy
-  Working with an interpreter process
-  Connecting Now - phone interpreting service for ACC

3.0 Conduct onboarding conversation

Cover Assessor, Specialist Cover Assessor

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

NOTE How many contact attempts should be made?

Claim lodged with ONLY ACC45 which does not fulfill complex claim criteria for direct allocation to Specialist Cover Assessor.

- Two attempts to contact client by phone, on different days/times, if unsuccessful send TI73.
- Request clinical notes from lodging provider
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

Claim lodged with ACC45 and ACC2152 or additional clinical notes

- Two attempts to contact client by phone, on different days/times, if unsuccessful send TI73.
- If we have been provided with sufficient information as to who provided the treatment on the lodging documents, it would be reasonable at this stage to request the clinical notes from those providers.
- If we receive no response from the provider after 14 days, remind the provider (letter/email) and after a further 14 days, if there is still no response from the provider or client - decline the claim.

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

Go to Activity 3.0 Update necessary records within the Issue Treatment injury cover decision process and decline the claim.

b Follow the 'TI Onboarding conversation' guide.

 TI Onboarding conversation

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

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


- In Eos, in 'General' tab, tick Triage indicator.
- In Eos, in 'Confirm cover decision' task, update the description to note [Critical decision is required - client's condition is rapidly deteriorating].
- Check that a rapidly deteriorating task has been transferred to PIC (Permanent Injury Compensation), if not please transfer that task to the CPIC - Requests queue.

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

If the client does not give consent to continue the investigation, document this in Eos and proceed to Issue Cover Decision (Treatment Injury) procedure.

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

Refer to NG GUIDELINES Managing Threat of Self-harm Calls for guidance.

 NG GUIDELINES Managing Threat of Self-harm Calls

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

If the client mentions their employer and you identify the employer is a registered AEP participant, advise the client their claim will be managed by their employer's Third Party Administrator and someone will be in touch with them soon.

If you need to verify this, contact the TPA admin team using the hunt line: ext 45394. Or alternatively use the relevant emails below:


Work claims: insurerliaison@acc.co.nz


Non work claims: TPAsupport@acc.co.nz

Follow the process link to 'Transition Claim to an Accredited Employer'.

NB: Clients are not able to opt out of AEP managed for work related claims, only for non-work related claims.

This process ends here.

 Accredited employers list (for work-related claims only)

 Participating Accredited Employers (Non-work claims only)

d Complete outstanding actions.

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

After the client onboarding conversation where you have obtained consent from the client to lodge this claim

- generate and fill out the Referral for New Claim Lodgement
- email the complete form to hamilton.registration@acc.co.nz (ensure you specify the date of lodgement is the date ACC received the claim, not the day you first spoke with the client).

 Referral for New Claim Lodgement

4.0 Request additional information

Cover Assessor, Specialist Cover Assessor

a Follow the appropriate process below for requesting additional information.

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


If the cover decision is being reviewed and the claim is in actioned cases department, go to 'Re-open claim' process. Recovery Administrators can only support additional information requests if the claim is 'active'.

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

If you require an ACC 2152 from the relevant provider go to Request Clinical Records process step

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

Refer to the 'Clinical questions guide'.

 Clinical questions guide

NOTE What if you require internal clinical, medical or technical guidance including hotline or written?

Please go to 'Seek Internal Guidance' process.

NOTE What if you require external clinical advice?

Go to 'Request External Clinical Advice (ECA) Report' process.

NOTE What if you require an archived physical claim file?

Go to 'Retrieve Archived Physical Claim Files' process.

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

Upload onto clients claim an ACC 612 Audiometric Report for Hearing Loss (this is the document that the client is required to take to their assessment with the Audiologist of their choice).

Create a 'Send Letter' task (this will be auto routed to Recovery Administration Team to send)

- Select 'create and send letter'
- Enter code and name of letter 'HLS14 Audiologist Test letter'
- Select your method of delivery
- Copy the information below and place into the additional comments section of the task or into the description box (the Recovery Administrator will follow these instructions to create the purchase order and letter:
 - Choose 'HL01' for entitlement code and rehabilitation action - hearing loss, click search
 - Under 'entitlement in purchase order' add '1.00' for Quantity approved and frequency as 'quarter' and create purchase order and save
 - For the purchase method choose 'Claimant Reimbursement'
 - Generate 'HLS14 Audiologist Test' letter and send to client
 - Please send attached document ACC612 with the HLS14 Audiologist Test letter
 - Please send task 'PRC HL: Review Claim & Check for Duplicate Claims' back to task creator advising 'Hearing assessment letter sent to client' edit target date for 20 working days.

Attach the ACC612 document to the task

- Select 'document' tab
- Select 'link'
- Select 'clear' in the associated documents date range
- Select ACC612 Audiometric Report for Hearing Loss
- Select 'OK'

NOTE What if a face to face Otolaryngologist/ENT assessment for a hearing loss claim is required?

1. Check that you have all of the client's audiometry records on file, including one performed in the last three months. If you do not have this on file, please request using the note above named 'What if an audiology assessment is required?' Ensure that the client is made aware that they will be receiving this letter and that they will need to organise an appointment (ACC will fund this appointment).
2. If you have all of the relevant clinical notes related to the condition that the client is requesting cover for and clinical notes regarding the treatment event or events that have resulted in the injury. (ie Radiation is the treatment cause, you will need all radiation fields and radiation dose summaries. If medication ie gentamycin is the cause, you will need all medication charts and biochemistry results of serum peak and trough levels).
3. Create a memorandum utilising Ear Nose and Throat Memorandum template below.' Ensure that the memorandum is included in the document group.
4. Perform privacy checks on documents.
5. Create a referral-specific document group with today's date and name it 'ENT assessment'
6. Add the necessary documents and include the ENT memorandum in the document group
7. Complete privacy checks. Refer to 'NG Supporting Information Inbound and Outbound Document Checks'.
8. Generate an 'Organise Internal referral' task (under the Specialist Cover Assessor name or creator)
9. Edit the 'Complete internal referral' subtask to state 'Face ENT assessment required, please send document group labelled ENT Assessment with the referral'.
10. Send the 'Complete internal referral' sub-task to 'hearing loss claims' department queue.



ENT memorandum.docx






NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

NOTE What if a mental injury assessment is required?

- 1) Ensure you have requested sufficient clinical notes of current state of alleged causes of injury to support assessment.
- 2) If this is a treatment injury mental injury (TIMI), upload to the claim a memorandum to request a psychiatric review (this document will provide a summary of the claim, relevant legislation and have particular questions for the psychiatrist to answer). If a sensitive claim is on file ensure you specify this in the memorandum.
- 3) If a sensitive claim is on file ensure you specify this in the memorandum.
- 4) Create a referral-specific document group with today's date and name it 'Mental injury assessment'
- 5) Add the necessary documents - if this is for mental injury ensure you review the clients party record for any other claims relating to mental injury or pain disorder and include this information
- 6) Add any specific questions that need to be included in the body of the letter
- 7) Complete privacy checks. Refer to 'NG Supporting Information Inbound and Outbound Document Checks'.
- 8) Discuss with your team leader regarding the next steps

Refer to the Psychiatric assessment memorandum example below for guidance on how this should be completed, and use the template below.

-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks
-  Psychiatric assessment memorandum template
-  Psychiatric assessment memorandum example

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

Go to 'Arrange Medical Case Review (MCR) Assessment' process.

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

-  How to manage legislative timeframes Policy

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

Go to 'Extend Cover Decision Timeframe' process.

- c** Updating Eos with relevant information

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

As you progress the claim, updating EOS with relevant information is important. Please add appropriate content to update TASK as well as CONTACT. Ensure that with any work that you have completed on the claim that you are recording this in the TASK as well as contacts section of the clients claim with the heading stating: CLAIM UPDATE.

For those claims within the TI admin queue being assessed by cover assessors, this includes the task template within the follow up cover task, and for SCA's this means your master task (Why this is important? This will allow your colleagues and peers to pick up where you have left off with greater ease, or to effectively support you in cases of unplanned leave.)

5.0 Review additional information

Cover Assessor, Specialist Cover Assessor

- a** Review new information to make a cover decision.

NOTE What if you need more information?

Go back to activity 4.0 Request additional information.

NOTE How do you review the ENT assessment?

Refer to the guide below.

-  Review ENT assessment

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

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

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

Proceed to 4.0, a, Request Additional Information, note 5 - What if you require written internal clinical, medical or technical guidance (Tier 3). Complete a referral for Psychology - TIMI.

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

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

Go to 'Extend Cover Decision Timeframe' process.

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

Follow up with the client via a phone call with two attempts, two different days and times. If consent to continue to investigate is not received ACC is to issue a decision 5 business days prior to legislative decision due date. Go to the process below.

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

- If the client is deceased contact the lodging provider to obtain contact details for the NOK (next of kin)
- Contact the NOK to determine if there is an executor of the estate, if there is an executor of the estate, obtain the relevant consent documents regarding this (copy of the will showing the named executor and send an ACC163, confirm with the executor of the estate that they wish to continue with the claim investigation
- If there is no executor of the estate, discuss with the Privacy team on Ext. 46464 that there is no executor of the estate and confirm that it is appropriate to then utilise the NOK as the authority on the claim
- If a client dies during the investigation of their claim, ensure that this is reflected in the party record by altering the 'Profile' tab and the 'Deceased Status' data field

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

- discuss the claim with a Practice Mentor first to agree on which role is best suited to continue with assessment.
- if the claim needs to be transferred to a Specialist Cover Assessor, go to the note 'What if it is a complex claim?' at step 4.0e in 'Triage and Allocate Claim (Treatment Injury)' process.

c Updating Eos with relevant information

6.0 Validate cover decision

Cover Assessor, Specialist Cover Assessor

a Review 'Claim validation framework guide'.

 Claim validation framework guide

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

NOTE What if you're unsure of the decision?

- Contact a Specialist Cover Assessor, or Practice Mentor to help validate your decision.
- In Eos, in 'Contacts' tab, add a contact to note who is validating your claim and what your pre-validation decision is.

If you're still unsure of your decision, go to 'Seek Internal Guidance' process.



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[Export](#)

Rule Name	What a written communication to a client is to specify
Statement	<p>A written communication for a decision [with review rights] relating to a claim of a client must specify all of the following information:</p> <ul style="list-style-type: none"> • The decision • The reason for the decision • Information about all of the following: <ul style="list-style-type: none"> ◦ the review rights of the client ◦ how the client can apply to review a decision • The timeframes for a review process
Motivation	This rule ensures that when ACC informs a client about a decision, the client is also informed about the decision rationale and their review rights
Rule ID	SupNot-002
Owner(s)	Manages Technical Services
Business Term(s)	claim ; client ; decision [with review rights] ; written communication
Business Rule Group(s)	Claim ; Client ; Decision ; Entitlement ; Notification ; Supports
Source(s)	Business Decision: Support Notification Business Rules - NGCM

Additional Information

Approval Date	25/07/2015	TBR	Y
Activation Date	12/08/2015	Rule Type	Obligator
Approver	[Out of Scope] Technical Policy Team Manager	Author	[Out of Scope]

Contact

If you have any comments or require any clarification, contact EBR@acc.co.nz.



What to include in emails to clients, providers and employers Policy v15.0



Summary

Objective

When writing emails to clients, providers and employers use a factual, friendly, sensitive and professional tone. Take extra care when writing emails as poor wording or inappropriate inclusions or exclusions can lead to case reviews and affect ACC's reputation. Remember that emails can be printed out and viewed by people who are not the intended recipient.

Owner

[Out of Scope]

Expert

Policy

1.0 Sending an email

- a When sending an email:
 - only send emails to a verified email address
 - always create your email through the EOS Email Toolset.
 - select any attachments through the 'Documents' tab in the client's EOS record using EOS Email Toolset. Do not attach documents from outside of EOS.
 - complete a privacy check. This includes checking that you have the correct recipient/s, their emails are verified, attachments are correct (open them to check) and information in the email body is correct.
 - complete housekeeping checks to ensure your email has correct grammar, spelling, and is professional. Remember that emails may be forwarded to others or may be released under the OIA or Privacy Act.
 - keep in mind that more than one person may be using or have access to an email account



Email verification



The easy guide to the email and instant messaging policy

2.0 What to include in emails

- a The attached table tells you what information you should include in an email message.



What to include in emails.docx

3.0 What to avoid in emails

- a The attached table tells you what not to include in an email to a client, provider or employer.

Do not include...	Reason
slang or jargon	The client may not understand these terms. Remember, our clients are multicultural and English may be their second language
confidential information	Financial and health-related information may be read by an unintended source, so be careful about what information is contained in the email
CAPITALS	Avoid using CAPITALS in emails as it implies an inappropriate tone, is SHOUTING. Bold is a better way to emphasize text
defamatory, offensive or obscene remarks	Avoid these at any cost. Using words that can be misinterpreted may impact negatively on the sender and ACC
sarcasm	Email communication does not convey emotions as well as face-to-face or telephone conversations. The recipient may not know if you are serious or joking, happy or sad, frustrated or satisfied, so keep text factual with a friendly tone



What to avoid in emails.PNG

4.0 Sending an email externally

- a If you send an email labelled 'UNCLASSIFIED' externally, a pop-up box will appear asking you to 'Confirm and send'. You must take a moment to confirm that you have selected the correct recipient and that their email address is correct, before you continue to send the email.
- b If you send an email labelled 'IN-CONFIDENCE' externally, a pop-up box will appear asking you to confirm that the recipient is intended/authorized to receive the information – before confirming and sending. You must take a moment to confirm that you have selected the correct recipient, that their email address is correct, and that it is appropriate to send them this information, before you continue to send the email.



More information on document classification and information protection

Summary

Objective

Diagnosis codes are used in healthcare to identify and categorise symptoms, disease, injuries and procedures. We use several diagnosis codes including ICD9, ICD10, ICD-11, DSM-IV, DSM-5, and READ codes.

The diagnosis code on the ACC45 of an accepted claim indicates the injury ACC has agreed to cover. Healthcare providers decide the code that best represents the client's injury diagnosis. In cases where a client has multiple injuries, each injury will have its own code. Having the correct code helps us to ensure we're covering the correct injury and providing the client with appropriate support.

See Assess Cover for an Additional Injury or Change in Diagnosis.

Owner

[Out of Scope]

Expert

Policy

PROCESS Assess Cover for an Additional Injury or Change in Diagnosis

1.0 Adding or changing diagnosis codes

- a** A case owner might need to change or add a diagnosis code in Eos if there is medical evidence that:
 - the initial diagnosis of the injury was incorrect, eg the code is for a sprain and the medical evidence confirms the injury sustained was a fracture
 - the initial claim form omitted an additional injury sustained in the same event, eg the medical evidence confirms a knee sprain and a concussion, but only the knee sprain is on the ACC45 claim form.

Before you change a diagnosis code in Eos, you must have medical evidence and a link to the mechanism that caused the injury to support this.

If you want to alter a code, you may wish to discuss this with a team manager (TM), or technical specialist (TS) before making the change. If there is a specific clinical issue (eg the new diagnosis doesn't seem to fit the injury, or appears to conflict with other evidence) please request medical advisor (MA) advice. See When to refer for Clinical Advice.

Note; if you're changing an existing diagnosis code it's important to consider if you need to formally revoke cover. For example if the original claim was made with a diagnosis of wrist sprain and later investigation reveals a fracture you may replace the original code and advise the client. However, if they original diagnosis was a complex diagnosis such as "rotator cuff tear" and later assessment reveals that ACC's responsibility extends to a simple shoulder sprain only then it will be necessary to formally revoke cover for the original diagnosis. If you're in doubt get advice from your TS or TM in the first instance. See Reasons to revoke cover.

You need to send a decision letter to the client and/or their provider informing them of our decision.

Reasons to revoke cover Policy

NOTE If cover was granted under the Accident Compensation Act 2001 (AC Act) then revoke cover under the AC Act 2001, Section 65

NOTE If cover was granted under an earlier Act If cover was granted under AC Act 2001, Section 390

2.0 Stopping entitlements and payments

- a** If the client has been receiving entitlements for 52 weeks or more and we revoke cover, the client must be given up to 4 weeks' notice that their entitlements will stop. The 4 weeks' notice starts from the date we advise the client that they no longer have cover for their injury.

3.0 When not to revoke cover

- a** Do not revoke cover if you're satisfied that we originally granted cover correctly, but the client's current condition does not relate to the personal injury. Under these circumstances:
 - decline the application if the client is applying for support
 - suspend the support if we've already been providing it.

When to Refer to the Technical Accounting Specialists (TAS) for Advice v9.0



Summary

Objective

The Technical Accounting Specialists (TAS) are a team of accounting professionals who are expert in evaluating detailed financial information alongside tax and ACC laws. Their role is to provide accounting advice to support case owners to make accurate weekly compensation decisions for clients who have complex financial situations.

This page details scenarios that may help you and your team manager or technical equivalent decide whether you can resolve a complex weekly compensation issue in your business unit or refer it to TAS for advice.

Owner

[Out of Scope]

Expert

Procedure

1.0 Scenarios you may need to refer to the TAS for advice

- a** Entitlement decisions for clients who have more complex financial situations may be referred to the TAS. Here's a list of typical scenarios that the TAS may give advice on.

b Examples:

- The client is self-employed or a shareholder employee but you're not sure they were in business at the time of their incapacity
- The client is self-employed or a shareholder employee. The client's income for the last tax year before their incapacity has increased 30% or more from the previous tax year (Note, if both amounts are below the full time minimum then no referral would be required. Call the TAS hotline if confirmation is required). Neither the client nor their accountant have provided a reasonable explanation for the increase, eg more responsibility, fewer shareholders, increased trading especially if the client has put in their tax return after their incapacity.

Examples:

- The client is self-employed and works part-time but there's no pattern to the hours they work or the income they receive.
- The client is self-employed but the client's business looks like it's a hobby and not a valid business. It seems unlikely that the business makes a profit or that the client needs to work for it in a full-time capacity.
- The client has changed from receiving income as the beneficiary of a trust to a PAYE, self-employed or shareholder employee in the last financial year.
- The client has earnings from a trust but you're not sure if the client either worked for the trust or was an employee of the trust at the time of their incapacity.
- The client has earnings from a trust other than beneficiary income, eg PAYE wages, shareholder salary, self-employed income.
- The client is a shareholder employee but their earnings in the year of incapacity are nil.
- There is a strong likelihood that the entitlement calculation may result in an adverse decision and you need expert accounting advice on whether the decision is defensible.
- There is more than one owner in the client's business. The percentage of profit paid to the client has changed from previous years.
- Anything else out of the ordinary that you're unable to resolve.

2.0 Scenarios you may be able to resolve without a referral to the TAS

- a** You may be able to resolve entitlement decisions for less complex cases without referral to TAS, such as when the client has filed their tax return before their accident. For examples of other scenarios you may be able to resolve without a referral, see the following:

b Example 1:

The client is in part-time or full-time self-employment and:

- they pay New Zealand tax on their earnings and they have no other source of income
- there's a recognisable pattern to their working hours
- they haven't had any income increases of 30% or more on the previous tax year.

c Example 2:

The client is self-employed but they weren't in business at the time of their accident or incapacity and they didn't have any other source of income.

You can decline the client's entitlement because they weren't an earner at the time of their accident or incapacity. For clients to be eligible for weekly compensation they must be an earner both at the time of their accident and immediately before their incapacity.

d Example 3:

The client has no other income other than as the beneficiary of a trust whether or not they 'worked' for the trust.

You can decline the client's entitlement because beneficiary income isn't considered earnings under the Accident Compensation Act 2001.

e Example 4:

The client is a schedular earner who has had their earnings for the relevant year auto - assessed by Inland Revenue. Refer to the TAS Team Space page for guidance: <http://thesauce/team-spaces/technical-services-ts/technical-accounting-specialists/schedular-earners--auto-assessed/>

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Summary

Objective

We can only refuse someone's request to access information about themselves if:

- it's appropriate to withhold it under sections 49-53 of the Privacy Act 2020
- another Act states that ACC does not have to provide access to the information.

The following rules apply to requests for personal information from the person themselves, eg a client or their representative or guardian.

Owner [Out of Scope]

Expert

Policy

1.0 Rules

- a** We must let the requestor know our reasons for withholding the information and inform them of their right to complain to the Privacy Commissioner about our decision.

You can do this by including the following paragraph (or similar) in your response: "If you're not happy with our response, you may want to address your concerns to the Office of the Privacy Commissioner through their website <https://www.privacy.org.nz/your-privacy/complaint-form/>, by phoning 0800 803 909, or writing to them at PO Box 10-094, Wellington 6143."

If you need to photocopy any part of a client's file, you must complete an ACC6173 Information disclosure checklist. See Privacy check before disclosing information.

2.0 Grounds for withholding personal information

- a** The following are the most relevant grounds under sections 49-53 of the Privacy Act for withholding personal information when a person requests information about themselves. For further guidance and examples, click on the relevant link.

We can withhold information under the Privacy Act when:

- releasing the information would:
 - prevent detection and investigation of criminal offences and the right to a fair trial - 53(c)
 - endanger a person's safety - 49(1)(a)(i)
 - involve an unwarranted breach of someone else's privacy - 53(b)
 - breach confidence where the information has been collected only for reasons to do with the individual's employment or to decide whether to insure the individual - 50(1)(b)
 - be contrary to the interests of a person under 16 years old - 49(1)(c)
 - breach legal professional privilege - 53(d)
- the request is frivolous or vexatious or the requested information is trivial - 53(h).

3.0 Releasing part of the information

- a** Sometimes it's appropriate to release only part of the information requested, either by deleting it from a document, or by blacking it out so that it can't be read. This is called redaction.

NOTE Examples

- When information identifies multiple individuals it may be appropriate to delete information about other people from the document before we release it
- When a client's medical practitioner advises that disclosing particular information would be likely to affect the client's physical or mental health.

b

The recipient must not be able to read any of the information that we remove.

4.0 Not sure what to do?

- a** If you're still unsure after referring to the individual pages above, discuss the request with your team manager or contact a member of the Privacy group.

Summary

Objective

The type of reimbursement the client has requested determines which ACC team processes the payment. ACC staff should send client reimbursement forms to the relevant team for payment.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a The attached table shows the addresses for sending requests for client reimbursement.

ACC Provider Invoicing, Auckland	ACC Provider Invoicing, Dunedin	Hamilton Service Centre
PO Box 50341 Victoria Street West Auckland Mail Centre 1142	PO Box 408 Dunedin 5054	PO Box 952 Hamilton



Who processes client reimbursements Policy.PNG

2.0 How to decide where to send a client reimbursement request

- a Use the attached table to find out where to send a client reimbursement request.

If the reimbursement request is for...	then send it to the...
<p>ACC86 Request for client reimbursement includes all ACC86 requests for client reimbursement, including non-contracted client reimbursements to care givers</p> <p>Note:</p> <ul style="list-style-type: none"> the ACC86 must be completed in full and show whether we should pay the client or the caregiver the processing team prefers a scanned copy by email to aucklandacc86@acc.co.nz <ul style="list-style-type: none"> when scanning, note in the document title: ACC86 - the client name batch file the original. Do not send it to the processing centre after scanning clients may email the ACC86 directly to the above address. Ask that they make the email subject line: ACC86 and their name if the client only has access to a fax machine, they can fax it to 09 354 5581 if urgent assistance is needed, contact the Auckland Invoicing team 	<p>Provider Invoicing, Auckland</p> <ul style="list-style-type: none"> see also Payment method for non-agency caregivers
<p>client travel, eg ACC250 Claim for transport costs</p> <ul style="list-style-type: none"> see also Reimbursing non-emergency travel costs <ul style="list-style-type: none"> dental work elective surgery and/or related costs 	<p>Hamilton Service Centre</p> <p>client.transport@acc.co.nz</p> <p>Provider Invoicing, Dunedin</p>
<p>orthotics</p>	<p>Hamilton Service Centre for assessment</p> <ul style="list-style-type: none"> they will send them to Provider Invoicing, Auckland for payment
<p>other costs, such as:</p> <ul style="list-style-type: none"> review costs housing modifications vehicle purchase equipment aids and appliances accommodation equipment hire 	<p>Send all the listed rehab client reimbursements only to aucklandinvoicing@acc.co.nz</p>



How to decide where to send a client reimbursement request.PNG



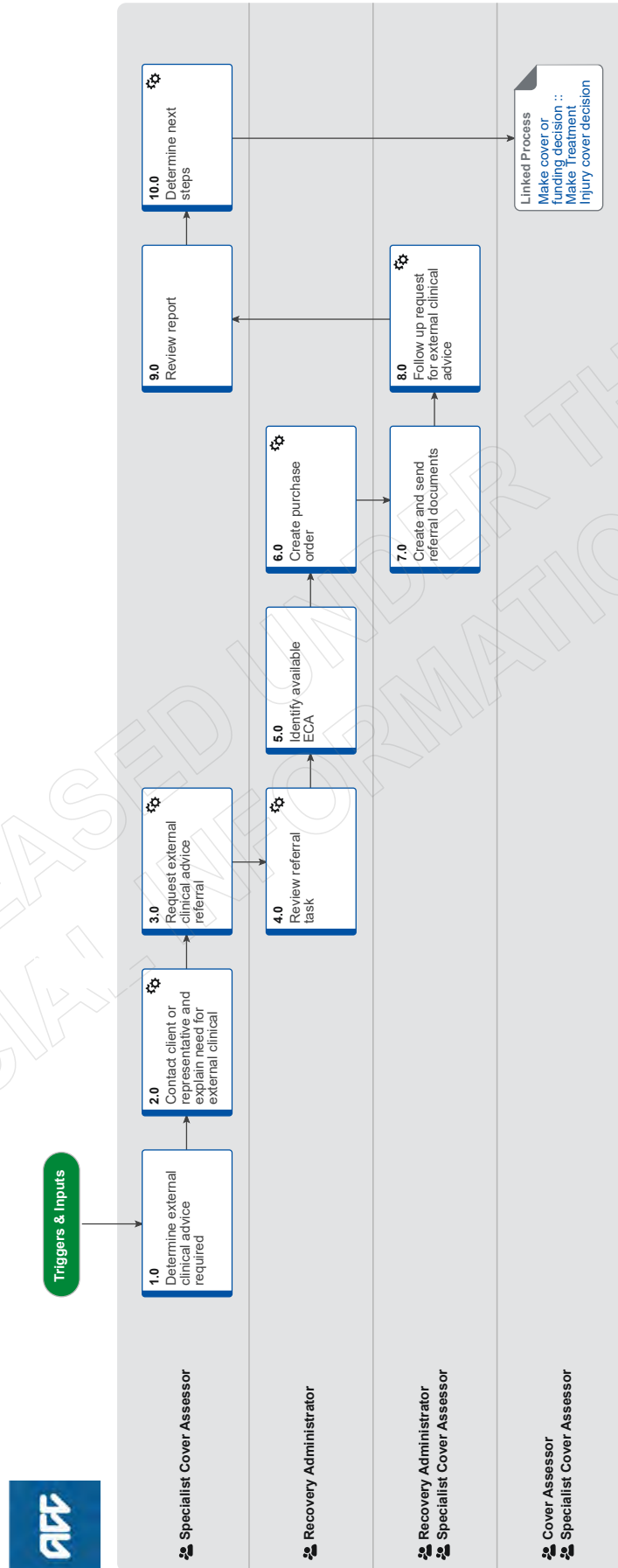
ACC86 Weekly Care Summary.doc



ACC250 Reimbursement of client travel expenses



Reimbursing Non-Emergency Travel Costs



Summary

Objective

To request a report from an independent third-party provider answering questions on the standard of care (if relevant), physical injury, causation, background population risk (necessary part of treatment), ordinary consequence of treatment etc.

Background

External Clinical Advice (ECA) is an opinion solely based on the paper file review from an independent provider. It helps to answer the questions on the standard of care (if relevant), physical injury, causation, background population risk (necessary part of treatment), ordinary consequence of treatment etc.

The ECA's role is to comment on clinical facts, accepted standard practice, whether a failure has occurred and likelihood of an injury occurring, taking into account the particular clients contributing factors.

ECA's do not interpret the legislation. It is the role of the Specialist Cover Assessor (SCA) and Cover Assessor (CA) to interpret the legislation against the clinical facts, and obtain further internal advice if required.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine external clinical advice required

Specialist Cover Assessor

- a** Confirm ECA is required.

NOTE When would you seek ECA?

- When you need specialised advice regarding failure, standard of care, appropriateness of the chosen treatment pathway, identification of a physical injury, causation and determining what contribution patient specific factors had in contributing to developing an injury and that advice would help you to determine cover.
- When you've had a conversation with a Review Specialist or following internal guidance and you determine external clinical advice is needed.
- You are not required to seek internal clinical advice before accessing external clinical advice.

- b** Identify the speciality of ECA needed.

NOTE How do you identify the speciality of ECA needed?

- Identify the consultant that the care was provided under.

Be mindful that this is not always the most appropriate speciality to provide comment (eg. client had cardiothoracic surgery and developed a bacteraemia, which then resulted in a sternal wound infection). It may be more appropriate to seek advice from an infectious diseases physician in this case.

- Look up their ECA speciality and sub speciality to ensure that you are seeking advice from a peer with similar training and registrations - (eg when considering cases where the treatment has been provided at a rural hospital, be mindful that a rural hospital does not have emergency physicians in their emergency department which is usually run by Rural Health General Practitioners).

- An ECA provider cannot provide comment on another practitioner's care if they do not have the same qualifications - (eg. an Obstetrician should not be providing comment on the standard of Midwifery care, we should be seeking comment from a Midwifery ECA if this is required).

NOTE Where can you access a list of ECA disciplines and specialities?

Click on the link below and navigate to the Provider details.

-  [Treatment Injury ECA Referral tool](#)

NOTE What if you are unsure of the correct ECA discipline and/or speciality to use?

Go To 'Seek Internal Guidance' process. Use Tier 1 (self service) and Tier 2 (Hotline) guidance process.

-  **PROCESS** [Seek Internal Guidance](#)

NOTE Can you request an ECA provider by name?


- You can instruct Recovery Administration on the medical discipline and speciality required. The Recovery Administrator will then select the next available provider, with the discipline and speciality required, that has capacity to receive a referral.

- You can request an ECA provider by name, if that provider has previously provided ECA advice on the same claim.

2.0 Contact client or representative and explain need for external clinical advice

Specialist Cover Assessor

- a** Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.

-  [Identity Check Policy](#)

- b** Explain that you are referring for external clinical advice, the reason seeking advice, what information will be included in the referral, what the advice will be used for and the possible outcomes.

- NOTE** What else do you need to make the client aware of?
- timeframe of when you expect to receive the written advice.
 - that sometimes the ECA may confer with other similar experienced vocationally registered health professionals, eg. a blind review
 - next steps after receipt of the written advice.

- NOTE** What if the client does not agree to proceed to ECA?
- Find out why the client does not want to proceed to ECA and consider their reasoning and alternatives which may include making a cover decision based on the clinical information that is held on the claim. Agree with the client the next step.

- c** In Eos, add a contact note as a record of the conversation.

3.0 Request external clinical advice referral Specialist Cover Assessor



- a** Identify all the documents that need to be sent with the referral.

- NOTE** What documents do you need to include?
- ACC45 Injury Claim Form
 - ACC2152 Treatment Injury Claim
 - All clinical notes (including radiology reports, laboratory results and other miscellaneous medical records on file)
 - Treating specialist(s) report(s)
 - Internal medical advice
 - Letters and notes provided by the client
 - Death Certificate
 - Coroners/Autopsy reports
 - Hard copies of clinical evidence (dental moulds, cytology slides, radiological images hard copy/ CD).

- b** Perform privacy checks on documents.

- NOTE** What do you need to check?
- Check documents:
- are relevant to the referral
 - do not contain any third party information
 - do not contain any other information that needs to be withheld.

For details on what checks you need to complete before sending documents out, refer to NG supporting information Inbound and Outbound Document Checks and the Privacy Check Before Disclosing Information policy.

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

- 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 specific redaction instructions, before adding the redacted document to the document group. You must not create and add to a document group until all redactions have been completed. Wait until you get the correct information back on the claim and then you can create your document group.

- c** Add the documents to the group.

- NOTE** What if there are documents incorrectly on other claims that need to be moved to the correct claim that has the referral-specific document group?
- To move documents from another claim to the correct claim see the system steps below for Move a Document to Another Claim.


-  Move a Document to Another Claim

- NOTE** What if there are documents from other claims that are relevant to the assessment?
- When a request for a referral is required and there are additional supporting documents on another claim, it is important to upload a copy of the documents to the claim that has the document group. This will ensure the right documents support the cover decisions for each claim, whilst retaining original documents on the correct claims.

- To upload documents from one claim to another:
- 1) Create a bulk print of all documents on the other relevant claim and complete mandatory fields and description
 - 2) Open PDF document from email link
 - 3) Upload the PDF document to the relevant claim that has the document group for the referral
 - 4) Repeat if there are relevant documents on multiple claims.

The PDF should be renamed to something short but relevant, identifying which claim number the information came from so that it is included/ printed in further referrals or copy files eg 'medical records and reports from claim 100xxxxxxx'.

Do not create a bulk print on one claim and then move it to another claim, renaming it and using it in a referral for advice as it will not appear in any file copy subsequently used.

-  Manage document groups
- d** Create a referral-specific document group with today's date and name it 'External Clinical Advice'.
- e** Perform final privacy check as per step 3.0, b on any documents that have been added to document group called 'External Clinical Advice'.

- NOTE** What if more than one ECA is requested for the same claim?
- Perform privacy checks as per step 3.0, b on documents to be sent to any other ECA.

- NOTE** What do you need to document on Eos regarding privacy checks?
- Create a contact in Eos stating you have completed privacy checks for the document group labeled 'External Clinical Advice' and the date this was done.

- f** From the Recovery Plan, add an activity for NGCM - Manage Referral task and choose the External Clinical Advice type.

NOTE How do you generate and send a referral task for Recovery Administration?

Go to System Steps NGCM Create a Referral Task.

What if this is a Mesh claim?


In the e-form sub-specialty list select Other, then use the free type box to note Mesh and note preferred specialist

 Creating Manage Referral Tasks - System Steps

NOTE How do you complete the eform that is associated with the External Clinical Advice type?

- Select specialty and sub-specialty
- Record the basis of the claim in the 'Questions for referral' field, then leave a space
- Enter your specific ECA questions in the 'Questions for referral' field, then leave a space
- Specify if you need to re-refer to a specific ECA

It is not necessary to link the document group to the task. The recovery administrator will be able to locate the corresponding document group that has been correctly labelled.

 Clinical questions guide

NOTE What if hard copy clinical evidence needs to be sent with the referral (ie specimens and radiological imaging)?

- send the whole ECA referral yourself via courier so the hard copy clinical material is together with the full referral. See below note about additional information you need to include in the task.
- complete activity 7.0 when you receive a General Task from Recovery Administration notifying you this is ready.
- if you need to send hard material, also record in the task description "Hard material - Specialist Cover Assessor will send referral".

NOTE What if additional clinical information is received after the referral has been sent to the provider?


- create a CM03 blank letter addressed to the ECA provider advising that we are sending additional information for them to consider as part of their report and state clearly what the additional information is (eg Medical notes from General Practitioner Dr XXX).
- create another document group that will include a CM03 blank letter and the additional clinical information for the ECA.
- create a NGCM Send Letter task and link the documents for recovery administration to send on your behalf.
- complete privacy checks as per step 3.0, b and document in a contact on Eos.

- g** Set the priority indicator on the task to 'high'.

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

If required information is missing from the task, contact the task creator.

If you need guidance on working within the Administration Team, refer to the link below.

 Principles of Working in the Administration Team

NOTE What if the referral task indicates the referral is urgent?

Contact the task creator to discuss the urgency and work together to progress the urgent referral.

5.0 Identify available ECA

Recovery Administrator

- a** Check the Treatment Injury ECA Referral tool for the medical discipline and speciality requested and confirm the next ECA provider in line to receive a referral.

 Treatment Injury ECA Referral tool

NOTE Where can you find guidance on how to use and update the referral tool?

The TI ECA Tool Guidance Info document is located in the referral tool using the weblink provided above or watch an instruction video below.

 TI ECA Referral Tool Training Videos

NOTE What if the referral task indicated the referral is urgent?

Work with the task creator to facilitate discussions with the relevant ECA provider to accept an urgent referral.

NOTE How do you know which ECA provider to use?

- review the medical specialty and sub-specialty requested in the task.
- search for providers which match the above requirement in the Treatment Injury ECA Referral tool:
 - Open Provider details and filter Specialty and Sub-specialty (eg General Medicine, Infectious Diseases)
 - Note the geographical location of the client and select a provider from outside of the client's geographical location.

If there are no providers outside of the client's geographical location, advise the task creator and discuss alternatives and/or email your Client Service Leader who will escalate to Clinical Services for resolution.

4.0 Review referral 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 How do you confirm the provider is available and has capacity to receive a referral?

In the Provider details tab of the Treatment Injury ECA Referral tool check:

- their availability is "Yes".
- the provider's Annual Practising Certificate (APC) is current.
- the notes section, some providers like to be called and asked whether the basis of the claim is within their scope of practice prior to us sending the request.
- compare the maximum referrals recorded (signalling the number of referrals they can manage at any given time), with the current volume already referred or wait-listed, and waiting receipt of advice
- If the maximum number of referrals has been reached and the referral is wait listed or waiting for an appropriate ECA provider to be recruited with the specific specialty needed. If so the Recovery Administrator to contact the task creator to let them know.

If in doubt, or specified by the provider, contact the provider to confirm capacity.

If the maximum referrals has not been reached and there is no wait-list, the provider has capacity to receive a referral.

NOTE What if you can't confirm the provider has capacity to receive a referral?

Select the next appropriate provider with the right specialty and sub-specialty.

NOTE What do you do if all providers with the required specialty and sub-specialty are at full capacity?

- 1) Extend the due date of the task, aligning it to when the soonest expected due date for receipt of an ECA from the identified providers this will keep the referral delay to a minimum.
- 2) Record a rationale in the task as to why you are extending the task due date this will help identify through reporting if additional ECA providers need to be recruited and added to the list.
- 3) Go to step b.

NOTE What do you do if there are no ECA providers on the Provider details tab with the required speciality and/or subspecialty?

- Email your Client Service Leader with the issue and they will escalate to CSAdminTeam@acc.co.nz for resolution.
- Extend the due date of the task out to three days to follow up resolution and record reasons why the task due date is extended. This information will be extracted for reporting as part of improving the ECA service.

- b** Update the booking schedule recording the relevant details in the appropriate fields against the confirmed selected provider.

NOTE How do you correctly update the booking schedule?

Refer to 'Populating & Maintaining the Booking Schedule' within the TI ECA Referral tool Guidelines document located in TI ECA Tool Guidance Info for full instructions on how to and what should be recorded in the columns.

When entering a new referral request:

- 1) From the Booking Schedule, click the '+ New' button on the top left of the screen
- 2) You will be presented with a form on the right side of the screen. Populate the applicable fields (refer to guidelines for definitions if necessary). When complete, click 'Save'.

When updating an existing referral request entry:

- 1) Select the referral request entry you wish to update.
- 2) Click edit.
- 3) You will be presented with a form on the right side of the screen. Update as necessary and click 'Save'.

NOTE Why is it important to correctly update the booking schedule?

It is vitally important that the tool is updated and that requests that have been received are removed from the list. This allows users of the tool to accurately assess the work load of providers. This will enable visibility to your colleagues of referrals sent, when ECA is due, referrals on the waiting list and when provider has capacity so that another referral can be released.

NOTE How do you manage urgent referrals when other referrals are on the waiting list with a provider?

Contact the Specialist Cover Assessor who requested the referral and work together to enable the referral to be placed at the top of the waiting list queue.

This should involve discussions with other Specialist Cover Assessors to agree priority based on each client situation, and to enable Specialist Cover Assessors to update clients on the status of their referral and expected timeframes.

NOTE What if this is a mesh claim?

In the task sub specialty will be noted as mesh. If a specialist is noted, find them in the ECA list. If no specialist is noted, filter by Mesh in sub - specialty (pending ECA tool update)


6.0 Create purchase order

Recovery Administrator

- a** In Eos, create a Purchase Order for the ECA referral by referring to the details in the e-form.

NOTE What do you add to the purchase order?

- In 'General Q+E' tab select 'Cover Assessment' under Rehabilitation Action, 'Treatment Injury-Cover' under intervention, and 'Non-Contracted' under Purchase Method.
- On Select Ent - select ECA01
- Enter 10 units for quantity approved and set frequency as 'Quarter'

 Create a purchase order


- b Add the vendor to the purchase order, as identified in the ECA booking schedule and Provider details, ensuring the vendor is also added as a participant on the claim.

- c Approve the purchase order.

NOTE What if the purchase order requires a higher delegation?

Save the purchase order and create and send a Request Authorisation Task from within the purchase order and send to a Recovery Leader for approval.

Refer to the link below.

-  Request Authorisation for a Purchase Order - System Steps

NOTE What if you get a 'Limited Payment' error message when authorising the purchase order?

Change the limited payment indicator.

- 1) In Eos, go to the 'Validations' tab, select 'Edit' and update the Limited Payment List Indicator to 'No'.
- 2) Select 'OK'.
- 3) Go back to the purchase order to authorise.

Once you have authorised the purchase order, remember to change the Limited Payment List Indicator to 'Yes'.

7.0 Create and send referral documents

Recovery Administrator, Specialist Cover Assessor

- a Create and edit the T140 External Clinical Opinion Request - Vendor letter (do not complete the document until sent to the vendor - this will allow the vendor to edit the document and enter their findings), populating with the extra information noted in the ECA task. Ensure you check that all relevant information within the task has been captured.

-  ADMIN TEMPLATE - External clinical advice.docx

NOTE When would a Specialist Cover Assessor complete this activity?

Only when hard copy clinical material is to be sent.

Recovery Administrators will complete the T140 as much as possible and save the document as Incomplete. Upon receipt of the General Task from Recovery Administration, the Specialist Cover Assessors will then edit the rest of the document through to completion and send the referral documents, ensuring all steps outlined in this activity are completed.

NOTE For Recovery Administrators: What do you do next if the referral task only requested a Purchase Order creation and approval due to hard copy clinical material needing to be sent by the Specialist Cover Assessor with the referral?

- 1) Ensure you have edited the T140 as much as you can and save the document as Incomplete.
- 2) Create a General Task and record that the purchase order has been approved and the referral is ready to be completed.
- 3) Add the purchase order number to the task description.
- 4) Transfer the General Task to the referral request creator.
- 5) Close the Medical Assessment Referral task.

Go to step 8 (the Specialist Cover Assessor will complete the rest of this activity).

- b Link the referral to the document group 'External Clinical Advice'.
- c Perform privacy checks using the Inbound and Outbound Document checks.


-  NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

- d Check the provider's preference for receiving the referral. If the providers preference is by email and the request is not associated with hard copy material, Recovery Administrator to ensure the provider's email address has been verified.

Update the Booking schedule in the Treatment Injury Referral tool with the date the referral is sent.

NOTE What if the email address has not been verified?

Go to (NGCM) Verify Provider and Vendor email addresses process.

-  **PROCESS** Verify an Existing Provider, Vendor or Facility Email Address

-  Treatment Injury ECA Referral tool

- e Create email using the requests and referrals template and attach the referral and document group.

-  Emailing from Eos using a template - System Steps

NOTE If you are unsure contact the ECA provider directly.


NOTE What if the document is too large to email?
Break it up in chunks, if required.

NOTE What if the request is urgent?
State this clearly in the email.

NOTE What if the referral documents need to be sent via courier?

Recovery Administrators - Refer to the process link below (NGCM) Prepare and Send Client Information by courier.

Specialist Cover Assessors - Refer to the Information link below Sending medical material to External Clinical Advice

-  **PROCESS** Prepare and Send Client Information by Courier

-  Sending medical material to External Clinical Advice

- f Complete a final dispatch check to ensure the client and vendor details are correct.

- g** Send the email or courier to the ECA provider. Use the email address provided under the Treatment Injury ECA Referral tool.

NOTE What if the TI ECA provider requests an update to their details or availability?

Pass the information on to CSAdminTeam@acc.co.nz (Attn: [Out of Scope]) to have the Provider list in the TI ECA Referral tool updated.

- h** After sending the incomplete TI40 letter to the vendor, save the document as complete this will allow the document to be edited by the vendor (to convert the document into a non-editable pdf).
- i** Close the assigned task and create a new "NGCM - Admin Request" task, edit the task description with "ECA Follow Up" Provider Name and Due Date. Set the due date for three weeks' time and put back into the queue.
- j** Check that you have correctly updated the Booking Schedule in the Treatment Injury ECA Referral Tool (locate the entry with your clients name and the vendor who has been previously selected under point 5.0), with the date the referral was sent to the vendor and then calculate a six week ECA report due date (first follow up on ECA referral at 6 weeks then 4 weekly after that).

NOTE Specialist Cover Assessors sending the referral will need to update the spreadsheet with the date referral sent and ECA due date.

8.0 Follow up request for external clinical advice Recovery Administrator, Specialist Cover Assessor

- a** Upon receipt of the NGCM - Admin Request task, perform a check of the documents on the claim to confirm the requested information has been received.

NOTE What if the ECA has been received?

- 1) Update the Booking schedule in the Treatment Injury ECA Referral tool with the ECA received date.
- 2) Close the "NGCM - Admin Request" task.
- 3) Create "NGCM - Action Attached Documentation" task and tick the box "Assign this work to me" at the bottom left of the EOS page so that you can make edits. Select next.
- 4) Write in task description "ECA received from Dr (enter name and specialty)", then allocate task to case owner/Specialist Cover Assessor.
- 5) Check if there is another referral on the waiting list for that provider that can now be sent to the ECA. If so, locate the referral task, change the due date to today's date, and record in the task description that the provider can now receive the referral.
- 6) Change the task to high priority so that the task can be allocated and actioned same day.

- b** Contact the ECA provider to follow up on the report if the ECA has not been received.

NOTE How do you contact the ECA provider to follow up on the report?

- 1) You can contact the provider by email or phone call and advise the ECA provider that the report is due back to ACC.
- 2) Check if referral has been received by them.
- 3) Ask the provider what the expected timeframe for ACC to receive this report.
- 4) Document this clearly in the contacts of the claim with the follow heading: ECA PROVIDER CONTACTED and write within the contact the agreed timeframe to receive the report.
- 5) Alter the 'NGCM - Admin Request Task' to reflect the new agreed timeframe or three further weeks and place back in the queue.

NOTE What if the provider can't complete the referral?

- 1) Make note and close follow up task.
- 2) Mark as report received in booking tool and note that the provider declined the referral.
- 3) Call specialist cover assessor and ask them to make a new task and make mention to not refer to previous provider OR indicate an alternative provider.
- 4) Consider if the provider's availability needs to be changed due to reason of the declined of services.

NOTE What if the ECA provider is not responding to follow ups?

If you experience repeated difficulty communicating with the provider, eg provider is not responding to a mix of emails and phone calls after three attempts, it is reasonable to engage the task creator to determine if the referral should be cancelled and a new referral sent to another ECA provider next on the list who has capacity to receive the referral.

NOTE What if the ECA provider indicates a lengthy delay and they haven't commenced the review?

ECA Providers are very good at advising delays or that they are unable to undertake the work. Some examples of this are, taking leave, or experiencing an increased workload in their routine practice (outside of ECA) and therefore unable to provide reports. If this occurs, inform the Specialist Cover Assessor and determine if the referral should be cancelled and a new referral sent to another ECA provider next on the list who has capacity to receive the referral.

NOTE For how long should you continue following up for the ECA report?

You should continue to follow up the ECA report for as long as required until the ECA report has been received.

NGCM - Admin Request tasks for follow up of the ECA report should never be closed unless the report has been received or you have been advised by the Specialist Cover Assessor that follow up is no longer required.

- c** Extend the NGCM Admin Request to reflect the earlier of the new agreed timeframe or three further weeks and place back in the queue.
- d** In the Booking Schedule, add in the comments field that follow-up has occurred and the expected new date of receipt of the ECA report.

NOTE Do not change the initial six week ECA due date recorded in the Booking Schedule as changing due dates will incorrectly inform provider service level agreement monitoring occurring in another part of the business.

 **PROCESS**


**Make cover or funding decision ::
Make Treatment Injury cover decision**
Cover Assessor, Specialist Cover Assessor

- e Receive the ECA report or the Alert: You Have Mail task notification from the Inbound Document Management Team that the ECA report has been attached to the claim, open and review the document.

NOTE What if you are a Specialist Cover Assessor and you receive the ECA report directly from the provider and upload it yourself?

Do not cancel the NGCM - Admin Request follow up task - update the task requesting the admin team to update the ECA booking tool and change the target date and priority level. This will allow the admin team to close the task after the ECA booking tool has been updated to avoid delays for other clients on the waitlist.

- f Perform Privacy and Relevancy checks on the received report.

 NG SUPPORTING INFORMATION Inbound and Outbound Document Checks

9.0 Review report

Specialist Cover Assessor


- a Review the report to ensure there are no clinical issues and that it is complete.

NOTE What if there are quality clinical issues or completeness concerns?

You are encouraged to deal directly with the Provider where you can, particularly if the concerns are around the completeness of the report, omissions or redactions.


However, where the quality of a report potentially falls below expectation and there may be a need to provide feedback to the ECA, these situations can be referred to a Clinical Advice Manager for consideration. The team will help you by reviewing the report and where necessary talking with the ECA Provider.

If you have any concerns relating to the quality of any ECA reports, please email the case and a summary through to CSAdminTeam@acc.co.nz.

 **PROCESS** Address Treatment Injury ECA Performance Issue

10.0 Determine next steps

Specialist Cover Assessor

- a Review ECA report and determine next steps.
- b Contact the client and confirm you are speaking with the right person by asking ACC's identity check questions.
 -  Identity Check Policy
- c Discuss the report and next steps.
- d In Eos, add a contact as a record of the conversation.
- e Go to 'Assess Cover for Treatment Injury Claim' step 5.0 Review additional information.



[Back to search results](#)

[Export](#)

Rule Name	Written communication of decisions
Statement	A written communication relating to a decision about a claim of a client must always be sent via one of the following: <ul style="list-style-type: none"> • Letter • Email
Motivation	This ensures staff comply with what ACC has identified as the meaning of written notice when communicating about any decision on a claim as required by the AC Act 2007
Rule ID	SupNot-003
Owner(s)	Manager Technical Services
Business Term(s)	written communication
Business Rule Group(s)	Claim , Client , Decision , Entitlement , Supports
Source(s)	Business Decision: Support Notification Business Rules - NGCM

Additional Information

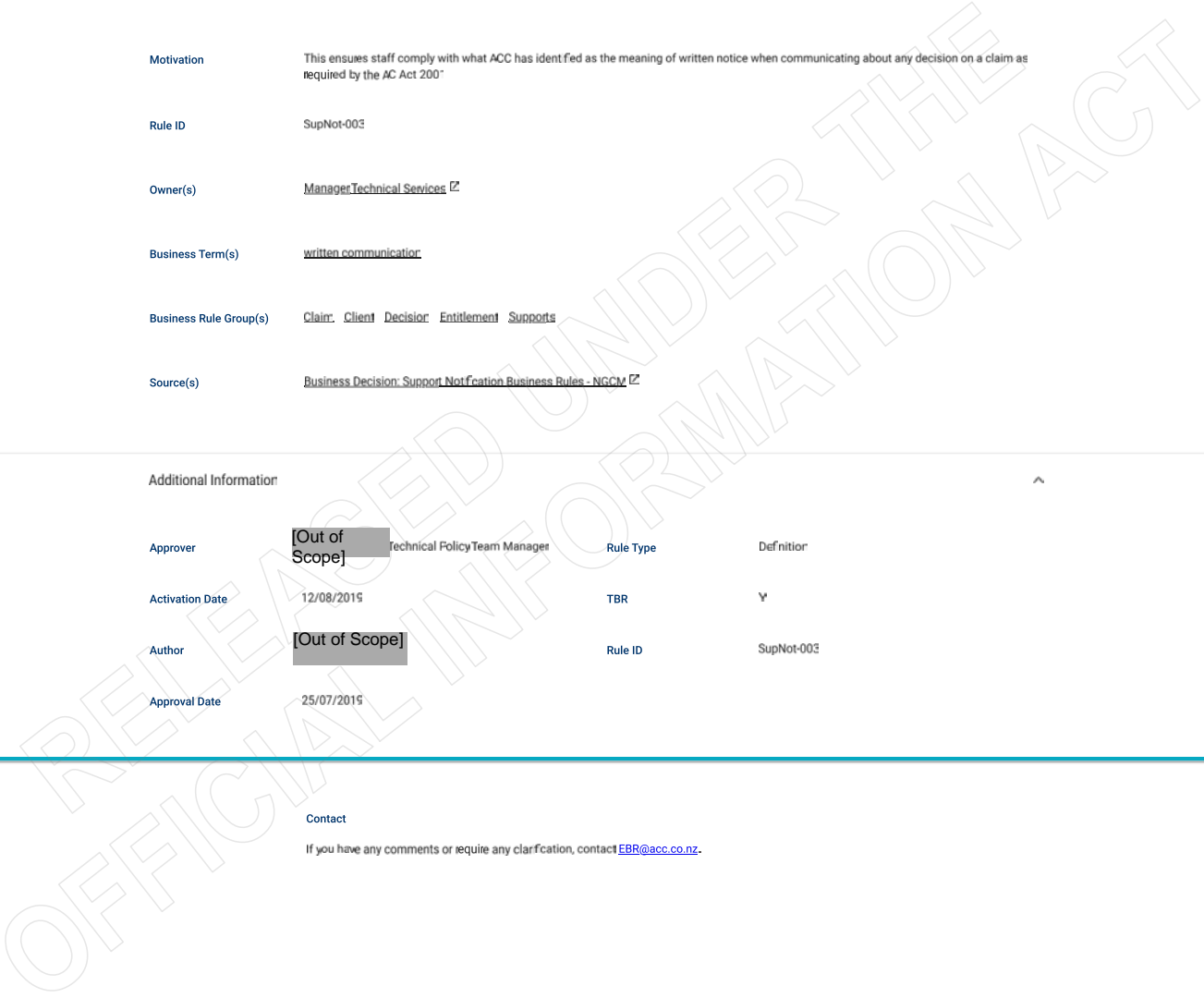
Approver	[Out of Scope] Technical Policy Team Manager	Rule Type	Definition
Activation Date	12/08/2015	TBR	Y
Author	[Out of Scope]	Rule ID	SupNot-003
Approval Date	25/07/2015		

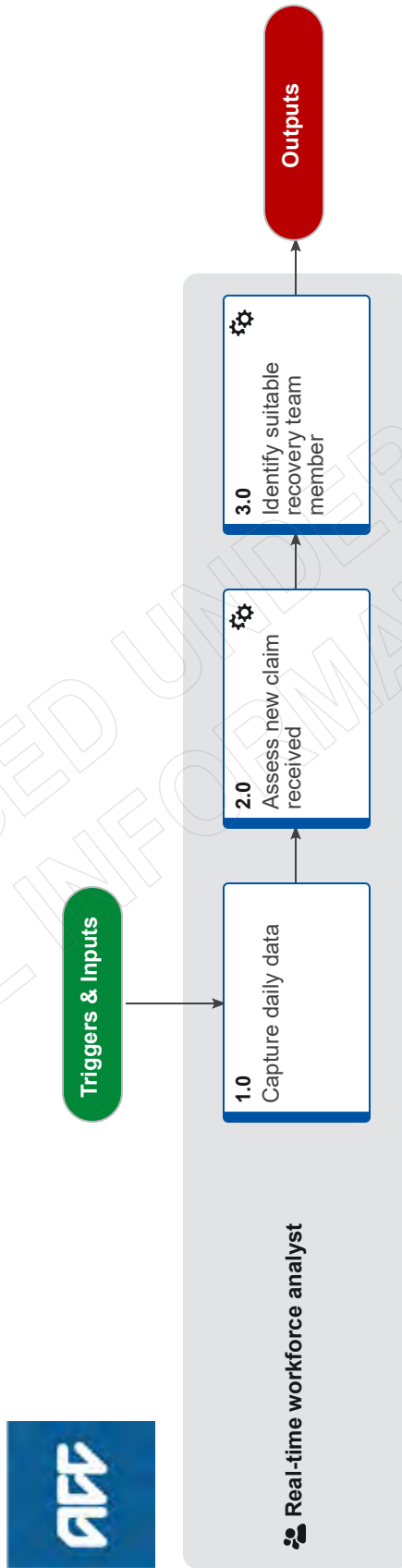
Contact

If you have any comments or require any clarification, contact EBR@acc.co.nz.

Retrieving Rules and Terms with all custom attributes

Searching Business Rules for 'written communication'





Summary

Objective

To allocate claims to individuals in the Partnered and Supported teams so that clients can be supported through their recovery. The number of claims will be monitored in this process to ensure workload and workforce management processes are triggered when required.

Background

Clients being managed by the Supported and Partnered Teams have a single point of contact at ACC, which means the whole claim (rather than just tasks) need to be assigned to a recovery team member to begin managing the client's recovery.

Owner

[Out of Scope]

Expert

Procedure

1.0 Capture daily data

Real-time workforce analyst

- a Receive updated capacity information and planned/unplanned leave by 9am each day.
- b Analyse the data to confirm who has capacity in each site via the allocation tool.

2.0 Assess new claim received

Real-time workforce analyst

- a In Eos, receive the incoming claims in the Supported and Partnered Department queues.

NOTE What if your claim needs specific allocation requirements?

WFM does not read specific information on claims in either contacts or tasks in relation to allocation needs. If you need the claim to be allocated to a specific person/location/other requirement, please email wfm@acc.co.nz at the time of transfer highlighting the requirements so that it can be taken into consideration.

- b Review the claim type and specific needs. Refer to the NG GUIDELINES Whole of Person Guidelines and Allocation Rules.

NOTE What claim types and specific needs should I be looking for?

- Sensitive Claims for children and adolescents
- Serious injuries for children and adolescents
- Complex mental injuries
- Complex physical injuries

 Whole of Person Guidelines

- c Review the claim queue and ensure the claim is in the correct queue

NOTE What if the claim is in actioned cases?

If the claim is in actioned cases, move the claim to the right queue otherwise the tasks may continue to be routed to the action cases queue.

3.0 Identify suitable recovery team member

Real-time workforce analyst

- a Determine which site the claim should be managed in.

- b Within the preferred site, consider the current caseloads of available staff and identify those with capacity.

NOTE What are the rules for allocating work to Supported Recovery?

Supported Allocation rules:

- Allocations are determined daily by the supported allocation tool. The tool will determine the appropriate skillsets and advise where the claim needs to be allocated.

- New team members will receive allocations through the capability tool based on the post-induction allocation plan. Leaders to advise WFM if this needs to be altered for specific Recovery Coordinators

- Allocations are made anytime up until 2pm. RTA's have the provision to allocate until 3pm if required but WFM will advise team leaders when this occurs.

- Allocations will be distributed as evenly as possible across the available FTE for the day.

- Requests for specific allocations/redistributions need to be completed through the "submit claim movement" ORCA tool on the sharepoint page and then move the claim into the Supported Recovery Department queue in EOS

- If an additional claim comes in for an already managed client, this will be allocated to the current Recovery Coordinator (even if they are on leave). It will not be counted as a new allocation however will be added to the total claims on hand.

- If a claim is reopened under 90 days after being closed by a Recovery Coordinator then the claim would go back to them if they are available, and will still be counted as an allocation. If the previous Recovery Coordinator is not available, the claim will be allocated to a different Recovery Coordinator.

- If a task is received on a closed claim, the allocation tool will send the task to the previous Recovery Coordinator. If they are not available or their workload does not support this, then the task will be sent elsewhere. This will not be counted as an allocation unless claim is required to be reopened. If this is the case the team leader will complete "submit claim movement" ORCA tool on sharepoint page and move the claim into the Supported Recovery queue in EOS for the tool to count claim as a new allocation

- If allocations are going to exceed 3 allocations in a day, WFM will communicate with the staff member's Team Leader.

 Supported Allocation Exemptions

NOTE What are the rules for allocating work to Partnered Recovery?

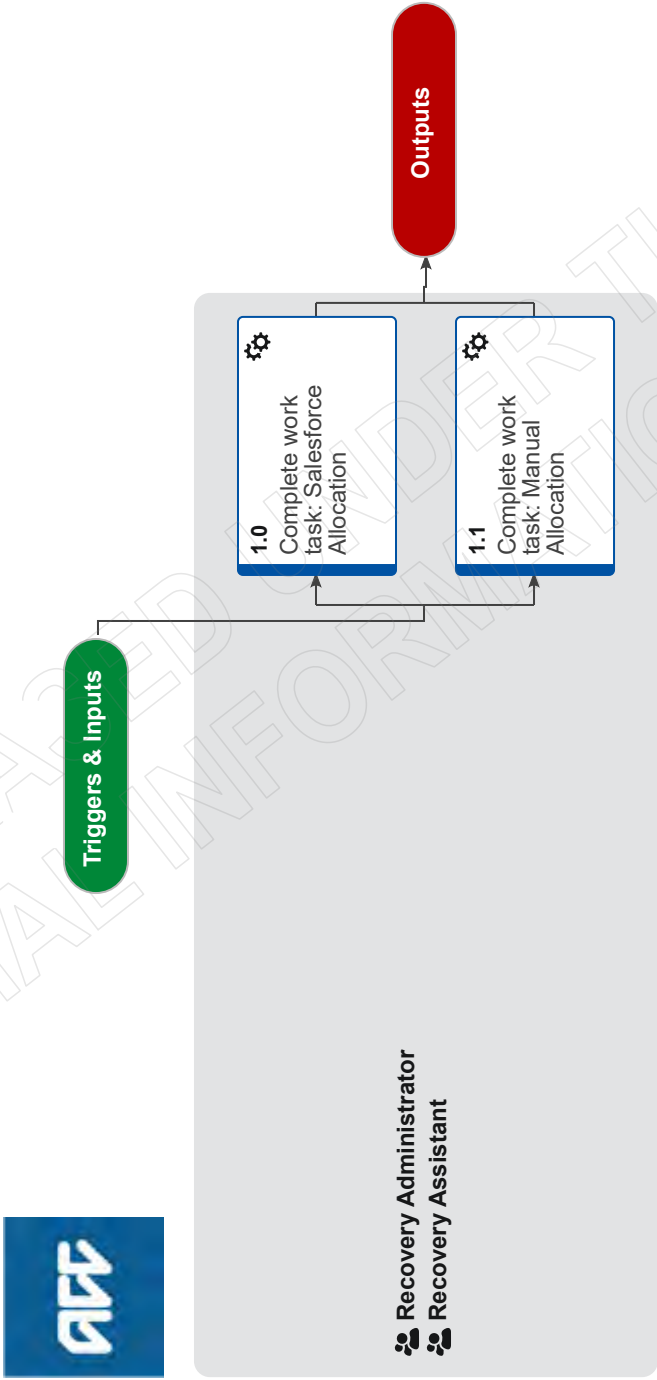
Partnered Allocation rules

- Physical Injury: All claims will be allocated to the local site, or may overflow to the region following discussion with CSL.
- Mental Injury: Priority for new allocations is within local site, and reengagements are to be with previous Recovery Partner (next priority would be within the same team/site). Claims are allocated based on a % allotment approach where each site receives the % of allocations equal to the % of overall FTE they have.
- Child and Adolescent claims will be allocated to Team Members with this preference, confirmed by their Team Leaders. All C&A claims will be allocated to client's region, and will only overflow out of site after approval from CSL.
- Allocations are made anytime up until 2pm. RTA's have the provision to allocate until 3pm if required but WFM will advise team leaders when this occurs.
- Requests for specific allocations/redistributions that are emailed through to WFM are likely to be actioned the following day due to allocation process requirements
- All reopened claims will go back to the previous Recovery Partner if available (PI - as long as they are at their home site). These will all be counted as an allocation for the day.
- If a task is received on a closed claim, the task is to be sent to the previous Recovery Partner. If the previous RP is unavailable, then the task can go to someone else in their team as an allocation. If there is no previous RP, then it will go to a staff member with lower allocations for the day at the client's home site. Once the task has been assessed by the Recovery Partner, if the claim needs to be reopened an email needs to be sent through to WFM to advise of this, including if it needs to be counted as an allocation or reallocated out to another RP due to availability, etc.
- If a Recovery Partner receives three or more allocations in a day, RTA will send an email to their Team Leader to advise.

 Partnered Allocation Exception Guidelines

- C** Assign the claim to the most appropriate recovery team member via the allocation tool.
Note that RTA's do not manually transfer claims in EOS.

 Transfer a claim



Summary

Objective

To allocate and action tasks to yourself within the Assisted Recovery and Recovery Administration teams so that tasks can be completed or progressed.

Background

The Assisted Recovery and Recovery Administration teams complete work by task allocation. As they're working in a one-to-many structure, Eos or Salesforce allocates the next priority task to each team member.

If Salesforce is unavailable, the leader needs to be advised and tasks will need to be manually allocated from Eos. If Salesforce has allocated a task, it will allocate any other overdue tasks on the claim (including Eos tasks and email tasks). If there are other tasks on the claim that are not overdue but can be actioned, these will need to be manually assigned in Eos.

One task should be taken at a time. Any tasks held in a personal queue should be completed as they are picked up. Tasks should only be held in a personal queue when inbound calls need to be answered during peak times. Once the post call activities are completed the allocated task should be completed.

Owner

[Out of Scope]

Expert


Procedure

1.0 Complete work task: Salesforce Allocation Recovery Administrator, Recovery Assistant

- a In Salesforce, ensure your user status is set to 'Available'. This will allow you to receive the next priority task.
- b Receive the work task and identify what actions are required to complete it and determine if you have enough information to progress.

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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to the link below.

 Principles of Working in the Administration Team

NOTE What if there are other tasks due on the claim that could also be actioned?


For Recovery Assistants, Salesforce will allocate your Eos task along with any other overdue tasks on the claim, this includes email tasks linked to the claim. To review the other tasks allocated to you, check your 'My Assigned Tasks' list view in Salesforce.

If there are other tasks on the claim that aren't overdue but can be actioned, you will need to assign those tasks to yourself from Eos so they aren't picked up by anyone else.

- c Complete the actions required.

NOTE What if assistance is needed to complete the actions?

Consider the following to assist:

- Promapp
- Induction materials
- Contact a Practice Mentor
- Use the Seek Internal Guidance process
-  **PROCESS** Seek Internal Guidance

NOTE What if the actions can't be completed for an Eos task?


For Recovery Admin: Refer to NG Principles Working in the Administration Team.

For Assisted Recovery: If the assigned task is unable to be completed and the task is for Recovery Check Ins, Agreed Interventions, Contact actions, and Reminder actions:

- Go to the Recovery Plan timeline
- Edit the action noting the change reasons and new date
- Save
- Transfer the task back to queue in Salesforce. The task will show the updated details from when the timeline action was updated.

If the assigned task is unable to be completed and is not one of the above tasks:

- Return the task to the queue using Salesforce
- Update the due date and description of the action required in the form on Salesforce
- Save the form and it will automatically return the task back to the queue

 Principles of Working in the Administration Team

NOTE What if the actions can't be completed for an email task?

File the email away to Eos and create the appropriate action/task for what needs to be completed

NOTE What if the post call actions following a phone call cannot be completed?

In the case that you receive a phone call that goes beyond when you're scheduled to finish work, complete any actions that require immediate attention i.e. weekly compensation. For all other post call activities required, ensure the appropriate reminder tasks are set for a colleague to complete when applicable. Please talk to your team leader about managing this appropriately, for example, by coming in a few minutes later the next day, or later in the week.


- d Close the task and then go back to Step a to complete the next task.
- e The process ends here.

1.1 Complete work task: Manual Allocation Recovery Administrator, Recovery Assistant

- a In Eos, open your department queue, select your role and use 'Get Next' to transfer the next priority task to your queue.
- b Identify what actions are required to complete the task and determine if there is enough information to progress.

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

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to NG Principles Working in the Administration Team

 Principles of Working in the Administration Team

NOTE What if there are other tasks due on the claim that could also be actioned?

You can action multiple tasks, however there are different scenarios to consider before deciding to action other tasks found in the claim:

- Overdue tasks are to be actioned at the same time.
- An overdue task and a task due the following day can be actioned by the same team member.
- An overdue task and a task due today can be actioned by the same team member, however it is important to transfer the task to yourself in Eos to minimise the chance of the task due today being allocated to another team member.
- An overdue task and a task due in the future, complete the overdue task and leave the other task for when it is due.
- There is a complementary task requiring action (ie MCR and Travel).

C Complete the actions required.

NOTE What if assistance is needed to complete the actions?

Consider the following to assist:

- Promapp
- Induction materials
- Contact a Practice Mentor
- Use the Seek Internal Guidance process.

 **PROCESS** Seek Internal Guidance

NOTE What if the actions can't be completed for an Eos task?


For Recovery Admin: Refer to NG Principles Working in the Administration Team.

For Assisted Recovery: If the assigned task is unable to be completed and the task is for Recovery Check Ins, Agreed Interventions, Contact actions, and Reminder actions:

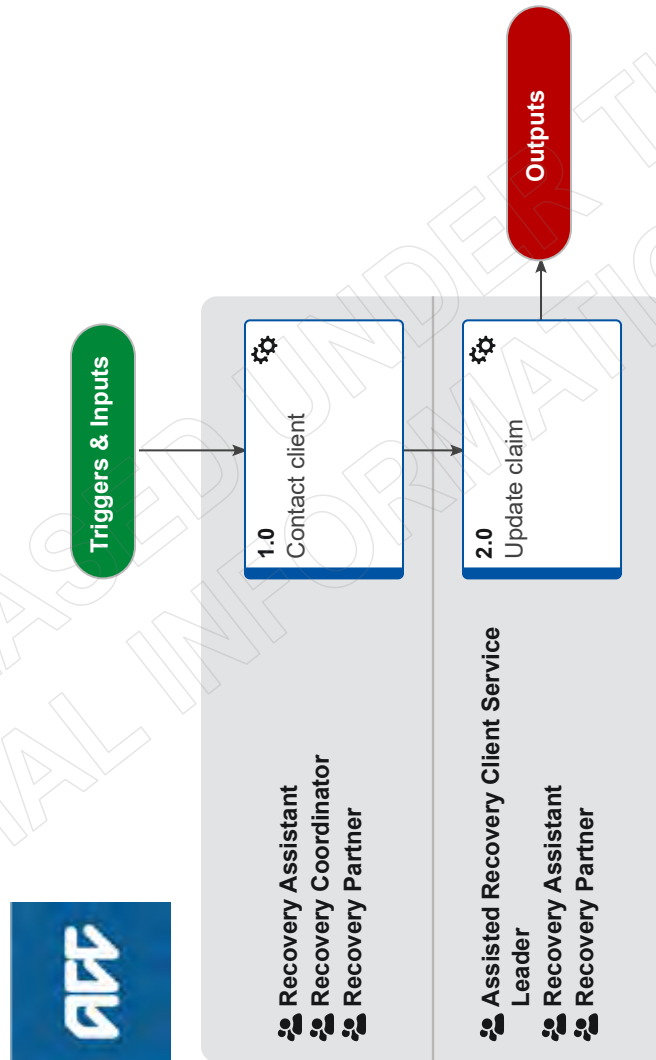
- Go to the Recovery Plan timeline
- Click the action and update the description with the reason the task could not be completed before selecting [Next].
- Transfer the task back to queue in Salesforce. The task will show the updated details from when the timeline action was updated.

If the assigned task is unable to be completed and is not one of the above tasks:

- Return the task to the queue using Salesforce
- Update the due date and description of the action required in the form on Salesforce
- Save the form and it will automatically return the task back to the queue

 Principles of Working in the Administration Team

d Close the task and go back to Step 1.1a to complete the next task



Summary

Objective

To setup an eligible claim where we have identified that the client has since left New Zealand for more than three months so that we can continue to support them.

Background

An overseas claim is where a client already has cover for a personal injury and qualifies for support and now lives outside of New Zealand. Overseas claims do not apply to clients ordinarily resident in New Zealand who incur an injury while overseas and seek cover for their injury on their return to New Zealand.

Owner

[Out of Scope]



Expert

Procedure

1.0 Contact client

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Review the claim history and the following policies to understand Overseas Claims.



-  Overseas Claim Policy
-  Payments to Clients Outside NZ Policy

- b** Confirm that the client has moved or is moving overseas for more than three months.

NOTE What if the client is overseas for less than three months?

If a client is in receipt of weekly compensation and is on holiday or living overseas for less than three months:

- you must manage them as if they were on holiday within New Zealand.
- ACC will only pay them weekly compensation or Independent Allowance Lump Sum (IALS). You must pay any amounts into a New Zealand bank account. See Payments to clients outside NZ.
- we do not pay for any GP visits, treatment, rehabilitation or social rehabilitation. See Accident Compensation Act, Section 128.
- the client is still required to participate in any vocational rehabilitation outlined in their Rehabilitation Plan, but at their own expense.

-  Payments to client outside NZ policy
-  Accident Compensation Act, section 128 - Payment for rehabilitation to claimant outside New Zealand <http://www.legislation.govt.nz/act/public/2001/0049/lat>

- c** Generate the 'OCU01' in Eos and manually replace the address details under the "Help us pay our client faster" with the following:

ACC
PO Box 952
Waikato Mail Centre
Hamilton 3216
New Zealand

Email: claimsdocs@acc.co.nz

Also remove the fax number from the letter.

NOTE Purpose of Letter

For the client to take to their treatment provider when overseas, it explains what is required in terms of medical certification.

- d** Send the completed OCU01 to the client along with the 'OCUIS01 Going Overseas' information sheet.

 OCUIS01 Going Overseas

NOTE Incorrect Version of OCUIS01 in EOS

When sending the 'OCUIS01 Going Overseas' information sheet this needs to be generated from Promapp FLIS link above.

NOTE What if the client has moved/is moving to Australia?

Clients in Australia have different tax obligations to other countries.

Create a 'CM03 - Blank Letter to Claimant' in Eos.

Copy the text from the 'Australian Tax Letter' below into the subject of the letter and send the letter to the client.

For more information, refer to the 'Taxation and double taxation agreement (Australia)' section of the Overseas Claim Policy.

 Australia Tax Letter

 Overseas Claim Policy

- e** Explain the obligations the client must meet to receive entitlements.

NOTE What are the client's obligations?

1. Continuing treatment/rehabilitation in a timely manner appropriate to availability in NZ. Some source via public health systems and these have long waitlists so are not ideal.

2. Supplying ACC medical information. Obtaining reports from ALL treatment providers to forward to ACC. Suggest they request these at completion of each consultation. This can be troublesome for the client and may need to supply a letter requesting information for client. Ensure that treatment provider is aware that any cost is the responsibility of the client (Section 128).

3. Supplying medical certification that meets ACC requirements. TS advice when receiving certification that does not meet requirements, process as case manager extension for 4 weeks and ask client to get cert amended.

2.0 Update claim

Assisted Recovery Client Service Leader, Recovery Assistant, Recovery Partner

- a** Activate the 'Overseas More Than 3 Months' Party flag in Eos to show that the client is or will be living outside New Zealand for longer than three months.

 Add a party flag (Eos Online Help)

- b** Update the client's notification preferences by ticking the "Stop Notifications" option on the party record.

 NG Guidelines Email and SMS Notifications

- c** Update the client's details as necessary with their overseas address and contact details.

NOTE What if the client's weekly compensation requires abatement?

Overseas earnings are abated using payslips. Exchange rate information should be taken from the Crown Revenue website – <https://www.rbnz.govt.nz/statistics/b1>

The last day of the abatement period rate should be used as these vary over a week. As these are weekdays only, use most previous if working week ends on weekend. Task is entered in comment box as – 15/3/19 – 21/3/19 20 hours \$400aud = \$429.12 .9521 (applicable exchange rate for 21/03/19).

Some have rolling abatements which is easier if their hours do not change significantly but a wash up is recommended of not amended when payslips available. Self employed abatement is as above but elect self employed as per standard practice.

NOTE How do you request clinical records for an overseas client?

The ACC6300 does not extend beyond New Zealand. Therefore, ACC cannot request information directly from treatment providers. Obtaining medical reports and information for ACC are the client's responsibility. This can be more difficult if they are being treated via a public health system. Requesting consultation notes from the doctor may also need a supporting letter from ACC as patients don't have the same access to these as we do in New Zealand. It is important that if you include that any cost for these are the client's responsibility on the letter.

Psychologist reporting is not objective based from overseas providers. A solution is to provide clients with ACC forms (ACC266/267/268) amended to remove CM approval and funding comments so their provider has an understanding of the information we require or may elect to use these. Check qualifications of provider as some are not psychologists but counsellors or social workers.

NOTE What if you receive certification that does not meet ACC requirements?

The client may need to return to the doctor to get this amended. In this situation, add an extension of 4 weeks only to allow this to happen. If you have the doctor's name and address you may send them a letter directly.

If the doctor supplies a letter in place of a certificate, it must still include:

- Client's name, address, date of birth
- Date of injury
- Pre-injury role (unfit to perform)
- Diagnoses/symptoms
- Timeframe up to 13 weeks
- Treatment plan
- Details and signature of treatment provider
- Signature of client.

This information is to ensure that:

- certificates have a treatment plan, and
- the doctor is aware of the work type they are signing off that the client is unable to perform and what their covered injuries are. NOT just at client's request.

NOTE How do you process medical certificates for an overseas client?

Clinical records for overseas clients are processed the same as a New Zealand certificate on EOS but:

- In the reference number put Overseas Medical Cert
- If dates are not all supplied, process as 13 weeks from doctors date of examination/ signature.
- In Provider ID – K95229 is used

Approve as per normal procedure.

NOTE What teams manage overseas claims?

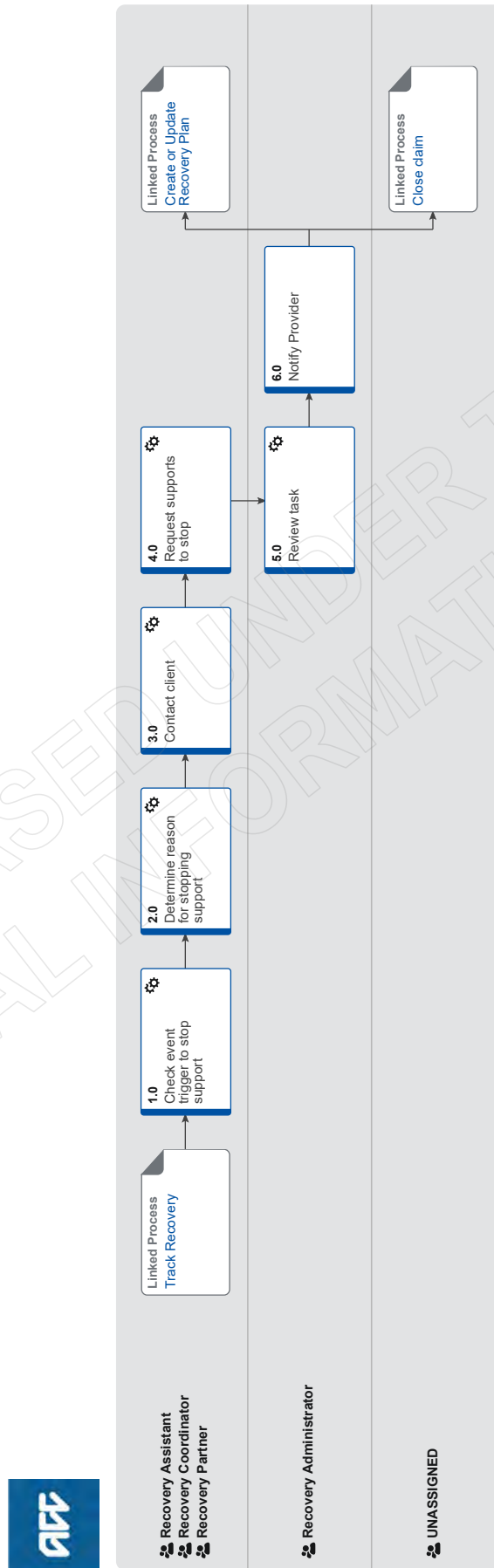
If the claim is a Serious Injury claim then it is managed in Te Ara Tika (in EOS this is Wellington Central Branch queue).

All other claims are managed by Assisted or Supported Recovery based on the clients needs.

NOTE How do you contact an overseas client?

If the client needs to be contacted, the preference is:

- 1) Send the client an email.
- 2) If no response, send the client a letter.
- 3) Phone the client (as a last resort, you will need to request delegation approval through your Team Leader to be able to call international numbers).



Summary

Objective

To stop a support.

Background

A support can be stopped for a variety of reasons, eg if the client recovers more quickly or slowly than expected or because an event has occurred that means the client is no longer eligible.

Owner

[Out of Scope]

Expert

Procedure



PROCESS

Track Recovery

Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Check event trigger to stop support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Review the notification via MyACC, phone, email or in person, to stop a support.

NOTE What if you have received a AUTO Alert: Weekly Comp Ceases 8 Weeks task?

Generate a "Stop Payment task", copy and paste the details from the original task to this task. This will auto-route to the Centralised Weekly Compensation queue for the payments team to action. The payments team will continue with the process below. Close the AUTO Alert: Weekly Comp Ceases 8 Weeks task. This process ends.

NOTE What if the task is about a sensitive claim?

If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims queue.

NOTE What triggers can generate a notification to stop a support?

The following can act as triggers to stop a support:

- Non-compliance
- Suspending entitlements
- Stopping payments
- Confirming WSI (wilful self-inflicted injury) or suicide
- Disentitling due to crime
- When the client voluntarily withdraws
- When the client has recovered more quickly than expected and has gone back to work prior to the expiry of their medical certificate.

NOTE What do you do if you are revoking cover?

Refer to the link below for what to do if you are revoking cover.

 **PROCESS** Revoking Cover

NOTE What do you do if your client is going to return to work?

Refer to the process linked below for what to do if your client is going to return to work

 **PROCESS** Close claim

NOTE What entities or parties can provide a notification?

Notifications from the following can trigger or generate a need to stop a support (these can be grouped as Client, Providers, Internal/External sources, Medical Reports):

- specialist
- GP and or other treatment providers
- other allied services such as data integrity information (i.e. when a client is in prison)
- receipt of a medical certificate or medical information such as medical reports
- other events such as non-compliance
- Vocational Independence (VI)/Medical Case Review (MCR)/Medical Single Discipline Assessment (MSDA) outcome
- information about their earner status (eg self-employed, earner or non-earner)

2.0 Determine reason for stopping support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Refer to the notes below to determine the reason for stopping the support.

NOTE What are the main mechanisms by which supports can be stopped?

There are two ways to stop support:

1) Suspension

We can suspend a support if there is evidence that, although the client might continue to need assistance, they are no longer eligible to receive it from ACC. This means that the client's symptoms or limitations relate wholly or substantially to something for which ACC is unable to grant cover, such as

- gradual process injury disease or infection, that does not have cover itself
- the ageing process
- the client no longer meets the relevant eligibility criteria for a support they are receiving.

2) Disentitlement

the client is remanded in custody or is serving a term of imprisonment

- the client was injured while committing a crime
- the client was receiving an entitlement while serving a term of imprisonment.

NOTE In what other circumstances would we suspend a support?

- the client has an overseas medical certificate that we do not recognise.
- supports can be suspended if the claim was accepted under 1972 or 1982 Act, however the criteria is different, refer to the 'Suspend entitlement when client is no longer eligible' policy below.



Suspend Support When Client is No Longer Eligible Policy

NOTE In what other circumstances would we disentitle a client?

Supports may cease because:

- the client was injured whilst committing a crime
- the client is in jail
- cover is no longer required
- supports have been suspended
- payments are being returned by the bank
- the client's mail is being returned
- the client cannot be contacted.

For further information, refer to the 'Disentitling Certain Crimes or Imprisonment' link below.

(Note: This is a BAU process which is currently being updated, contact a practice mentor when using this process).

 [Disentitling Certain Crimes or Imprisonment](#)

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

NOTE What if you think an entitlement or support should be stopped?

What if you think weekly compensation should be stopped?

If you are suspending weekly compensation where the client has been paid for 6 months or less:

You will require clinical guidance however not technical guidance. The final decision on suspending weekly compensation will be based on the clinical guidance in consultation with your Team Leader.

The recovery team member will create a NGCM General Task and assign it to a Team Leader for their endorsement. Record the following in the description field:

Decision type [SUSPEND] DECISION

- Provide in detail what information you are basing your decision on (eg "report shows that the injury has resolved, the ongoing incapacity is due to other non injury related issues").
- What documents/information you have based this decision on.
- The final decision. ("I consider we should suspend weekly compensation as the covered injury is no longer causing incapacity")
- Who was consulted (eg "Recovery Support").

If you are suspending weekly compensation where the client has been paid for 6 months or more:

You will need to request written guidance. Refer to the Seek Internal Guidance process below to confirm when technical services comment is required. You will also require technical guidance in the following scenarios:

- When issuing a decision to suspend weekly compensation due to the client no longer being entitled to support where they have been in receipt of this support for longer than 6 months.
- Non compliance.
- When entering into the vocational independence assessment process via the ACC191.
- Completing the final sign off of vocational independence via the ACC198.

For more information regarding seeking Internal Guidance, please refer to the Seek Internal Guidance process below.'

What if you are suspending other supports.

The recovery team member can make the decision following a review of the information.

Should you want to seek input from your Team Leader is required, you will create a NGCM General Task and assign it to a Team Leader for their endorsement. Record the following in the description field:

Decision type [APPROVED/ADVERSE/DECLINED/PARTIALLY APPROVED] DECISION


- Provide in detail what was requested (eg "6 hours home help per week over next 4 weeks").


- The final decision recommendation.

- b Review all information and ensure it is correct prior to stopping any supports/entitlements or payments.

NOTE What if you need more information on stopping supports/entitlements or payments?

Refer to the Stop Recurring Client Payment in Eos process and Suspend Support When Client is No Longer Eligible Policy below.


 **PROCESS** Stop Recurring Client Payments in Eos

 Suspend Support When Client is No Longer Eligible Policy


3.0 Contact client

Recovery Assistant, Recovery Coordinator, Recovery Partner

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

 View a 'safe contact'

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

 Identity Check Policy

NOTE What if you are unable to establish contact?

- If you are unable to reach the client on your first attempt, leave voicemail message and send a call back notification if appropriate. Create a Contact Action on the Recovery Plan to contact the client again in 3 days' time (unless urgent). Note in the task description that this is the first attempt to contact the client.

- 2nd attempt in 3 days: leave voicemail message and send another call back notification if appropriate. Consider contacting other stakeholders for an update and to confirm client contact details. Push out the task for another 5 days.

- 3rd attempt in 5 days: leave voicemail message. If you are unable to make contact with the client, seek internal guidance on whether it is appropriate to send the decision letter.

 **PROCESS** Seek Internal Guidance

 Recovery Plan - Create Contact Actions - System Steps

- c Discuss stopping the supports with the client and ensure you have the client's understanding that supports will stop. Clearly outline what supports will stop. This may include weekly compensation, treatment or social rehabilitation.

NOTE What are the legislative timeframes for stopping supports?


The associated timeframes for this are:
VI= 3months = legislation
MCR= ACC policy

Current policy is:
2 weeks (if claim was under 365 days, and 4 weeks if over).

NOTE What if your client requires ongoing financial assistance or support outside of the scope or remit of ACC supports?

Refer to Partnering with MSD overview and Partnering with MSD Flowchart which outlines the supports provided by MSD that may be helpful for our clients.

 ACC Partnering with MSD

 ACC Partnering with MSD Flowchart

- d In Salesforce, against the client's claim, record the details of the discussion with the client, including the decision to stop the support.

- e Create a new contact. Record the following in the description field:

- Decision Letter sent
- The final decision
- Who was consulted
- Rationale for the final decision

- f Generate the SPD998 decision letter for the client if ACC has made the decision to cease or suspend entitlements.

NOTE What if the client wants to stop receiving a support they are otherwise still entitled to? (Voluntary withdrawal)

A support can be ended for a client who indicates that they don't want to receive it anymore, as long as the following steps are completed:


- 1) Call the client, identify check the client and ask them to confirm:
 - What date they want to end the support (it needs to be on or before the expiry date of their latest medical certificate)
 - That they understand that: "This won't affect your eligibility for other ACC support such as treatment costs. But if you change your mind at a later date, and want to resume payments of weekly compensation, we will need to consider if you are still eligible at that stage."
 - That the request to end the support is their decision, and not a decision ACC is making


- 2) Determine whether you need to send the client a written communication about their support ending. You must send the client the 'VOL100 Voluntary withdrawal from a support - client' letter via post or email if either:
 - you have any doubts that the client fully understands or agrees to the terms of stopping the support due to voluntary withdrawal, or
 - the claim managed by Supported or Partnered Recovery (If the claim is managed by Enabled or Assisted Recovery and you're comfortable the client understands and agrees to the terms, then no written communication is needed)-

- 3) Create a new contact. Record the following in the description field:
 - the phrase 'voluntary withdrawal'
 - a summary of the agreement by the client to the terms of stopping a support due to voluntary withdrawal
 - if applicable, note what written communication was sent to the client

- 4) Update the Recovery Plan with the outcome.

- 5) Go to 4.0 Request supports to stop.

 SPD998 Suspension or cessation of entitlement - client

 Voluntary Withdrawal from receiving a Support Policy

 VOL100 Voluntary withdrawal from a support - client

- g Send the decision letter to the client.

NOTE What if the client's preferred method is via email?

Confirm the email address is verified, then send the letter to the client.

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

NOTE What if the client's preferred method is via mail?

Generate the 'NGCM - Send letter task' and attach the letter if your client's preferred method is via post.

- Send letters from Client Recovery and Claims Assessment

h Update the Recovery Plan with the outcome.

4.0 Request supports to stop

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Generate the relevant task for the appropriate team to action.

NOTE What if all supports are being suspended due to an injury being resolved?

If clinical services deem incapacity is no longer injury related, all supports ie treatment, social rehabilitation, training for independence, Stay at work and weekly compensation would stop and therefore we would always update the injury resolved indicator.

1) In Eos, go to the ACC45 Claim, 'Indicators' tab and Add an 'Injury Resolved Indicator' to prevent further payments being made to the client.

2) Set the Status as 'Confirmed' and the From Date for when all supports will cease as per the recovery team members instructions.

3) Notify all relevant stakeholders the date when ACC supports will cease. The reason for the decision to stop supports should not be disclosed to the stakeholders.

NOTE What if the decision is to suspend or disentitle supports? Eg Home Help, Training for Independence, Stay at Work?

All purchase order end dates will have to be amended to match the end date of the service as per the Recovery Team member instructions.

In Eos, create a "NGCM - Suspend or Stop Entitlements" task and fill in the task description with:

- Purchase Order Number
- Date you want the purchase order to end

This will auto-route to Recovery Administration for them to action.

Provide the purchase order numbers and the end dates for each if there are ongoing purchase orders.

NOTE What if the decision is to stop weekly compensation payments?

1) Update the approved incapacity to reflect the advised end date for weekly compensation.

2) In Eos, go to the ACC45 Claim, 'Indicators' tab and Add a 'Limited Weekly Compensation Indicator' to prevent further incapacity being approved and further payments being made to the client (set the status as Active).

3) Generate a 'Stop Payment' task if a task is not automatically generated. Send to the Client Payments team by manually transferring to the Centralised Weekly Compensation queue for the payments team to action. The payments team will continue with the process below.

 **PROCESS** Stop Recurring Client Payments in Eos

NOTE What if the task is about a sensitive claim?

If the claim is sensitive, transfer the task to Weekly Compensation Sensitive Claims queue.


5.0 Review task

Recovery Administrator

a In Eos, 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?

If required information is missing from the task, or you need guidance on working within the Administration Team, refer to NG PRINCIPLES Working in the Administration Team.

 Principles of Working in the Administration Team

b Edit and change the end date of each line of the purchase order. This information should be in the task. Purchase orders should not be cancelled.


6.0 Notify Provider

Recovery Administrator

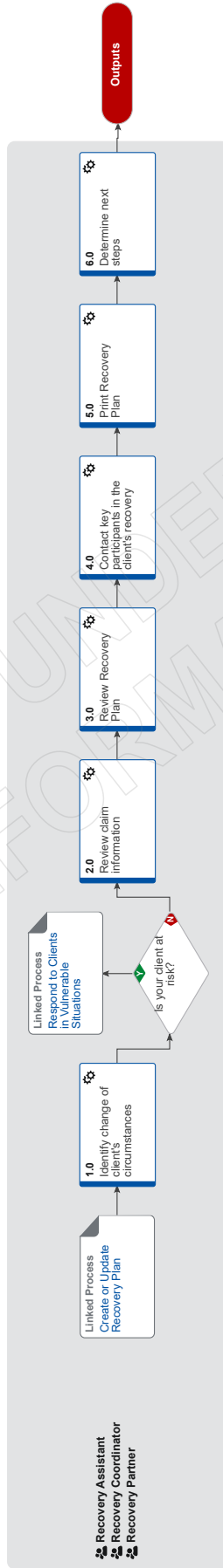
a Email the Provider and inform them which supports and treatment have been stopped.

NOTE What email template do you use?

Use the 'Cancelling Service Email' template.

 **PROCESS** **Create or Update Recovery Plan**
Recovery Assistant, Recovery Coordinator, Recovery Partner

 **PROCESS** **Close claim**
UNASSIGNED



RELEASED UNDER THE OFFICIAL INFORMATION ACT



Summary

Objective

To ensure we are effectively tracking how a client's recovery is progressing. The process identifies the steps to determine if and what intervention is required to progress a client's recovery when their circumstances change.

It allows us to be proactive in a client's recovery, including identifying if a client is in a vulnerable situation, eg there is a potential threat to their safety, health, or wellbeing. If you're working on someone's claim and recognise the signs that they may be in a potentially vulnerable situation, you must immediately report your concerns to your manager so decisions can be made about reducing the chances they will come to harm.

Background

Track recovery identifies changes that occur during the different stages of recovery. Injury recovery can proceed through four key stages: acute, rehabilitation, adaption and stable. Healing can progress backward or forward depending on internal and external factors.

In many circumstances when the Recovery Plan is created, the client circumstances change, for example the client is not coping with job loss, is suffering pain, or there are concerns and/or requests for supports or information. Track recovery identifies the triggers that will help us to proactively respond to a client's needs and take the required action or interventions. There are many different types of referrals and assessments and each one of these has an opportunity to proactively inform when intervention is required. Examples include treatment reports, vocational rehabilitation and independence reports, social rehabilitation, inbound contact, eg regarding a change of circumstances, such as not managing, job loss, pain, concerns and/or requests for supports, or information received indicating ACC or a client may be in breach of legislative compliance, such as code complaints, review, fraud, etc.

While providing support to our clients, we may identify that they are at risk. It is important to understand how to respond to vulnerable situations. Vulnerable situations for clients come in many forms. Sometimes the potential for harm comes from the addictions, mental health conditions, or aggressive or anti-social behaviours the person exhibits. Sometimes it is the person's poor health or medical conditions in combination with the conditions they're living in. Sometimes the potential harm comes from others the person is living with.

Owner [Out of Scope]

Expert

Procedure



PROCESS

Create or Update Recovery Plan
Recovery Assistant, Recovery Coordinator, Recovery Partner

1.0 Identify change of client's circumstances

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Receive information for changes in circumstances via email, fax, inbound mail, digital, face to face or phone call from the client, providers, vendors, general practitioner (GP), employer, family members, whanau, associates, safe contact person, clinical staff member or advocate.

NOTE What information can indicate a change in circumstances?

- recovery milestones are not met
- updated or new supports required
- change in diagnosis
- additional diagnosis
- needs and level of support from ACC has increased or decreased
- client is planning to return to work
- change in employment circumstances
- recovery complication, ie infection.
- a new ACC18 has been received post the client returning to work
- client has been transitioned to a different Recovery Team
- new claim received

NOTE What if the Client advises you they have resigned, been terminated or received redundancy?

If it is a work injury, and the client has now lost their job:

- 1) Add the same employer as a second employer participant
 - 2) Update them to previous
- This ensures the employer stops receiving incapacity updates via their MyACC4B account

Add an Employer to a Claim

Client resigns, loses job / termination, is made redundant

NOTE What if the change of client circumstances is a new claim being received that requires cover to be assessed?

Refer to the GUIDELINES Assessing claim for cover in Recovery Team to identify the actions you will need to complete on both claims.

NOTE What if you receive information that confirms a client is no longer entitled to receive a support or entitlement?

Go to Stop Supports.

PROCESS Stop Supports

GUIDELINES Assessing claim for cover in Recovery Team

NOTE What if the client's claim is in Enabled Recovery?

Clients streamed to Enabled Recovery do not require a Welcome Conversation and can self manage by either using MyACC or by calling us when they need support.

If a client calls us to set up weekly compensation or supports, you can set up these for them by completing (only) the relevant sections of the Welcome Conversation in Salesforce, however please encourage them to continue to self-manage via MyACC.

If a client is having trouble with MyACC, go to MyACC for Client process to support them.

Task management

It is not mandatory to have an open task or Recovery Plan on Enabled claims. If you receive a task via Salesforce such as MyACC or Electronic Medical Certificate, you would action the request appropriately and then close the task in Salesforce.

If you are unclear on whether the client should be in Enabled or Assisted Recovery, refer to the transition guidelines in Transition Claim process.

PROCESS Invite Client to MyACC

NOTE What if you receive information from Integrity Services?

Integrity Services might pass on information they receive about a client that doesn't warrant an investigation from them but may be useful for the management of the client's recovery.

In these cases, you will receive a "Contact Party" task from Integrity Services, requesting that you contact them to discuss the information. After discussing with Integrity Services, you can continue to follow the Track Recovery Process to determine how to proceed, as with any new information received about a client.

It is crucial that you do make and maintain contact with Integrity Services when acting on information that they have passed on. While it may not be a matter as serious as fraud, there still may be a delicate situation that Integrity Services can advise you how to handle. For example, it is important that you do not breach the anonymity of whoever has provided the information when in contact with the client.

Identify Claims for Rapidly Deteriorating Clients

NOTE What if information indicates the claim needs to be transitioned to another Recovery Team?

Go to Transition Claim process to determine if the claim should be transitioned.

PROCESS Transition Claim

NOTE What information should be reviewed if claim is transitioned from Assisted Recovery?

Go to Transitioned Client Claim Review to review the appropriate information when a claim is transitioned into Supported Recovery or Partnered Recovery

Transitioned Client Claim Review

b Review client information:

- Check if the client has an identified language need.
- Confirm who is the best person to speak with. If your client has a complex injury, this may be family/whanau, a clinical staff member or a safe contact person.
- Review recent contacts to minimise the client repeating themselves.

c Review the medical certificate details:

- Check if the client is employed, and whether they are off work or currently working.
- Review medical certificates and understand how their recovery is progressing.
- Understand the Expected Claim Outcome (ECO) for the client's injury.

Refer to the information below - Supporting Recovery at work - to consider how to support your customer at work.

Supporting Information - Supporting Recovery at Work

NOTE What if the medical certificate indicates a change to your client's ability to work, including a return to full-time work?

In Eos, update the incapacity details to ensure weekly compensation payments are correct. For details about eligibility and steps to follow, go to the Maintain Weekly Compensation process.

PROCESS Maintain Weekly Compensation

NOTE What if the client is planning to return to work part-time?

In Eos, review and update the incapacity details to adjust weekly compensation details. Review income and weekly compensation details to adjust amount paid going forward. Go to the Manage Abatement in Eos process.

PROCESS Manage Abatement in Eos

NOTE What if the medical certificate indicates this is a subsequent incapacity?

Refer to the Policy below to determine this is a 'Date of Subsequent incapacity. If eligible, go to Conduct Recovery Check-in Conversation process.

PROCESS Conduct Recovery Check-in Conversation

Subsequent Inability to Work (Subsequent Incapacity)

? Is your client at risk?

Recovery Assistant, Recovery Coordinator, Recovery Partner

YES.... **PROCESS** Respond to Clients in Vulnerable Situations

NO.... Continue

2.0 Review claim information

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Decide if the client is being supported in the most appropriate way for their goals and needs.


NOTE What if the provider indicates on the medical certificate 'Support needed to stay at work/ return to work'? (Task 'AUTO Alert: RTW Request - ACC18 Incapacity' or 'AUTO Alert: RTW Request - ACC18 No Incapacity')

- Contact provider to discuss request if it isn't clear what they are asking for
- Check the claim to see if vocational rehabilitation support is already in place and that client is eligible.
- If the client already has vocational support in place then you do not need to do anything else with this request and the task can be closed with no further action.

Consider the following actions and decide which is most appropriate for your client:

- If there is no support in place and the client and employer are managing a return to work between themselves, consider checking in on how this is going and whether they need further support.
- If this is a change in incapacity for the client; if they have moved from 'fully unfit' to 'fit for selective work' then this could suggest vocational rehabilitation is ready to begin. Consider whether they need our support to do this.
- If the client has the functional capacity to engage in return to work activities. Do the client and employer need support to explore this?
- Consider whether your client still holds employment. This will determine what type of vocational support we put in place if any is needed.
- Ensure to close the loop with the certifying treatment provider via email if you haven't had contact yet to say what you've done following their med cert

If Stay at Work support is required:

 **PROCESS** Set Up Stay At Work Support

NOTE What if the provider indicates on the medical certificate 'Clinical Review of Patient's fitness for work needed'? (Task 'AUTO Alert: RTW Request - ACC18 Incapacity' or 'AUTO Alert: RTW Request - ACC18 No Incapacity')

- Review the cover on the claim and whether we are clear on the reason for the clients ongoing incapacity.
- Contact the certifying treatment provider to understand what their concerns are and what they feel needs to be addressed.
- Once the concerns/barriers are clear, consider what ACC interventions might overcome these barriers.

NOTE What if the provider indicates on the medical certificate 'ACC to contact me'?

- Contact the provider to understand their request
- In Salesforce, create a contact action
- Record outcome of the conversation in the contact action
- What if you are unable to contact the provider?
 - In Salesforce, create a future contact action
 - Record the provider name and reason for the contact, ie 'ACC18 indicated ACC to contact (insert provider name), unable to contact provider, follow up contact with provider required
 - Set due date for 5 working days.

- d** Review or confirm existing cover decision(s). Cover must be reviewed whenever you receive new information or a request for an additional entitlement. This can occur at any stage during the life of a claim.

NOTE What do you need to consider?

- Understand what the injury is and how it happened.
- Has there been a change in diagnosis?
- Is there an additional injury on an existing claim?

For more information on the 'Confirm existing cover decision', refer to the web link below.

 [Confirming Existing Cover Decision](#)

3.0 Review Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** In Salesforce, review the Recovery Plan details and where the client is in their recovery, eg the client's goals, Recovery status life area details including their current treatment plan, supports, work status, medical certificates and any potential recovery obstacles that you will need to check on.
- b** Identify any obstacles. During the client's rehabilitation journey, there may be flags or barriers that can potentially impact on their recovery pathway. When we identify these, they are known as obstacles. These should be noted in the Life Areas in Salesforce.

NOTE How do you identify flags and barriers?

Refer to the 'Identifying obstacles to recovery' section of the Recovery Management Guide for details.

 [NG GUIDELINES Recovery Management](#)

NOTE Is the client in the correct team?

Go to Transition Claim process for further information.

 **PROCESS** Transition Claim

- c** Review open tasks.

NOTE What are the Task Management Principles?

Refer to the Recovery Management Guide for these principles.

 [NG GUIDELINES Recovery Management](#)

4.0 Contact key participants in the client's recovery

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a** Receive tasks.

NOTE What to consider for outgoing call interactions?

Almost all our outgoing call interactions are planned, and we are reminded to have these interactions through tasks. These are often scheduled contact tasks, with information to support the interaction.


b Prepare for interaction.

NOTE Why do we need to prepare before holding an interaction?

Before we speak with a key participant it is important to ensure we have authority from the client and have checked the safe contact, this helps us to start thinking about:

- 1) the information we want to share
- 2) the information we need to collect
- 3) what we might want to ask during the call
- 4) what support the client might need at this stage in their recovery
- 5) check if there is an alternative or a safe contact.


If you need to gather further information, refer to the web link below.

 Gather Additional Information or Advice

c Determine if a face-to-face meeting is required.

NOTE What are the guidelines if the conversation is to be a face-to-face conversation?

Assess the suitability of having a face to face meeting. Go to the process below, and refer to Client Face to Face Meetings guidelines to determine if a meeting is required.

 **PROCESS** Arrange Face to Face Client Meeting

d In Salesforce, if you have identified that you will be collecting medical or other information, confirm that the client has provided authority.


 View Client Consent

NOTE What if the client has not granted ACC authority to collect medical and other records?

You will need to obtain the client's authority to collect medical and other records. Go to the process below.

 **PROCESS** Obtain Client Authority to Collect Information

e Contact the participant and initiate the interaction. If contacting a participant or a person with Authority to Act (ATA) for them, perform the relevant identity check to confirm you are speaking to the right person.


 Identity Check Policy

NOTE What if the participant advises they are unable to have the conversation now, or during the conversation they are unable to continue?

Agree a date to continue, and update the due date in the task to this date. Add a note in the description field of the task advising the conversation was paused and needs to be completed.


NOTE What if the client's employer is a Third Party Administrator or an accredited employer?


Go to the process below.


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

NOTE What if you can't establish contact?

- Attempt a maximum of 2 contacts over 2 full working days before leaving a voicemail or sending a notification to request client contact.
- If you are unable to reach the client, extend the task for additional 2 working days and note in the task description that this is the 2nd attempt to contact the client.
- On the task due date and if there is been no response from the client to the voicemail or notification, send the CM04 - Advise client that you were unable to reach then by phone letter.
- Extend the task date as appropriate to take into account postal delivery and note in the task description this is the 3rd attempt to contact the client and the CM04 letter has been sent.
- On the task due date and if there is no contact from the client and they are continuing to receive support, seek internal guidance to determine next steps.
- If you're in Partnered and no contact is made with the client after three attempts, you must contact the provider, GP or other verified contact on the claim.

 What to say in a voicemail message

 Decline Entitlement When Client is Non-compliant Policy

 CM04 Advise claimant that you were unable to reach them by phone

NOTE How can you confirm client contact details?

Consider the following options:

- check details on the ACC45
- check the latest ACC18
- contact the client's treating provider
- contact the client's employer.

f Identify any obstacles.

Obstacles may be identified during a conversation with a client, provider or employer or via correspondence received, such as medical reports, provider assessment reports or emails. We can also identify psychosocial obstacles through asking the 'How are you coping gauge' questions.

NOTE Identifying obstacles during interactions

Client – Each communication with our client, either verbal or written, is an opportunity to identify any obstacles that have arisen during the client's journey. Our interactions with our clients need to be proactive and outcome focused, not process driven, so that we can build a valuable relationship with our clients. This results in them getting the right support from us at the right time to address any obstacle.

Provider – Providers play an essential role in a client's recovery. We empower the provider and give them a clear understanding of the client's treatment and support. Providers, as part of their role, are continually assessing and treating clients. They gather valuable information by identifying obstacles. From time to time we will refer to providers to help us address the obstacle.

Employer – Employers play an essential role in being the gatekeeper to re-entering the place of employment. By encouraging the employer to become involved in the rehabilitation planning, they can communicate with us any past and/or present examples of obstacles they have encountered.

5.0 Print Recovery Plan

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a If your client has requested a copy of their Recovery Plan, confirm how they want to receive this.

Ensure that the client has agreed to each specific intervention in the Recovery Plan. Agreement to interventions must be evidenced in contact notes either following discussions with the client/ATA or email. This means that the client's signature is not required on the printed Plan.

An employer must be given an opportunity to participate in the preparation of the Recovery Plan, however it does not mean they need to see a copy of the plan. Ensure you do not show any sensitive client information to the employer. Check all auto-populated fields and remove data as necessary. Where there is a sensitive claim we must follow directions by the client and not involve the employer.

- b Generate a copy of the Recovery Plan for the client.

NOTE How do you generate a copy of the Recovery Plan?

Click Send PDF to Eos on the Salesforce Recovery Plan.

Result: This will generate ACC7979 form.

- c Arrange to send your client a copy of their Recovery Plan.

NOTE What if the client wants the Recovery Plan sent to them by email?

Follow the Emailing from Eos – System Steps.

 NGCM - FINAL Emailing from Eos - System Steps

NOTE What if the client wants the Recovery Plan sent to them by mail?

Refer to 'Send letters from Client Recovery and Claims Assessment'.

 Send letters from Client Recovery and Claims Assessment


6.0 Determine next steps

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a In Salesforce, update the plan with the new information or outcome of the interaction.

NOTE How do you update the Recovery Plan?

Go to Create or Update Recovery Plan process.

 **PROCESS** Create or Update Recovery Plan

- b Assess the information in the Recovery Plan and determine if the next step is clear and obvious.

 Vocational Services Roadmap


NOTE What if you need help to determine next steps of the client's recovery?

Talk to your Team Leader first, then use the Recovery Support Decision Tree to help with next steps.

 Recovery Support Decision Tree


NOTE What if you need clinical information to help complete the client's recovery plan?

Go to Request Clinical Records process.

 **PROCESS** Request Clinical Records

NOTE What if your client requires an assessment to allow more information to be gathered about their injury or recovery needs?

Go to Arrange Medical Single Discipline Assessment process.

 **PROCESS** Arrange Medical Single Discipline Assessment

- c Consider if your client needs to be transitioned to another team as your client is either tracking ahead or behind their Recovery Plan.

NOTE What if your client needs to be transitioned to another team?

Remember to align the due date for Recovery Check-in conversations with key milestones.

Go to Transition Claim process.

 **PROCESS** Transition Claim

- d Determine the type of support required to help your client to achieve their recovery goal(s) and confirm their eligibility. Consider our Decision-making principles in the Recovery Management Guide.

To find details about how to create tasks for other types of financial supports, search for the support type in Pro-mapp (eg lump sum, independence allowance, HCSS payments).


 NG GUIDELINES Recovery Management


NOTE What if you need to set up supports for the client?

If you need to:

- set up social supports for the client, go to Manage Social Interventions / Supports web link.
- set up vocational supports for the client, go to Manage Vocational Interventions / Supports web link.
- respond to a treatment request, go to Manage Treatment Interventions / Supports web link.


 Manage Social Interventions / Supports

 Manage Vocational Interventions / Supports

 Manage Treatment Interventions / Supports

NOTE What if you need to set up weekly compensation for the client?

Go to the Request Set Up of Weekly Compensation Payments process.

 **PROCESS** Request Set Up of Weekly Compensation Payments


NOTE What if you need to reinstate Weekly Compensation?

In Eos, at ACC45 level, complete the reinstatement information in the Non Standard WC Setup Eform, (documents tab, stand alone eform category). Then create a Setup weekly comp Entitlement task (the eform is linked automatically). The task auto routes to the Centralised Weekly Compensation queue.

- e Determine if your client is unlikely to be able to return to their pre-injury occupation due to their injury, or if they are vocationally independent.

NOTE How do you arrange an IOA to identify the types of work that may be appropriate for the client?

Go to Arrange Initial Occupational Assessment process.

 **PROCESS** Arrange Initial Occupational Assessment (IOA)

- f Determine if your client no longer needs support.

NOTE What if the client has confirmed they don't require any supports?

Go to Stop Supports.

PROCESS Stop Supports

- g** Respond to a notification that the client has passed away. You may be notified that the client has passed from contact with either a family member, provider or via death notices.

NOTE What if you are advised the client has passed away?

Refer to the Record Date of Death process below.

PROCESS Record Date of Death

NOTE What if you are advised that the client has passed away due to (or possibly) as a result of their injury?

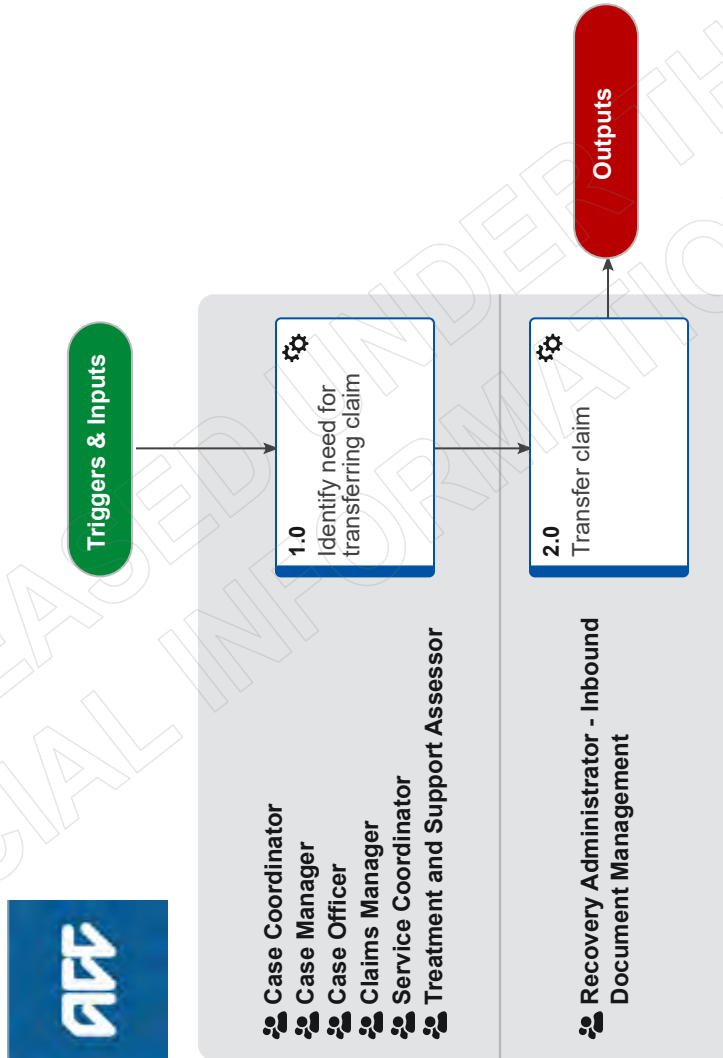
This will require investigation by Cover Assessment. You will need to:

- Add a contact in Eos recording the details of the notification (ie date of death, who advised of the death and their relationship to the client, who the key family contact would be (and their contact details) and what you have been notified as being the cause of death).
- Go to Stop Supports process to stop any supports.
- RTM to provide ACDIS01 and ACC21 to the clients' family or representative and provide the contact number for the representative to call when they are ready 0800 222 075. Internal hotline ^{s 9(2)} or V_CAS_FATALS in Genesys if they ^{(a) 1} wish to speak to someone now

PROCESS Stop Supports

Transfer a Claim from a BAU Actioned Cases Department

v15.0



Transfer a Claim from a BAU Actioned Cases Department

v15.0



Summary

Objective

Use this process to request a claim is transferred from the BAU Actioned Cases department which is a site that has been transitioned to NGCM.

Background

Tranche Actioned Cases departments refers to ACC teams/units which have transitioned from BAU to NGCM

Notes:

- Assisted Recovery will transfer claims themselves when new recovery management tasks are received in the Managed Claims queue.
- If you only require access to the claim's physical file, do NOT use this process. Please use the "Retrieve Archived Physical Claim Files" process
- The Recovery Administration involvement in this process is specific to the Inbound Document Management team. If you are not in this team then do NOT refer to this process

Owner

[Out of Scope]

Expert

Procedure

1.0 Identify need for transferring claim

Case Coordinator, Case Manager, Case Officer, Claims Manager, Service Coordinator, Treatment and Support Assessor

- a** In Eos, identify the claim needed for transfer, and the reason why this is required.

NOTE When would you need to transfer the claim?

- When the client has requested an entitlement that needs to be managed

NOTE What if a physical file is required?

Refer to the process below

- PROCESS** Retrieve Archived Physical Claim Files

- b** Create a 'General' task requesting the CLAIM or FILE to be transferred to your department or name and send the task to Dunedin SC – Administration queue.

2.0 Transfer claim

Recovery Administrator - Inbound Document Management

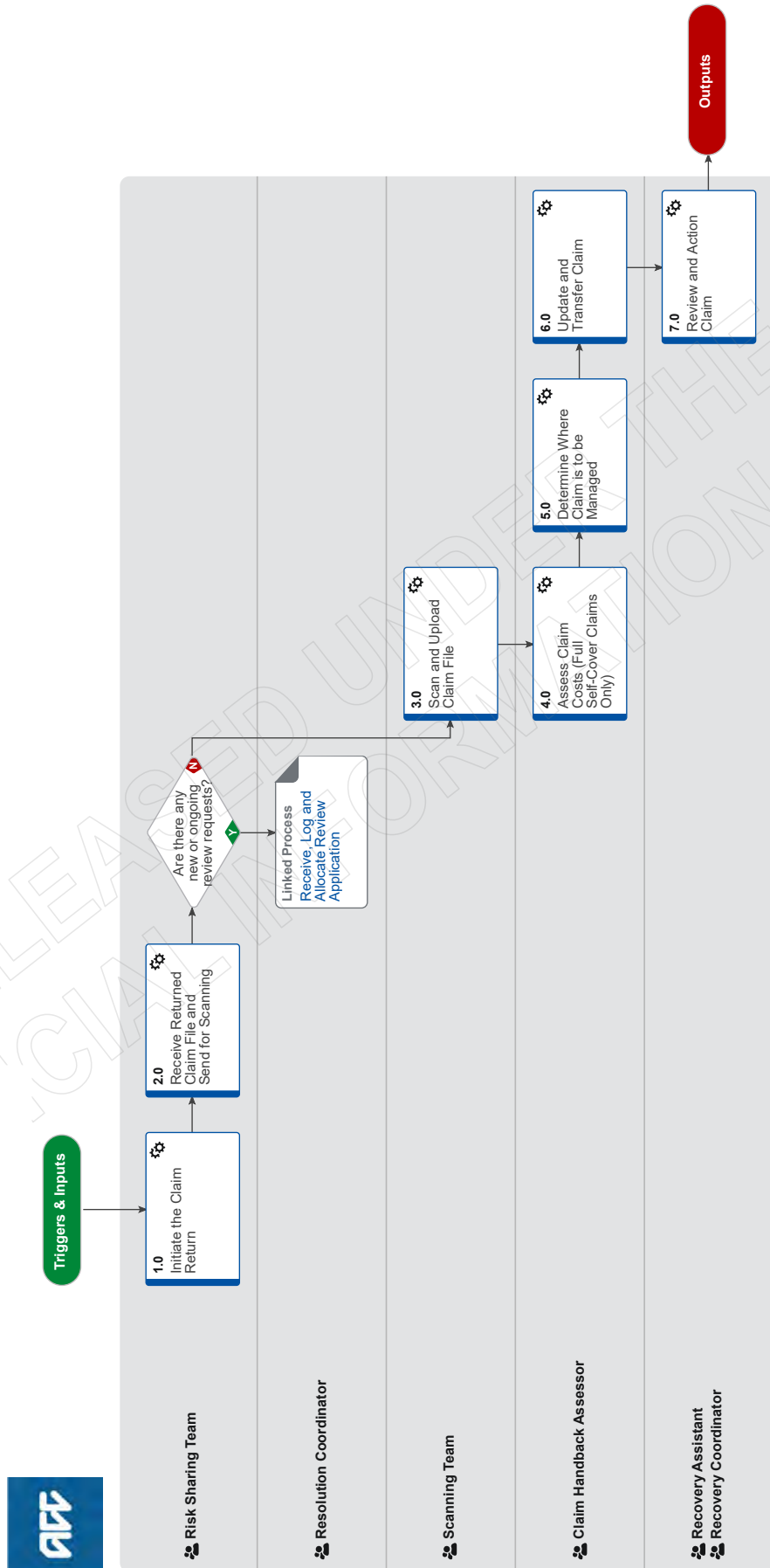
- a** In Eos, open the general task requesting for the claim to be transferred.

- b** Transfer the claim to the appropriate department or user.

Transfer a claim (Eos Online Help)

- c** Edit the task description and transfer the task to the appropriate department or user.

- d** This process ends.





Summary

Objective

A comprehensive end-to-end process for the Accredited Employer Programme annual claims handback, including:

- Initiating the return of active claims from Accredited Employers and Third Party Administrators by the end of March each year;
- Assessing all Full Self Cover claims for liability and invoicing purposes;
- Deciding where claims need to be sent for ongoing management by ACC and
- Determining what claims management is required.

Background

The Accredited Employer Programme (AEP) allows the employer to manage their employees' work injury claims, including the paying of any entitlements throughout their claims management period (CMP). The minimum CMP is 12 months (plus the year of the accident) whereas the maximum is 48 months (plus the year of the accident). An Accredited Employer (AE) can subcontract a Third Party Administrator (TPA) to manage claims on their behalf, however liability remains with the AE.

At the end of the CMP - 31 March each year - claims that are still active need to be returned to ACC for ongoing management. For Full Self Cover (FSC) claims, liability is calculated and invoiced to the AE on return of the claim. For Partnership Discount Plan (PDP) claims, this doesn't occur.

As a part of this annual claims handback two FTE from the Supported Recovery team are required to work with the Risk Sharing team for approximately three weeks in February and March. Their function is referred to as "Claims Handback Assessor" in this process.

Each year, prior to the annual claims handback commencing, you'll need to check the following:

- All references and links to spreadsheets and document templates are updated to reflect the most recent iteration
- All references to columns (either by letter or by name) are checked for validity, if the spreadsheet has been changed to add or remove any information

Owner

[Out of Scope]

Expert

Procedure

1.0 Initiate the Claim Return

Risk Sharing Team

- From December, receive automated 'PP_Handbacks_OpenCases' reports which identify Accredited Employer claims that meet the criteria to be handed back to ACC. This will continue through to May of the following year.

NOTE What are the criteria that need to be met for a claim to be considered ready for handback?

An active claim is one that has:

- Reached the end of the Accredited Employer's claim management period;
- Received any type of payment after 30 September of the previous year;
- Been declined but is within the review period;
- A review pending;
- Had a review held but where the decision hasn't been issued or
- An appeal pending

- Add the Accredited Employer claim data to the 'Tracker 2020-2021' spreadsheet. Ensure you add the data to the correct tab, depending on what type of plan the claim belongs to.

NOTE How do I determine what type of plan the claim belongs to?

The "Plan Type" column in the 'PP_Handbacks_OpenCases' report (column Q) specifies 1 or 2:

- 1: Partnership Discount Plan (PDP)
- 2: Full Self Cover (FSC)

NOTE What information needs to be added to the spreadsheet?

Column A: "Date of report" - the date the PP_Handbacks_OpenCases report was received.

Column B: "Report number" - where December = 1, January = 2... and May = 6.

Column D: "ACC Managing (Situation C)" - Y(es) or N(o), if ACC has assumed management of the claim before the end of the claims management period. Specified in the 'Situation C Master Document'.

Column AB: "Case number (Event ID)" - from column A ("Case Num") of the PP_Handbacks_OpenCases report.

Column AC: "Surname" - from column C ("Surname") of the PP_Handbacks_OpenCases report.

Column AD: "First name/s" - from column D ("Given Names") of the PP_Handbacks_OpenCases report.

Column AE: "DOB" - from column E ("Date of Birth") of the PP_Handbacks_OpenCases report.

Column AF: "DOI" - from column G ("Accident Date") of the PP_Handbacks_OpenCases report.

Column AG: "Hearing Loss" - Y(es) or N(o) from column L ("Hearing Loss") of the PP_Handbacks_OpenCases report.

Column AH: "Fatal" - Y(es) or N(o) from column AD ("Fatal") of the PP_Handbacks_OpenCases report.

Column AI: "Paid WC" - Y(es) or N(o) from column AC ("Paid WC") of the PP_Handbacks_OpenCases report.

Column AJ: "Cost WC 6M" - dollar value of weekly compensation that has been reported in the last 6 months, from column AM ("Cost WC 6M") of the PP_Handbacks_OpenCases report.

Column AK: "ACC45 Number" - from column B ("ACC 45") of the PP_Handbacks_OpenCases report.

Column AL: "ACC Claim Number" - from Eos.

Column AM: "PP Contract Number" - from column M ("PP Contract Number") of the PP_Handbacks_OpenCases report.

Column AN: "Prime ACC number" - from column N ("Employer") of the PP_Handbacks_OpenCases report.

Column AO: "Employer Name" - from column O ("Employer Name") of the PP_Handbacks_OpenCases report.

Column AP: "Cover year" - from column P ("Cover Year Mar31") of the PP_Handbacks_OpenCases report.

Column AQ: "Plan 1=PDP/Plan 2=FSC" - from column Q ("Plan Type") of the PP_Handbacks_OpenCases report, where 1 = PDP.

Column AR: "Claim management years" - from column R ("Claim Mgmt Years") of the PP_Handbacks_OpenCases report.

Column AS: "TPA" - the name of the Third Party Administrator (Wellnz, WorkAon or GB. "Self" if there is no TPA), found in Juno.

NOTE Where do I get the Claim Number from?

In Eos, search for a claim using the ACC45 number to find the Claim number (if the claim has been registered). Record this in column AL of the 'Tracker 2020-2021' spreadsheet.

NOTE What if the employee works for a subsidiary of the employer?

Check that the employer noted is the contract name. If it isn't, add the name of the subsidiary employer from the 'PP_Handbacks_OpenCases' report in brackets after the contract name e.g. Fletcher Building Holdings Ltd (Laminex Group NZ Ltd) in column AO. Also change the ACC Number in column AN to the prime ACC number for the contracted employer.

NOTE What if the Accredited Employer/Third Party Administrator advises ACC of claims that need to be removed from the handback list?

Assess whether the reason for removal is appropriate. If it is, copy the contents of column AM-AS, AB-AF and AK-AL and paste them into the corresponding columns in the "Removals" tab of the 'Tracker 2020-2021' spreadsheet (B-H, I-M and N-O respectively). Add the date this removal was actioned in column A and the reason for doing so in column P. Finally, ensure the data is no longer present in the "FSC" or "PDP" tabs.

- c Ensure the claim is registered in Eos. If it is, record this as a "Y" in column J of the 'Tracker 2020-2021' spreadsheet.

 Search for a claim

NOTE What if the claim isn't registered in Eos?


Record an "N" in column J of the 'Tracker 2020-2021' spreadsheet. Request the ACC45 claim form from the Accredited Employer or Third Party Administrator when you provide the list of active claims to be returned. Mark this as urgent in your email.


- d Create a 'Handback Claim List' for each employer using the template below, with the claims that need to be returned.

 Handback Claim List Template

- e Email the Accredited Employer and Third Party Administrator (if applicable) copies of the 'Handback Claim List' spreadsheet (this must be password protected, as it contains individual claim information) along with an 'ACC413 AE Claims Transfer Summary' form, 'Courier label for ALL files' and the '2020-2021 Claim Handback Instruction Sheet' requesting the return of the physical claim file. Update the 'Tracker 2020-2021' spreadsheet with the date you sent the request (column E).

You will need to email the Accredited Employer or Third Party Administrator at the beginning of each month from December to May.

 ACC413 AE Claims Transfer Summary_interactive_April2019.pdf

 Courier Label for ALL Files

 2020-2021 Claim Handback Instruction Sheet

NOTE What if ACC (the employer) identifies that a claim for return is for a current ACC employee?

ACC (the employer, represented by the Health, Safety & Wellbeing Manager) will check for employee status. If a claim to be returned is for a current staff member they will advise their Third Party Administrator to return the claim file directly to the TPA Support team, Level 2, Shamrock House, Wellington. The TPA Support/Insurer Liaison team will follow the appropriate steps below.

NOTE What if the Accredited Employer/Third Party Administrator advises ACC of claims that need to be added to the handback list, separately from this report?

Add the claim details to the 'Tracker 2020-2021' spreadsheet as per task b. Ensure you provide the date the Accredited Employer/Third Party Administrator advised you of this in column C.

- f Receive the ACC45 claim form from the Accredited Employer for claims that haven't yet been registered. Move this to the following directory: \\ACCfiles\Data\Public\RAWC\Registration\Electronic Documents\ILM Handbacks so they can be handled by the Lodgment team. Also save a copy to the following directory in SharePoint: 'Documents > Handbacks > 2020-2021 > 01 ACC 45s'. Record the date that this was received in column L on the 'Tracker 2020-2021' spreadsheet.

2.0 Receive Returned Claim File and Send for Scanning

Risk Sharing Team

- a Receive the returned claim file from the Accredited Employer or Third Party Administrator. Record the date that the file was received, the box you're storing the file in and the number of volumes the claim file includes in columns G, H and I of the 'Tracker 2020-2021' spreadsheet respectively.

NOTE What if the claim file hasn't been returned by the due date noted in the email to the Accredited Employer/Third Party Administrator.

Send a weekly reminder email to the Accredited Employer or Third Party Administrator until it has been returned. Record these follow up dates in column F of the 'Tracker 2020-2021' spreadsheet.

- b Check each of the following:

- That the claim has been registered in Eos (when the ACC45 wasn't initially available) and the Claim number has been added to the 'Tracker 2020-2021' spreadsheet - enter Y(es) or N(o) for both. If either column is blank or N, find the ACC45 and have the Lodgment team lodge the claim - the claim cannot be scanned until this is done.
- All required information has been provided by the Accredited Employer/Third Party Administrator - enter Y(es) or N(o).
- Medical certificate dates - enter the expiry date (only where a claim is receiving weekly compensation/is expected to receive weekly compensation at 1 April). If the medical certificate has expired and the client is expected to have a new one, this needs to be sought from the Accredited Employer.
- If there are any reviews pending - "Y(es)" or "N(o)". If there are reviews pending on a claim, refer to the "Receive, Log and Allocate Review Application" process below.

Record this information in the 'Tracker 2020-2021' spreadsheet in columns J & K, M, N and O. Finally, check that the ACC413 has been loaded as a separate document.

NOTE What if you haven't received all of the required information from the Accredited Employer/Third Party Administrator?

Reply to the Accredited Employer/Third Party Administrator requesting the information that you're missing. Record the date you requested additional information in column R of the 'Tracker 2020-2021' spreadsheet.

- c Add the claim file data to the '2020-2021 AE Claims for Scanning' spreadsheet.

 2020-2021 AE Claims for Scanning

NOTE What information needs to be added to this spreadsheet?

Column A: "ACC45#" - from column AK ("ACC45 Number") of the 'Tracker 2020-2021' spreadsheet

Column B: "ACC Claim Number" - from column AL ("ACC claim number") of the 'Tracker 2020-2021' spreadsheet

Column C: "# of Volumes" - the number of "folders" that make up the claim file, from column I ("No of volumes (if more than 1)") of the 'Tracker 2020-2021' spreadsheet

Column D: "Date sent to Otago House" - the date the claim file was sent to the Scanning team

Column E: "PDP or FSC" - the plan type (PDP or FSC) from column AQ ("Plan 1=PDP/Plan 2=FSC") of the 'Tracker 2020-2021' spreadsheet

Column F: "Claim open or closed" - Open or Closed, from column P ("File open or closed (From ACC413)") of the 'Tracker 2020-2021' spreadsheet

Column G: "Box number" - the box the claim file is couriered in

- d Courier the claim file to the following address:

ACC AEP (Inbound Documents)
ACC Level 6, Otago House
Cnr Moray Place & Princess Street
Dunedin

- e Copy the data from column D and G of the 'AE Claims for Scanning' spreadsheet into column V and W of the 'Tracker 2020-2021' spreadsheet respectively.

- f Add a contact to the claim in Eos

NOTE What are the contents of the contact?


Physical claim file received from the Accredited Employer and sent for scanning. ACC assumes management of the claim from 1 April 2021, so if the client contacts ACC prior to this date they should be referred back to their Accredited Employer or Third Party Administrator. If you have any other questions, please contact aepqueries@acc.co.nz.

- g Once the Scanning Team have scanned the file into Eos, record that this has happened with a Y(es) in column Y of the 'Tracker 2020-2021' spreadsheet.

- h Add a note to the Engagement Life Area in Eos.

NOTE What are the contents of the contact?

This claim was managed by an Accredited Employer (AE) or Third Party Administrator (TPA) until [INSERT DATE]. ACC is required to communicate with AE's prior to revoking a decision made by the AE's or TPA on their behalf. If you want to revoke a decision that has been made prior to ACC's management of this claim you need to contact them to discuss before decision has been issued.

 **Are there any new or ongoing review requests?**
Risk Sharing Team

YES.... **PROCESS** Receive, Log and Allocate Review Application

NO.... Continue


3.0 Scan and Upload Claim File

Scanning Team

- a Update the '2020-2021 AE Claims for Scanning' spreadsheet with the date the file is received (column H)
- b Prepare, scan and upload files into Eos:
 - All open FSC and PDP files need to be scanned within 24 hours
 - All closed FSC files need to be scanned within 24 hours
 - Closed PDP files can be scanned as time allows

NOTE How do I upload files into Eos?

Refer to the 'Upload Physical Documents Received via Postal Services' process below.

 **PROCESS** Upload Physical Documents Received via Postal Services

- c Update the '2020-2021 AE Claims for Scanning' spreadsheet with the date the file was scanned (column I)

4.0 Assess Claim Costs (Full Self-Cover Claims Only)

Claim Handback Assessor


- a This activity is only required for Full Self-Cover claims. For Partnership Discount Plan claims, proceed to Activity 5.0 Determine Where Claim is to be Managed

NOTE What if the claim is for a current ACC employee?

All returned claims for current ACC employees will be Full Self-Cover. For these claims, activity 4.0, 5.0 and 6.0 will be completed by a TPA Business Advisor in the TPA Support/Insurer Liaison team.

- b Complete a full file review of the claim file using the scanned copy in Eos
- c Complete the liability assessment spreadsheet - '2020-2021 CHB Template' and '2020-2021 Claim File Summary'

NOTE How do I assess claim costs for a Full Self-Cover Claim?

 **PROCESS** Assess Accredited Employers Programme (AEP) Claims Costs

NOTE What if the claim is related to occupational noise induced hearing loss (ONIHL)?

Risk Sharing Team completes liability assessments for these.

NOTE What if the liability assessment exceeds \$50,000?

Liability assessments exceeding \$50,000 must be peer reviewed by a member of the Risk Sharing Team:

- Liability assessments between \$50,000 and \$74,999 are peer reviewed by Risk Specialists
- Liability assessments exceeding \$75,000 are peer reviewed by the Risk Sharing Manager

- d Update the 'Tracker 2020-2021' spreadsheet

NOTE What information needs to be added to this spreadsheet?

Column AT: "Assessment completed" - the date the assessment was completed, or Y(es)

Column AU: "Name of assessor" - the name of the person who completed the liability assessment

Column AV: "Date assessed" - the date that the liability assessment was completed

Column AW: "WC Calculated" - Y(es) or N(o)

Column AX: "Assessed value" - the dollar value of future liability from the assessment

Column AY: "File complete and ready to go to actuaries" - Y(es) or blank

Column AZ: "Assessor Notes" - the things from the assessment that people ought to know

Column BA: "Peer review required" - Y(es) or N(o)

Column BB: "Peer reviewer \$50K +" - Y(es)/ Done and the name of Risk Specialist completing the peer review

Column BC: "Peer reviewer \$75K +" - Y(es)/ Done and the name of Risk Sharing Manager completing the peer review

5.0 Determine Where Claim is to be Managed

Claim Handback Assessor

- a Review claim to see what further action is required on it

NOTE Which aspect(s) of the claim need to be reviewed?

Review the ACC413 AE Claims Transfer Summary along with any other relevant information on the claim file e.g. application for review, to get an indication of current requirements on the claim:

- Is there weekly compensation or other entitlements required?
- Is there a treatment request that requires prior approval e.g. surgery or hearing loss?
- Is there an additional cover decision and nothing else required?
- Is there a review pending?

A claim is considered open if it requires ongoing management by ACC of any of the above (or other) entitlements and/or supports. A closed claim is one where no ongoing management or support is required.

The ACC413 has an option for the Third Party Administrator/Accredited Employer to tick if the claim requires active management after 31 March. ACC's definition of a claim requiring active management is different to the Third Party Administrator's/Accredited Employer's so you must check and draw your own conclusion on management requirements.

- b In Eos, create a contact on the claim. Complete the contact using the appropriate note below

NOTE What if the claim is Full Self Cover and you've determined it requires ongoing management by ACC?

Provide the following narrative in the contact:

"This claim is part of the most recent Accredited Employer Claims Hand back, it was a Full Self Cover (FSC) claim which has reached the end of the Accredited Employers claims management period. As management is still required on this claim, ACC need to take over claim management from 1 April. Please note: if weekly compensation is required as a part of the ongoing management of the claim, it is important that this is set up and ready for payments to commence from the 1st of April.

The current AEP/TPA Case Manager's contact details are on the ACC413. You're welcome to contact them to help assist with a smooth transition from the Accredited Employer to ACC claim management.

Please refer to activity 7.0 of the 'AEP Annual Claims Handback' process in Promapp for relevant process steps. If you have any further queries, contact the Risk Sharing team at aepqueries@acc.co.nz

'Full Self Cover' means that the employer has financial liability for the lifetime of the claim, so future decisions by ACC may impact significantly on the employer. Note that where ACC proposes to amend or revoke any decision of the Accredited Employer, ACC must first discuss the matter with the Accredited Employer and must advise the Accredited Employer of such revised decision and any review rights it may have. Enquiries in the first instance should be referred to aepqueries@acc.co.nz."

NOTE What if the claim is Full Self Cover and you've determined it doesn't require any ongoing management by ACC?

Provide the following narrative in the contact:

"This claim is part of the most recent Accredited Employer Claims Hand back, it was a Full Self Cover (FSC) claim which has reached the end of the Accredited Employers claims management period. On review the claim does not currently require any support from ACC. Should management be required by ACC in the future, this claim is ready to be picked up and managed as required

'Full Self Cover' means that the employer has financial liability for the lifetime of the claim, so future decisions by ACC may impact significantly on the employer. Note that where ACC proposes to amend or revoke any decision of the Accredited Employer, ACC must first discuss the matter with the Accredited Employer and must advise the Accredited Employer of such revised decision and any review rights it may have. Enquiries in the first instance should be referred to aepqueries@acc.co.nz."

NOTE What if the claim is a part of the Partnership Discount Plan and you've determined it requires ongoing management by ACC?

Provide the following narrative in the contact:

"This claim is part of the most recent Accredited Employer Claims Hand Back, it was a Partnership Discount Plan (PDP) claim which has reached the end of the Accredited Employers claims management period. As management is still required on this claim, ACC need to take over claim management from 1 April. Please note: if weekly compensation is required as a part of the ongoing management of the claim, it is important that this is set up and ready for payments to commence from the 1st of April.

The current AEP/TPA Case Manager's contact details are on the ACC413. You're welcome to contact them to help assist with a smooth transition from the Accredited Employer to ACC claim management.

Please refer to activity 7.0 of the 'AEP Annual Claims Handback' process in Promapp for relevant process steps. If you have any further queries, contact the Risk Sharing team at aepqueries@acc.co.nz"

NOTE What if the claim is part of the Partnership Discount Plan and you've determined it doesn't require any ongoing management by ACC?

Provide the following narrative in the contact:


"This claim is part of the most recent Accredited Employer Claims Hand Back, it was a Partnership Discount Plan (PDP) claim which has reached the end of the Accredited Employers claims management period. On review the claim does not currently require any support from ACC. Should management be required by ACC in the future, this claim is ready to be picked up and managed as required"

- c Upload the relevant 'Claim File Summary 2020-2021' and '2020-2021 Memo to Case Owner' documents to the claim in Eos
- d Update the 'Tracker 2020-2021' spreadsheet

NOTE What information needs to be added to this spreadsheet?

Column O: "Team file should be assigned to" - Supported or Partnered
Column P: "File open or closed (From ACC413)" - Open (those requiring ongoing management by ACC) or Closed (those requiring no ongoing management by ACC)

Refer to activity 3.0 in the 'Match Claim to Recovery Team' process for tools and guidelines to help you identify which team the claim should be managed by.

 **PROCESS** Match Claim to Recovery Team

6.0 Update and Transfer Claim

Claim Handback Assessor

- a Update claim status and details in Eos

NOTE Which aspects of the claim need to be amended in Eos?

- Update Cover Status (General Screen)

Change 'Cover Status': "Accept/Decline" (as per Accredited Employer decision)

Edit 'Cover Status Reason': "Criteria for Cover are Met"

Enter 'Cover Status Change Reason': "Claim Returned to ACC for ongoing management as the Accredited Employer claim management period has ended"

Set 'Send Auto Accept Letters?' to: "No" (to suppress letters)

Click OK

- Edit reassessment and Accredited Employer details (General Screen)

Click edit by 'Reassessment and Accredited Employer Details'

Amend 'Claim Returned Reason' to show "AE Management Period Ended"

Set 'Send Employer Notification Letters' to "No" (to suppress letters)


Click Ok

- b** If the claim requires ongoing management by ACC, create a general task on the claim. Complete the description field of the task using the contents of the contact on the claim (from activity 5.0b)

NOTE What if the claim doesn't require any ongoing management by ACC?

Check that the claim is sitting in the 'Actioned Cases - Registration' department in Eos. If it isn't, transfer it there. This process ends here


- c** Transfer the claim to the appropriate department in Eos

 Move a claim from BAU to NGCM

- d** Consider the contents of the task description/contact on the claim and action the next steps - create and conduct a recovery check-in conversation with the client.

NOTE How do I create a recovery check-in conversation?

Refer to the process below.

 **PROCESS** Conduct Recovery Check-in Conversation

NOTE What if weekly compensation needs to be set up?

Create a 'Non-Standard WC Setup' Eform in Eos, ensuring the following information is included (either on the claim or on the form):

- ACC413 Accredited Employer Claim Transfer Summary form
- Pre-incapacity earnings documentation is present and complete.
- Post-transfer earnings have been abated, if applicable.
- Information to confirm there is appropriate medical cover.
- Client contact information and verified bank account details.
- Signed authority from the client if the payment is to be made to an advocate/legal representative.
- If it is a reopened claim, earnings information for the exclusion period i.e. earnings around previous weekly compensation and the new weekly compensation period (DOSI).

Refer to the 'Add a Non standard WC set up Eform' system steps for further instructions on how to create this Eform.

Once the Eform has been created, create a 'Setup Weekly Compensation' task. Ensure you include the following information in the task:

- Bank Account
- IRD number
- Tax Code
- Work Pattern
- Average hours worked per week
- Incapacity approved in EOS (in line with DOFI/ DOSI)
- Incurred Date in EOS (general tab) in line with DOFI

Once the task has been created it will automatically route to the 'Centralised Weekly Compensation' department. Refer to the 'Add a Weekly Compensation setup task' system steps for further instructions on how to create this task.

 Add a Non standard WC set up Eform

 Add a weekly compensation set up task

7.0 Review and Action Claim

Recovery Assistant, Recovery Coordinator

- a** Review the claim and check for open tasks.

NOTE What if the claim requires support beyond your remit?

Transfer the claim to the Partnered Recovery department in Eos.

 Move a claim from BAU to NGCM

- b** Update details in Eos

NOTE Which aspects of the claim need to be amended in Eos?

- Check Employment, Injury and Medical tabs

Click the 'Employment' tab and check Employer is correct and set to "default"

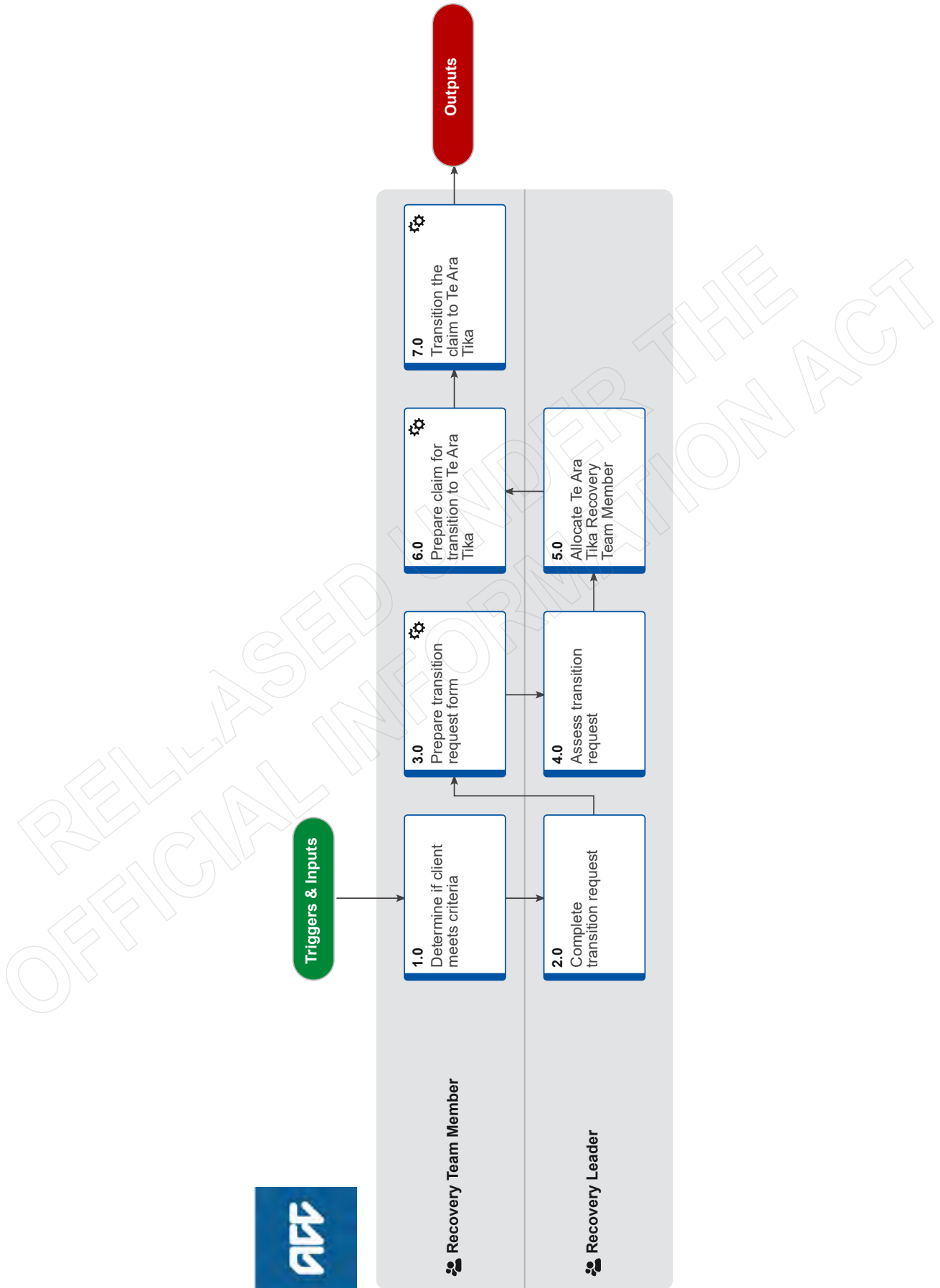
Click the 'Injury' tab, edit Accident Details and check 'did the accident happen at work?' is set to "yes"

Click the 'Medical' tab and compare accepted injuries against what has been recorded by the Accredited Employer on the ACC413 AE Claim Transfer Summary in the claim file.

- c** Review the claim history.

NOTE What if there is part of the claim history that you aren't sure about?

Contact the Risk Sharing team by emailing aepqueries@acc.co.nz.





Summary

Objective

To consider and transition a client to Te Ara Tika so that the client can be managed effectively and appropriately.

Background

The purpose of Te Ara Tika is to offer a flexible yet consistent client service delivery option to clients. This ensures complex clients will be managed in the one place allowing us to be flexible yet consistent in looking after the client's needs. Te Ara Tika was previously known as the Wellington Central Branch (WCB).

Any staff member can recommend transferring a claim to Te Ara Tika. Prompts for considerations include:

- The client has placed unreasonable demands on staff time, to the extent the support of the client has become challenging in the view of the Recovery Team Leader and/or Client Service Leader.
- The relationship between the client and ACC has become fraught, and the client openly shares negative opinions of ACC.
- The client may present with unreasonable behaviour, non-constructive communication, name calling, low impact non-directive threats
- The client submits frivolous requests, complaints or have phone calls/correspondence of a confrontational nature
- The client regularly contacts the media, senior managers, CEO, Minister and/or MPs

It is not a requirement for the client to have an active care indicator or a trespass order for them to be transferred to Te Ara Tika.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine if client meets criteria

Recovery Team Member

- Open the Partnered Decision Making Tool for transfer to Te Ara Tika to identify whether the client meets the criteria to be managed within the Te Ara Tika team.

Partnered Decision Making Tool for transfer to Te Ara Tika

- Take a screenshot of the recommendation from the Partnered Decision-Making tool.

NOTE What if the tool has recommended not to transition the client?

Continue to support the client in your Recovery Team.
Seek help around communication plans and ways of dealing with the client from one of the Te Ara Tika Team. This process ends.

- Send the screenshot to your Recovery Team Leader, and include the rationale for why the client should be considered for transition.

2.0 Complete transition request

Recovery Leader

- Review the information provided by the Recovery Team Member.

NOTE What should you consider before completing the transition request?

Before approving the transition check for the following:

- Consideration has been given to changing the client's Recovery Team Member
- Recovery Team Leader(s) are aware of the client's behaviour
- Consideration has been given to transition the client to another hub/Team
- Evidence of attempts to implement a communication plan and/or management plan with the client
- Evidence of attempts to manage the client's behavior with the support of specialised teams within ACC

NOTE What if you disagree with the transition of the claim to Te Ara Tika?

Consider alternative management options and discuss them with the Recovery Team Member or consider contacting the Te Ara Tika Team Leader for guidance.
This process ends.

- Contact the Te Ara Tika Team Leader to discuss the transition of the claim.

NOTE What if the Te Ara Tika Team Leader advises the client does not meet the transition criteria?

Request support from the Te Ara Tika Team Leader in developing a communication plan for the client.
Advise the Recovery Team Member of the decision.
You should also consider moving the client to another team member, suggest ways to manage the client through coaching and support to formalize boundaries with the client and using the support of other teams such as Practice Mentors, the Complaints and Resolution team, Cultural Capability teams and Psychology advisors.
This process ends

- Confirm the client meets the transition criteria to transition with the Te Ara Tika Team Leader.
- Advise the Recovery Team Member the claim will be transitioned and to complete the ACC6267 Te Ara Tika transfer form.

3.0 Prepare transition request form

Recovery Team Member

- In Eos, create and complete the ACC6267 Te Ara Tika transfer form.

ACC6267 Te Ara Tika transfer

- Send the completed ACC6267 to your Recovery Team Leader.

- Continue to manage the claim during the transition process, according to ACC Best Practice, this includes actioning an new tasks or requests, all contacts and documents and labelled correctly and the recovery plan is up to date in Salesforce.

4.0 Assess transition request

Recovery Leader

- a Review the ACC6267 Te Ara Tika transfer form, ensuring you have received sufficient information to confirm that all the following management options have been exhausted:

NOTE What if you don't have enough information?

- Obtain more information from the Recovery Team Member.
- If you are unable to obtain further information from the Recovery Team Member, then discuss with other Leaders, other options and appropriate strategies.

NOTE What if you disagree with the decision to transition the claim to Te Ara Tika?

Consider alternative management options and discuss this with the Recovery Team Member and their team leader. This process ends.

- b Sign the ACC6267 Te Ara Tika transfer form, scan and upload it to the client's claim.

- g Set up a meeting with the new Te Ara Tika Recovery Partner and the client.

- h Conduct the meeting, confirm with the client the timeframes for transition to allow for a smooth transition.

- i In Salesforce, add a contact to record the main points of the conversation with the client.

- j Inform your Team Leader the client is fully prepared to transition to the Te Ara Tika team.

7.0 Transition the claim to Te Ara Tika

Recovery Team Member

- a In Eos, transfer the claim to the Wellington Central Branch queue.

- b Contact the Te Ara Tika Team Leader and the Te Ara Tika Recovery Partner to inform them that the claim has been transferred to the queue.
-

5.0 Allocate Te Ara Tika Recovery Team Member


Recovery Leader

- a Identify the most appropriate Te Ara Tika Recovery Partner to manage the claim when transitioned.
- b Advise the new Te Ara Tika Recovery Partner of the new claim that will be allocated to them.
- c Advise the current Recovery Team Leader of the new Recovery Partner and ask them to let the current Recovery Team Member know.

6.0 Prepare claim for transition to Te Ara Tika

Recovery Team Member

- a In Eos, create and complete the ACC29 File summary and overview, making sure the next steps are clear and highlight any matters outstanding.

 ACC029 File summary and overview

- b Contact the new Te Ara Tika Recovery Partner to discuss the claim and expected timeframes for when the claim can be transitioned.

- c Contact the client to inform them of the transition to Te Ara Tika.


NOTE What if you're unable to contact the client?

Continue to manage the claim until you're been able to contact the client. The claim cannot be transitioned until it's been discussed with the client.

NOTE What if the client has a communication plan in place?

Discuss this with your Recovery Team Leader/ and or future Te Ara Tika Recovery Partner to decide the best plan would be for the client going forward.

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

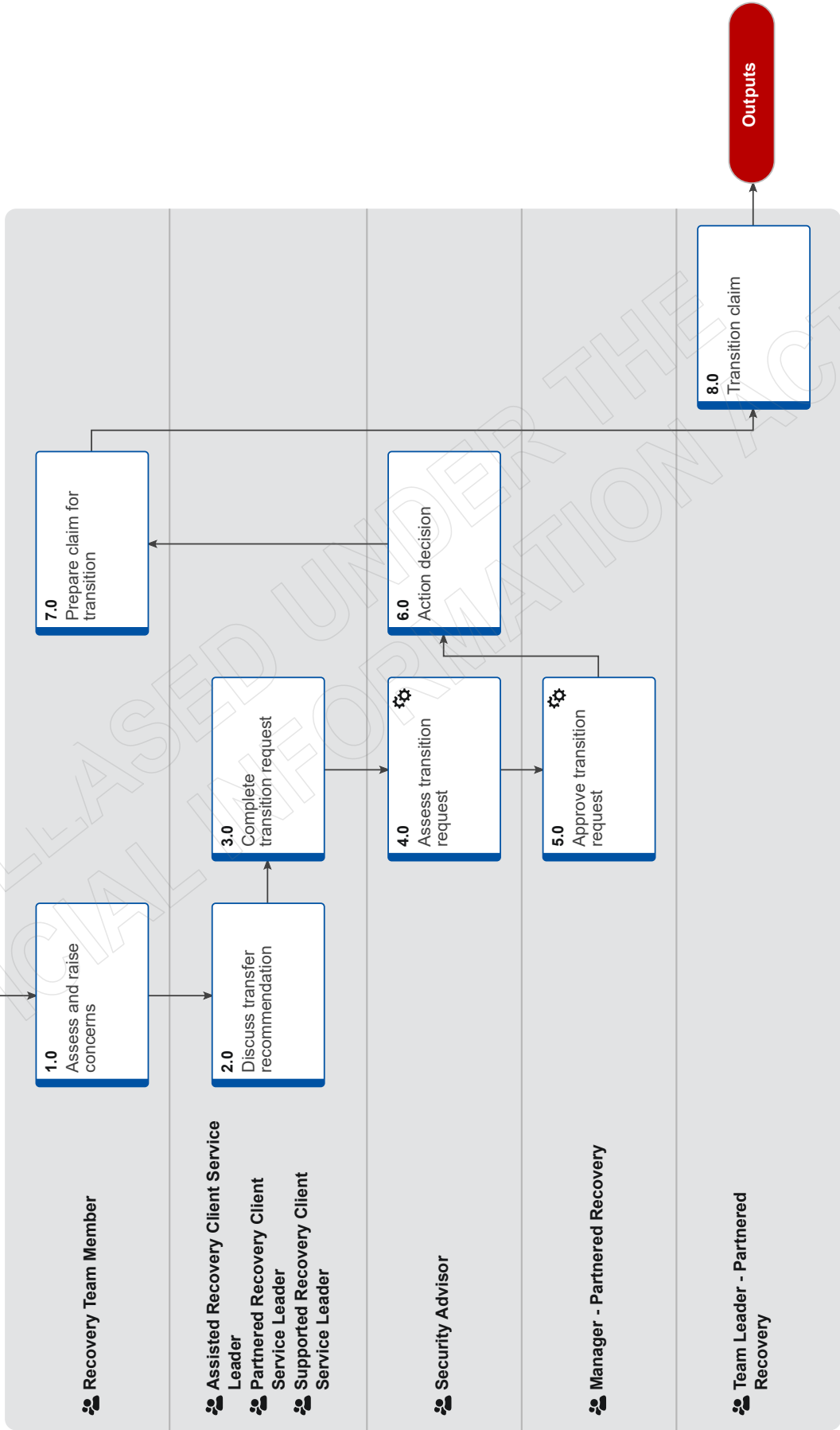
 Identity Check Policy

- e Advise the client of the transfer to a new Recovery Partner in the Te Ara Tika team, when they will be transitioned and the new contact details.

- f In Salesforce, add a contact to record the main points of the conversation with the client.



Triggers & Inputs



Summary

Objective

The purpose of this process is to consider transitioning a client into the Remote Claims Unit (RCU) so that they can receive the appropriate level of support for their recovery and to ensure safety of staff.

Background

The Remote Claims Unit (RCU) was established in 2000 as an initiative to provide for the health and safety of employees while still maintaining service delivery to clients who present a serious health and safety risk.

- A client who is managed in the RCU will not have face to face contact with ACC employees.
- The location of the RCU, and the people who work there, is strictly confidential
- On transfer to the RCU, a client's Care Indicator will be updated, or a new indicator will be activated, and the policy in relation to Care Indicators (including regular review of indicators and disclosure of information about indicators) continues to apply
- Communication with the client will be by email, post and controlled telephone contact.

Owner

[Out of Scope]

Expert

Procedure

1.0 Assess and raise concerns

Recovery Team Member

- Ensure you have completed the two processes linked below before you continue with Task b.
 - Assessing a clients risk level
 - Managing care indicated clients
- Raise any concerns you have with your team leader if you think the claim should be considered for transfer to the Remote Claims Unit (RCU).
- Prepare your concerns in writing to discuss with your team leader and client service leader. Consider and document the following:
 - details of the risk events that led to the care indicator being put in place
 - details of any events or actions that demonstrate the client could pose a direct risk to the safety of staff or providers
 - historical information about the client
 - the reason why the RCU transfer is the best course of action.

2.0 Discuss transfer recommendation

Assisted Recovery Client Service Leader, Partnered Recovery Client Service Leader, Supported Recovery Client Service Leader

- Discuss concerns raised and client transfer to the RCU with the team leader and recovery team member, focusing on the specific threats made to ACC staff or providers.
- Review the client's claim to confirm all other options for management have been exhausted first.

NOTE What alternative management options needs to be considered first?

- Consideration has been given to changing the client's recovery team member
- Client service leader(s) are aware of the client's behaviour
- Consideration has been given to transition the client to another hub/team
- Evidence that attempts have been made to implement a communication and/or management plan with the client
- Limiting communication by phone, email or mail
- All documentation from the client has been responded to in a timely manner.

- Using the Remote Claims Unit (RCU) criteria, confirm that the client meets the threshold to transfer to the RCU team.

NOTE What is the RCU criteria?

To determine whether a client poses a risk of harm all relevant information should be considered including one or more of the following:

- An incident has occurred causing immediate concern in relation to the safety of staff
- The client has demonstrated violent, aggressive or threatening behaviour (in person, by mail or by phone) that indicates there is a risk to employee and/or provider safety
- A trespass order is in place in relation to ACC premises
- Information has been received from a reliable source (e.g. Police; Assessors; Mental Health Services; Doctor) to the effect that genuine concerns are held regarding the potential threat the client may pose to ACC employees.

NOTE What if the claim doesn't meet the criteria for transfer?

Continue to manage the claim as appropriate and consider alternative management options as previously outlined. This process ends.

- Managing care indicated clients
<http://thesauce/team-spaces/chips/issues/care-indica>
 - Managing a client with an active Care Indicator
- Confirm that the claim should be considered for transfer to the RCU team and advise the recovery team member and team leader of the next steps.

3.0 Complete transition request

Assisted Recovery Client Service Leader, Partnered Recovery Client Service Leader, Supported Recovery Client Service Leader

- Fill out the ACC2222 Remote Claims Unit referral form, ensuring you've documented the necessary information.

ACC2222 Remote Claims Unit referral form

NOTE What information must be completed?

- Claim details
- Reason for referral
- Threatening behaviour
- Relevant history and background
- Security interventions
- Recovery Management Plan of Intervention.

- Email the ACC2222 referral form to the Security Advisor to review the issues raised.

4.0 Assess transition request

Security Advisor

- a** Receive the transition email from the client service leader and review the:
- Party Record in Eos
 - client's file
 - ACC2222 Remote Claims Unit referral form.

- b** Discuss the claim with the Partnered Recovery, Client Service Leader and provide a recommendation and rationale to the Manager, Partnered Recovery on whether there are reasonable grounds to find that the transfer criteria are met.

NOTE What if the claim doesn't meet the criteria for transfer?

Advise the relevant client service leader and provide advice about ways to address the concerns about health and safety. This process ends.

- c** Get the form signed and dated by both yourself and the Partnered Recovery, Client Service Leader.
- d** Email the completed ACC2222 referral form to the Manager, Partnered Recovery to review and approve.

5.0 Approve transition request

Manager - Partnered Recovery

- a** Receive the transition email from the Security Advisor and review the:
- Party Record in Eos
 - client's file
 - ACC2222 Remote Claims Unit referral form.

- b** Confirm that the claim should be transitioned to the RCU team for ongoing management.

NOTE What if the claim shouldn't be transitioned to the RCU team?

Provide your rationale to the Security Advisor, with alternative management options. This process ends.

- c** Email the Security Advisor of your approval for the transfer.


6.0 Action decision

Security Advisor

- a** Review the decision from the Manager, Partnered Recovery.

NOTE What if the Manager, Partnered Recovery, declined the transition to RCU?

Liaise with the relevant client service leader and provide advice about ways to address the concerns about health and safety. This process ends.

-  Managing care indicated clients
<http://thesauce/team-spaces/chips/issues/care-indica>

- b** Inform the Partnered Recovery Client Service Leader and the client service leader where the claim is currently managed, of the approved decision.

- c** Contact the Recovery Team Member who raised the issue and request that they organise for all Recovery Admin tasks to be closed off.

7.0 Prepare claim for transition

Recovery Team Member

- a** Ensure all Recovery Admin tasks on the claim are closed. Contact the Recovery Admin team to request that they close these tasks without actioning them, including any requests for written guidance or notes. Make a note on the claim detailing which tasks have been closed.

8.0 Transition claim

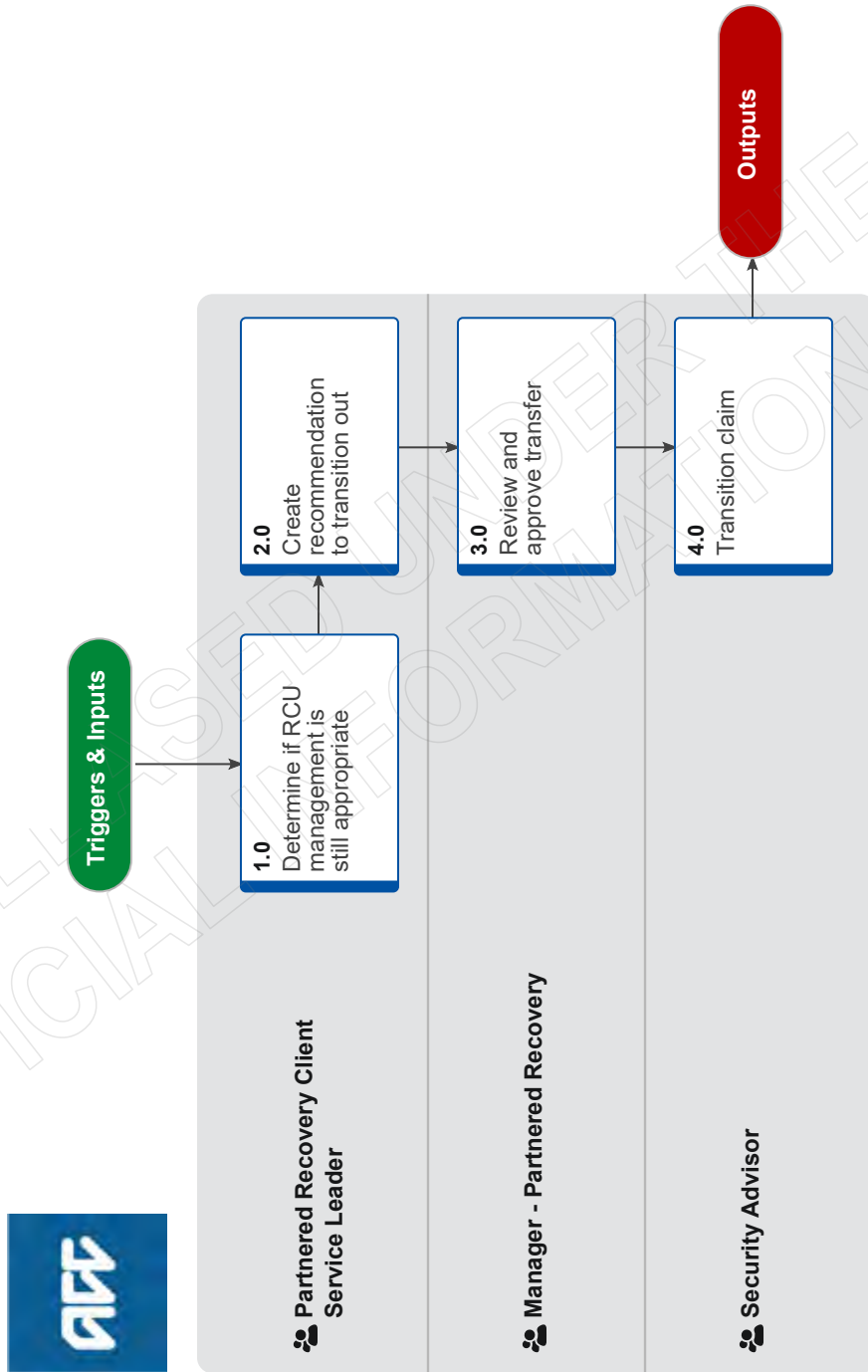
Team Leader - Partnered Recovery

- a** Transfer the claim to the Remote Claims Unit Department Queue.

NOTE What if the client has got more than one active claim?

Transfer all active claims to the Remote Claims Unit Department Queue.

-  Transfer a claim (Eos Online Help)





Summary

Objective

The purpose of this process is to consider transitioning a client out of the Remote Claims Unit (RCU), if and when they no longer meet the RCU criteria.

Background

The Remote Claims Unit (RCU) was established in 2000 as an initiative to provide for the health and safety of employees while still maintaining service delivery to clients who present a serious health and safety risk.

The Partnered Recovery, Client Service Leader will review whether a client continues to meet the criteria to be managed in the RCU as necessary, and at least every 6 months, when the review of the Care Indicator occurs.

Owner

[Out of Scope]

Expert

Procedure

1.0 Determine if RCU management is still appropriate

Partnered Recovery Client Service Leader

- a Review the claim to determine if a client no longer meets the criteria to be managed in the Remote Claims Unit (RCU).

NOTE **When is it appropriate to review a clients RCU management?**

At least every 6 months or when the review of the Care Indicator occurs.

Activate, Review and Deactivate Care Indicators

NOTE **What is the criteria for on going RCU recovery support?**

To determine whether a client poses a risk of harm, all relevant information should be considered including one or more of the following:

- An incident has occurred causing immediate concern in relation to the safety of staff
- The client has demonstrated violent, aggressive or threatening behaviour (in person, by mail or by phone) that indicates there is a risk to employee and/or provider safety
- A trespass order is in place in relation to ACC premises
- Information has been received from a reliable source (e.g. Police; Assessors; Mental Health Services; Doctor) to the effect that genuine concerns are held regarding the potential threat the client may pose to ACC employees.

- b Confirm that the client should be transitioned out of the RCU.

NOTE **What if the client still meets the criteria to be managed in the RCU?**

Continue to manage the claim. This process ends.

- c Contact the Client Service Leader of the client's home region to discuss the option of returning the claim to them.

NOTE **What if they're uncertain if the claim should be transitioned back?**

- Discuss and understand their concerns
- Consider alternative locations or Recovery Team that might be more appropriate for the claim
- Use this discussion to inform your decision on where it should be managed.

2.0 Create recommendation to transition out Partnered Recovery Client Service Leader

- a Contact the Security Advisor and advise that the client no longer meets the criteria for RCU recovery support.

NOTE **What if the Security Advisor disagrees and recommends that the claim stay in the RCU?**
Continue to manage the claim. This process ends.

- b Email a recommendation to the Manager, Partnered Recovery, to request approval to transition the claim from the RCU.

3.0 Review and approve transfer

Manager - Partnered Recovery

- a Receive email and review the recommendation.
- b Approve decision to transition out of RCU.

NOTE **What if RCU management is still required?**
Decline the request to transition the claim out of RCU.

- c Email decision to the Client Service Leader - Partnered and Security Advisor.

4.0 Transition claim

Security Advisor

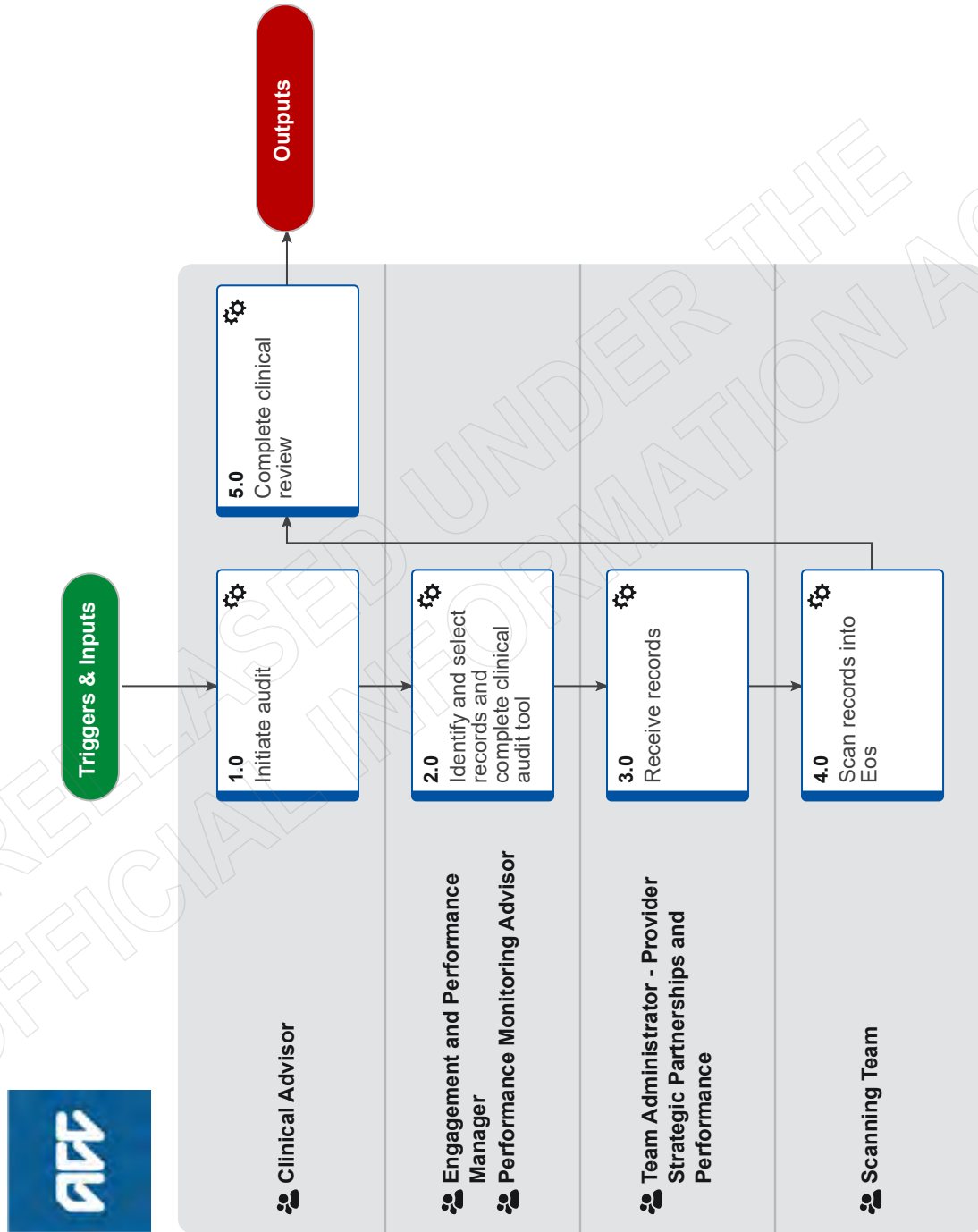
- a Contact the Client Service Leader of the client's home region and outline the reasons why the client no longer meets the criteria for management within the RCU.

NOTE **What if the Manager, Partnered Recovery declined the transition request?**

- Inform the Partnered Recovery Client Service Leader that the claim will stay in the RCU
- Update the client's care indicator
- Provide advice on any future safety issues.

- b Update the client's care indicator and transfer the claim.

- c As required, provide advice and on any future safety issues.



Summary

Objective

This process defines the steps to take when clinical records require auditing by a clinical advisor

Owner

[Out of Scope]

Expert

Procedure

1.0 Initiate audit


Clinical Advisor

- a Contact EPM to discuss issue and sample size

2.0 Identify and select records and complete clinical audit tool

Engagement and Performance Manager, Performance Monitoring Advisor

- a Identify claims from InFact, provider reports or integrity services
- b Update audit tool with your name, vendor name, provider name, issue description and claim numbers and date sections (the yellow sections) for each of the sample records being requested

 4_Clinical Record Audit Toolv1.2 FINAL.xlsx


- c Create a folder for the provider in the shared drive. Folder name should be set up as first name, space, surname (e.g. John Smith). Save the semi-completed audit template and clinical advice work request form in the folder. Use the following naming techniques to assist the admin team with their tasks
 - Audit template <date> (e.g. Audit template 06_06_19)
 - Work request <date> (e.g. Work request 04_06_19)

NOTE Where's the shared drive?

W:\Public\Clinical Records Review Data

- d Request clinical records from provider with attached password protected spreadsheet, If e-mailing the provider, Bcc the clinical advisor and PSD Admin team (ClinicalRecordsReview@acc.co.nz) so they are aware of the request.

 PSD05 Uplift clinical records

 Table of services with missing clinical records TEMPLATE.xlsx

- e If not already done in 2.0 (d), notify Provider Service Delivery Administration team (via ClinicalRecordsReview@acc.co.nz) and clinical advisor that the notes have been requested and the date they are due.

3.0 Receive records

Team Administrator - Provider Strategic Partnerships and Performance

- a Receive records via ClinicalRecordsReview@acc.co.nz email
- b open clinical note and type each service date into the audit tool under the relevant claim number,
- c record if its a clinical note or a client declaration

- d move to email subfolder DMT processing within the clinical records review
- e email clinical advisor and EPM to notify notes sent for scanning


4.0 Scan records into Eos

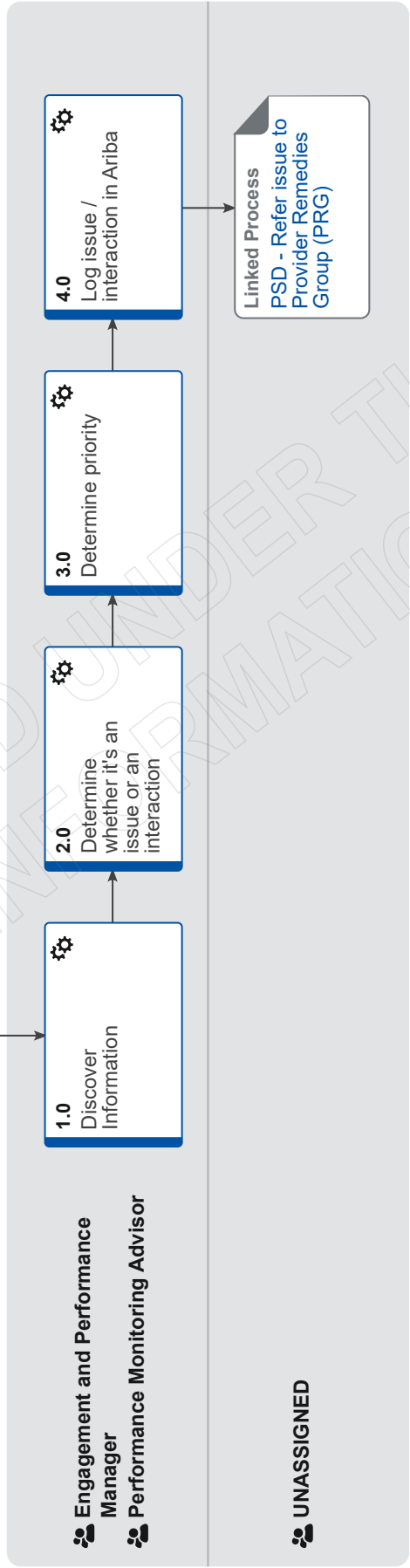
Scanning Team

- a Receive request via DMT email subfolder to scan records into Eos
- b Scan documents into Eos

5.0 Complete clinical review

Clinical Advisor

- a Check Eos that notes have been scanned and are available
- b Complete clinical review using the audit tool saved in the shared drive
- c Complete draft audit report using the report template
 -  RP01 - clinical notes audit report.doc
- d Send report to relevant team manager for review and approval
- e Once approved, create 2 versions one with appendix and one without for provider and save in shared folder
- f Notify EPM that reports available and discuss next steps
- g Return to the "request clinical advice" process



RELEASED UNDER THE OFFICIAL INFORMATION ACT

Summary

Objective

To describe the steps that Performance Monitoring Advisors and Engagement and Performance Managers take when a potential provider / supplier issue has been identified.

Issues and interactions are recorded in Ariba to enable ease of tracking and reporting and to provide a more complete history of issues and interactions for a particular provider should information be needed in the future.

If this process is not suitable for the situation you are managing, discuss it with your manager.

Background

Identifying and recording an issue correctly in Ariba ensures that all parties that may need information on the issue can:

- easily find documents related to the issue
- extract data from Ariba to support reporting (eg for PIMG / PRG / ad hoc reports)
- identify who is the responsible lead for the issue.

Owner

[Out of Scope]

Expert

Procedure

1.0 Discover Information

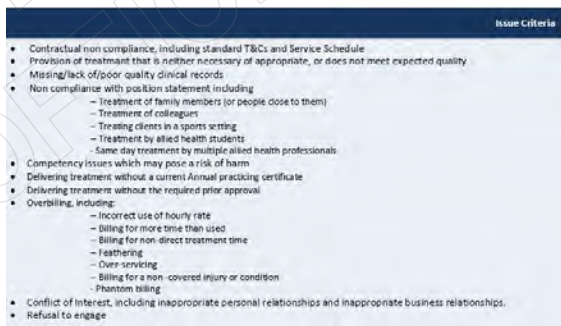
Engagement and Performance Manager, Performance Monitoring Advisor

- a Discover information that requires a formal issues management process, clicking on the image to see the issue criteria.

NOTE Where does the information come from?

Information may come from:

- Provider Indicator Reporting (PIR)
- the HIPP tool
- allegations and / or complaints
- invoice analysis
- previous provider issues, etc.
- Integrity services IDEA reports.

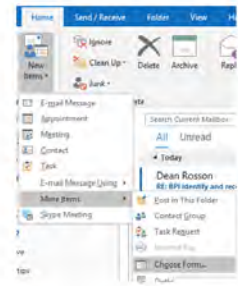


Issue criteria.JPG

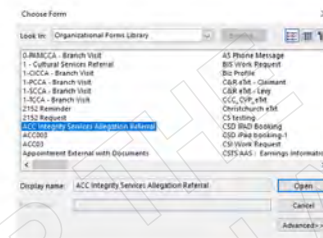
- b Gather sufficient information to progress the issue to the next step, including checking Ariba to see if there is any previous history of issues for that provider, supplier or vendor.

NOTE Do you need more information to clarify whether the issue criteria is met?

Integrity Services advice can be requested by completing the integrity insights e-mail form. Clicking on the image shows the system steps to refer.



In your e-mail, in the Home tab, select New Items, More Items, Choose Form.



In the choose form box, select ACC Integrity Services Allegation Referral.

Find the IS referral form PNG.PNG

2.0 Determine whether it's an issue or an interaction

Engagement and Performance Manager, Performance Monitoring Advisor

- a Use the Provider Issue Criteria to determine whether the information needs to be recorded in Ariba:
 - as an issue using a Provider Issue E-form (PIE)
 - as a supplier interaction (SIP).

NOTE Does the information meet the Provider Issue Criteria?

clicking on the + in the first image above shows the criteria.

Yes - Go to step 3.0

No - Go to step 4.0 b to record an interaction.

NOTE What if you are unsure?

Review the different types of issues, P15 and onwards in the Provider Remedies Framework Operational Guidelines and talk to your manager if you need assistance.

Provider Remedies Framework Operational Guidelines

3.0 Determine priority

Engagement and Performance Manager, Performance Monitoring Advisor

- a Determine a priority rating using the Provider issues prioritisation tool as this is required in Ariba when creating a PIE. Provider issues risk tool I:/PSD/01 Team/03 SP&P/04 Performance Review Team/Projects/Prioritise and Log issue improvements/Provider Issues risk tool.xlsx

NOTE What if the priority rating is high?

Discuss with your manager and agree on the approach to be taken to manage the issue, including informing others.

NOTE What if there is a media risk?

Complete the Media Risk Issues Alert template by clicking on the link below.

Media Risk Issues Alert Template

NOTE What if the priority rating is minor / low / medium and you feel it needs Provider Issues Management Group (PIMG) consideration?

Discuss with your manager and if agreed, add the issue to the PIMG high risk issues report that the SPP Administrator issues monthly.

4.0 Log issue / interaction in Ariba

Engagement and Performance Manager, Performance Monitoring Advisor

- a Create a Provider Issues E-form if the issue requires formal management as PIEs need to be recorded in Ariba for all providers, ie T1,2,3 or 4.
- b Ensure the naming convention outlined in the Ariba Reference Guide below is used for creating a PIE (YYYY_MM_DD Provider Issue, provider / supplier name, Issue Type).

NOTE Example:

2019_10_21 Provider Issue, Ultimate Physiotherapy, Invoicing issue

NOTE What if there is more than one issue type identified?

A separate PIE form needs to be created for each issue to enable accurate reporting of types of issues being seen. Using the correct naming convention will enable these PIEs to be distinguished in Ariba and for reporting purposes

 Ariba Reference Guide

- c Create a supplier interaction if the issue does not require formal management and ensure the naming convention outlined in the Ariba Guide is used for creating a SIP (YYYY_MM_DD Interaction, Provider / supplier name)

NOTE Example:

2019_10_21 Interaction, Ultimate Physiotherapy

NOTE What if the interaction is with a T1,2 or 3 supplier?

Only interactions for providers / suppliers who are not loaded in CRM need the interaction recorded in Ariba. CRM business rules should be followed for Tier 1,2,3 suppliers.

- d Consider whether a submission needs to be made to either the Provider Remedies Group or the Provider Issues Management Group.

NOTE What if there is a clear Risk of Harm to the public?

If a clear potential risk of harm to the public is identified, an early notification to the appropriate regulatory authority may be made before a full investigation is completed. Discuss with your manager if you are unsure.

 **PROCESS** PSD - Refer issue to Provider Remedies Group (PRG)
UNASSIGNED

Summary

Objective

This policy defines vocational independence. Use this policy to understand:

1. What is vocational independence
2. Determining Vocational Independence
3. Implications of a Vocational Independence decision
4. When to complete Vocational Independence Assessment
5. Eligibility and entry criteria to Vocational Independence Assessments
6. Other points to check before deciding to assess Vocational Independence
7. Clients with planned surgeries
8. Clients with previous Vocational Independence assessments relating to the same injury

Background

When a client is unable to work due to their injury, the initial focus is usually on supporting them to return to, or regain fitness for, their current or pre-injury employment.

For some clients, a more appropriate outcome is to help prepare them to be 'work ready' for alternative employment. This rehabilitation outcome is known as Vocational Independence (VI).

Owner

[Out of Scope]

Expert

Policy

1.0 What is Vocational Independence

- a** Vocational independence (VI) is defined as the ability for a client to return to work suitable to them based on their skills gained through education, training or experience and having the ability to perform this work at least 30 hours per week.

This rehabilitation outcome is used when a client is no longer able to regain work fitness for their pre-injury employment or it is no longer reasonably practical to assist them to do so.

Vocational rehabilitation (VR) has been targeted in assisting the client to become work ready in alternative work types to that of their pre-injury employment.

Once VR has been completed, the client's ability to achieve VI can be determined.

Vocational Independence Journey

2.0 Determining Vocational Independence

- a** We determine a client's VI by obtaining two independent vocational assessments. These are:

- Vocational Independence Occupational Assessment (VIOA)
- Vocational Independence Medical Assessment (VIMA)

Vocational Independence Assessments [VIOA/VIMA] Policy

- b** These assessments will consider:

- whether the VR provided has met the client's needs
- what types of work are suitable for the client based on their skills gained through education, training or experience
- how the client's injury is affecting their ability to work
- whether they're medically fit to work for 30 hours or more a week in the identified suitable work types

The client is considered to have achieved VI when they are assessed to have suitable work types that they can medically sustain for 30 hours or more per week.

PROCESS Arrange Vocational Independence Occupational Assessment (VIOA)

PROCESS Arrange Vocational Independence Medical Assessment (VIMA)

3.0 Implications of a Vocational Independence decision

- a** If a client is assessed and found vocationally independent, the client is provided with a notice period of up to 3 months before their weekly compensation ceases. This would also mean the client is no longer eligible to receive vocational rehabilitation support.

A VI decision does not impact the client's access to treatment or other entitlements related to their injury.

We can also assist the client with:

- budgeting and counselling assistance
- a list of employment agencies
- ongoing case management support
- help with enrolling with Work and Income

4.0 When to complete Vocational Independence assessments

- a** We should only assess a client's VI when:

- the client has completed the vocational rehabilitation that we agreed to provide; and
- we believe that the client is likely to achieve vocational independence

We can also reassess a client to determine if they have lost their vocational independence (see VI Deterioration).

About Vocational Independence Deterioration Policy

5.0 Eligibility and entry criteria to Vocational Independence Assessments

- a** To be eligible for assessment of VI, the client must:
- be receiving (or be entitled to receive) weekly compensation
 - be unable to regain work fitness for their pre-injury employment, or it must no longer be reasonably practical to support them to do so
- The following criteria must also be met:
- a current consent form is on file
 - an initial occupational assessment (IOA) and initial medical assessment (IMA) have been completed
 - the outcome of the IOA and IMA are recorded in the client's Recovery Plan (RP) / Individual Rehabilitation Plan (IRP)
 - all vocational rehabilitation that we have agreed to provide has been completed
 - consideration has been given to the potential impact of any remaining injury-related medical treatment, e.g. planned surgery
 - any injury-related barriers that may prevent the client from sustaining 30 or more hours of work per week have been addressed
 - a Technical Specialist and Medical Advisor have agreed in the ACC191 Vocational Independence Assessment: File Summary team review and Quality Check (191K) that the client is likely to achieve VI

6.0 Other points to check before deciding to assess Vocational Independence

- a** It is essential that we perform a thorough check to ensure a client is ready to have their VI assessed. You must ensure that:
- where there is more than one set of initial assessments (IOA/IMA), the most recent sets have been used
 - the IMA gave consideration to any non-injury-related issues that were affecting the client
 - we have recognised any paid or unpaid work the client has engaged in since their accident
 - any VR that we are liable for, or have provided, has been completed and within a reasonable timeframe (prior to the client's entry into the VI process)
 - we have considered the potential impact of any remaining injury-related medical treatment, eg pain issues or surgery
 - we have addressed any changes from the original diagnosis, and updated cover where appropriate
 - we have considered injuries from any other relevant claims (i.e. sensitive claim)

7.0 Clients with planned surgeries

- a** Make sure you take into consideration any surgery that the client has got planned before scheduling the VI Assessments. It is important you let both the Medical Advisor and the Technical Specialist approving entry into VI know of any planned surgery for your client. We must take into account the nature of the surgery, the date of the surgery, and the client's circumstances when determining whether to start or delay the VI Assessments for clients with upcoming surgery.

8.0 Clients with previous Vocational Independence assessments relating to the same injury

- a** When a previous VI assessment determined that a client was not vocationally independent, the following additional criteria must be met before a new VI assessment can be made:
- there is evidence of fresh consideration of the client's vocational or medical needs
 - we have updated the client's Recovery Plan (RP) / Individual Rehabilitation Plan (IRP) with all additional rehabilitation that addresses their injury-related barriers to employment or achieving VI
 - the additional rehabilitation was thorough and has been completed

9.0 Links to legislation

- 📄 Accident Compensation Act 2001, section 107 - Corporation to determine vocational independence
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- 📄 Accident Compensation Act 2001, section 108 - Assessment of claimant's vocational independence
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- 📄 Accident Compensation Act 2001, section 109 - When claimant's vocational independence to be assessed
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- 📄 Accident Compensation Act 2001, section 110 - Notice to claimant in relation to assessment of vocational independence
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- 📄 Accident Compensation Act 2001, section 111 - How determination that claimant has vocational independence is to be regarded
<http://www.legislation.govt.nz/act/public/2001/0049/lat>
- 📄 Accident Compensation Act 2001, section 112 - Claimant with vocational independence loses entitlement to weekly compensation
<http://www.legislation.govt.nz/act/public/2001/0049/lat>

Summary

Objective

This policy defines vocational rehabilitation. Use this policy to understand:

1. What is vocational rehabilitation
2. Eligibility to vocational rehabilitation
3. Vocational Rehabilitation and the Recovery Plan (RP) / Individual Rehabilitation Plan (IRP)
4. Preferred vocational rehabilitation options
5. Requirements for vocational rehabilitation
6. Duration of vocational rehabilitation
7. Legislation Reference

Owner

[Out of Scope]

Expert

Policy

1.0 What is Vocational Rehabilitation

- a** We define Vocational Rehabilitation (VR) as the assistance necessary to achieve a meaningful and sustainable vocational outcome, whether this be to assist a client to return to work or where this is not reasonably practical, prepare the client for work readiness.

The goal of VR is to assist the client to:

- Maintain employment ('Return to my preinjury role'); or
- Obtain employment ('Return to a lighter work type'); or
- Regain or acquire vocational independence ('Work and manage my life'). Refer to the Vocational Independence Journey for more information.

 Vocational Independence Journey

2.0 Eligibility to Vocational Rehabilitation

- a** We must provide VR to any client who has a covered personal injury and is either:
- entitled to weekly compensation or Loss Of Potential Earnings (LOPE)
 - likely to be entitled to weekly compensation if we don't provide vocational assistance
 - no longer entitled to weekly compensation because they've reached the NZ Superannuation Qualifying Age (NZSQA)
 - on parental leave.

We must start to consider VR as soon as we decide that a client is likely to be eligible.


3.0 Vocational Rehabilitation and the Recovery Plan (RP)

- a** All clients who could be entitled to VR must have a Recovery Plan (RP).

You must develop the RP within 13 weeks of the client's injury being accepted for cover.

When determining a client's VR you must take into account the VR outcome agreed in their RP.

For more information see:

-  Recovery Plan Policy
-  Create or Update Recovery Plan

4.0 Preferred Vocational Rehabilitation options

- a** You must determine whether the client can return to the same employment and employer they had before their incapacity. If this isn't possible, decide which of the following is the most reasonable and practical option for the client:

- return to a different kind of employment with their previous employer
- return to the same kind of employment with a different employer
- use their experience, education, or training in a different kind of employment with a different employer
- help the client to use as many of their pre-injury skills as possible to get employment.

5.0 Requirements of Vocational Rehabilitation

- a** The vocational rehabilitation provided to a client must meet the following criteria:

- be likely to achieve the vocational goals recorded in the client's RP
- cost-effective and perhaps help to reduce other costs, such as weekly compensation
- appropriate in the client's circumstances
- sustainable by the client in the long term
- tailored to the client's needs and abilities, especially if they have a serious injury

NOTE Examples

A client's pre-injury work required them to have a specific tertiary qualification. They can't return to that particular type of work. We can provide rehabilitation assistance to support them in doing other similar work that also uses that qualification

A client's brain injury means they can never return to their previous level of employment. We aim to return them to the closest equivalent level of employment that their injury will allow them to sustain





6.0 Duration of Vocational Rehabilitation

- a We must provide VR for the minimum period necessary to achieve the client's vocational outcome in their RP, but typically must not provide it for longer than 3 years (which needs not be consecutive).

ACC can provide VR for longer than 3 years at its discretion if it still fulfils the requirements of VR. Technical guidance should be sought in this circumstance.

We must resume VR, with the client's agreement, if they are unable to sustain their return to work or work readiness after the initial VR. You must note the agreement in their RP.

7.0 Links to Legislation

-  Accident Compensation Act 2001, Section 85 - Corporation liable to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 86 - Matters to be considered in deciding whether to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 87 - Further matters to be considered in deciding whether to provide vocational rehabilitation
<http://legislation.govt.nz/act/public/2001/0049/latest/D>
-  Accident Compensation Act 2001, Section 88 - Vocational rehabilitation may start or resume if circumstances change
<http://legislation.govt.nz/act/public/2001/0049/latest/D>

Summary

Objective

This policy explains the impact of adverse events on experience ratings and will help you to decide if a claim is related to an adverse event. Experience ratings are governed by the Accident Compensation (Experience Rating) Regulations 2011.

The Minister for ACC decides whether to declare an adverse event.

Owner

[Out of Scope]

Expert

Policy

1.0 Criteria for managing adverse events

- a The Minister for ACC can declare that an event will be treated as an adverse event for experience rating purposes.

Adverse event declarations only relate to work-related personal injuries.

Work-related personal injuries that directly or indirectly result from a declared adverse event are not counted for experience rating purposes, provided the employer did not contribute materially to the injury.

Work-related personal injury claims will be attributed to an employer and form part of their claims history until it is considered that the injury resulted from an adverse event.

If it is determined that a work-related personal injury has resulted from an adverse event, the injury will be excluded from the employer's experience rating claims history.

Work-related personal injuries that are not considered to have resulted from an adverse event will be included in an employer's experience rating calculations.

2.0 Adverse Event Management Group

- a If an adverse event has occurred that will impact upon experience ratings, multiple areas of the business will need to be advised.

These areas are known as the Adverse Event Management Group (AEMG) and, although who should be contacted on a case-by-case basis, the following parties should always be informed:

- Claim Lodgement
- Client Contact Centre (CCC)
- Injury Prevention Partnership and Delivery
- Insurance Delivery
- Experience Rating Support Team
- Actuarial Services.

Depending on the nature of the event, the following may also need to be included in the AEMG:

- Business managers
- Weekly Compensation
- Area managers (specifically in areas affected by the event)
- Health Service and Provider Relationships
- Levy

3.0 Further information

- a If you have any queries about whether a work-related personal injury is included or excluded for experience rating calculation purposes, please contact the Incentive Team via email business@acc.co.nz

Summary

Objective

An advocate is someone who acts on behalf of a client. They may get involved when a client wishes to be supported while working with ACC.

Clients can request that another person, eg an advocate, relative or friend, act on their behalf when dealing with a claim by completing an ACC5937 Authority to act form, which is added to their party record in Eos.

Owner [Out of Scope]
Expert [Redacted]

Policy

1.0 Legislation

- a The following legislation and codes govern our communications with client advocates:

-  Code of ACC Claimants' Rights.pdf
-  Health Information Privacy Code 2020
<https://www.privacy.org.nz/privacy-act-2020/codes-of->
-  Privacy Act 2020
<https://www.legislation.govt.nz/act/public/2020/0031/l/>

2.0 Community advocacy

- a ACC has a contract with two suppliers to provide a community Navigation Service to ACC clients. These providers are:
 - Way Finders
 - Workplace Injury Advocacy Service (WIAS)

The Navigation Service is a free and independent service that our clients can use at any time, from pre-claim lodgement through to the point of a review hearing. It is available throughout the country, using the following 0800 phone numbers:

- WayFinders: 0800 273 030
- Workplace Injury Advocacy Service: 0800 486 466

3.0 Advocacy groups and ACC

- a ACC works in partnership with advocates and advocacy services through the Voice of the Customer (VoC) programme, to ensure that the voice of the customer is heard and recognised by ACC. You can email the programme manager directly at voc@acc.co.nz.

They:

- work with advocacy organisations to improve the quality and availability of advocacy services for ACC clients
- coordinate the ACC Consumers' Outlook Group (a group of people who talk to ACC as representatives of the wider community)
- coordinate the Older People Advisory Group (OPAG), which is particularly concerned with injury issues for older people in the community.

4.0 Written communication

If the client gives us...	then we must address any letter, email or fax to the...
signed authority	client, with a copy to the advocate
both: <ul style="list-style-type: none"> • signed authority • written advice to send all communication via their advocate 	advocate, with a copy to the client
written advice to send all communication to their advocate only	advocate

 Written communication.PNG

5.0 Telephone communication

- a You must make telephone contact with the advocate acting for the client, not with the client.

6.0 Exception

- a Court order provisions take precedence over these rules, eg Protection of Personal Property and Rights Orders.

When there is a Court order in place, we must comply with its provisions.

Summary

Objective

This page contains information on eligibility for a serious injury (SI) profile.

Owner

[Out of Scope]

Expert

Policy

1.0 Rules

- a It is important that SI profiling occurs as soon as possible after the injury occurs. This will ensure that the case is identified and transferred to a Serious Injury Case owner for specialist management at the earliest opportunity, enhancing the potential outcomes for the client.

It is up to the unit referring the claim to the NSIS for profiling to ensure:

- requirements for clinical information are met
- clinical evidence is attached to the profiling request.

If there is insufficient information the claim will be returned un-profiled.

2.0 Clinical evidence

- a SI profiling is completed based on clinical evidence about the outcome of the injury. The way the injury occurred is not a factor in this consideration.

3.0 Clients with complex needs or Challenging behaviours

- a Clients with complex needs or with challenging behaviours are not automatically SI clients. Referrals for SI profiling should only be made when there is sufficient clinical evidence related to the SI profiling criteria to support the referral.

4.0 Older injury

- a Consider the benefits of assigning a profile for older injury claims. For an older injury claim to be profiled, as well as meeting the clinical criteria, there must be good evidence of benefit in terms of:

- the likelihood of significantly improved outcomes for the client that couldn't be achieved with the current case owner or team
- the opportunity for ACC to achieve significant cost savings that couldn't be achieved with the current case owner or team
- the management of an identifiable future liability growth risk, ie unfunded services.

For older traumatic brain injury claims that are more than six months post-injury, the clinical details will not always be available. In these cases, the Serious Injury Advisor will consider alternative evidence consisting of:

- a recent neuropsychological assessment (considers the ongoing impact of the injury)
- a recent needs-based assessment.

The referring units are responsible for securing these assessments before making the referral for profiling.

5.0 Delegation for assigning an SI profile

- a The Serious Injury Advisors are

6.0 Assigning an SI profile


- a Claims can only be allocated an SI profile if they satisfy the clinical description of one of the profiles mentioned in the table below.

Some flexibility is required when considering children with traumatic brain injuries (BTI), especially those aged three and younger. This is because it can be difficult to determine Glasgow Coma Scale (GCS) and post-traumatic amnesia (PTA) accurately at these ages. Further consideration should be based on evidence for long term support needs, especially around attendant care.

Clients with non traumatic brain injury, eg cerebral palsy as a result of brain damage, or anoxia at birth or in childhood, may be either:

- Profile 05 – Severe brain injury
- Profile 06 – Moderate brain injury.

This is based on the comparative severity of the injury.

 [Assigning an SI profile.docx](#)

- b Note:


A number of older SI profiles are no longer in use and no longer required after the introduction of the clinically based profiling criteria from 3 December 2007. This includes:

- Profile 13 – Recent brain injury.

7.0 American spinal injury association (ASIA) scale

- a Internationally, spinal cord injuries are classified using the American Spinal Injury Association (ASIA) scale. This describes a client's functional impairment as a result of their injury. This scale can usually be found in the medical notes of a client who has been admitted into either of the Spinal Units.

ASIA Classification	Description
A	Complete. Motor and sensory loss is complete
B	Incomplete. Sensory but not motor function is preserved below the neurological level and includes sacral segments S4-S5
C	Incomplete. Motor function is preserved below the neurological level and more than half of the key muscles below the neurological level have a muscle (strength) grade of less than 3
D	Incomplete. Motor function is preserved below the neurological level and more than half of the key muscles below the neurological level have a muscle strength grade greater than or equal to 3
E	Normal. Motor and sensory function is normal

 American spinal injury association (ASIA) scale.PNG

RACI

RESPONSIBLE

Roles that perform process activities

None Noted

Systems that perform process activities

None Noted

ACCOUNTABLE

For ensuring that process is effective and improving

Process Owner

[Out of Scope]

Process Expert

CONSULTED

Those whose opinions are sought

STAKEHOLDERS

None Noted

STAKEHOLDERS FROM LINKED PROCESSES

None Noted

INFORMED

Those notified of changes

All of the above. These parties are informed via dashboard notifications.

Triggers & Inputs

TRIGGERS

None Noted

INPUTS

None Noted

Outputs & Targets

OUTPUTS

None Noted

PERFORMANCE TARGETS

None Noted

Process Dependencies

PROCESS LINKS FROM THIS PROCESS

None Noted

PROCESS LINKS TO THIS PROCESS

None Noted

Systems

None Noted

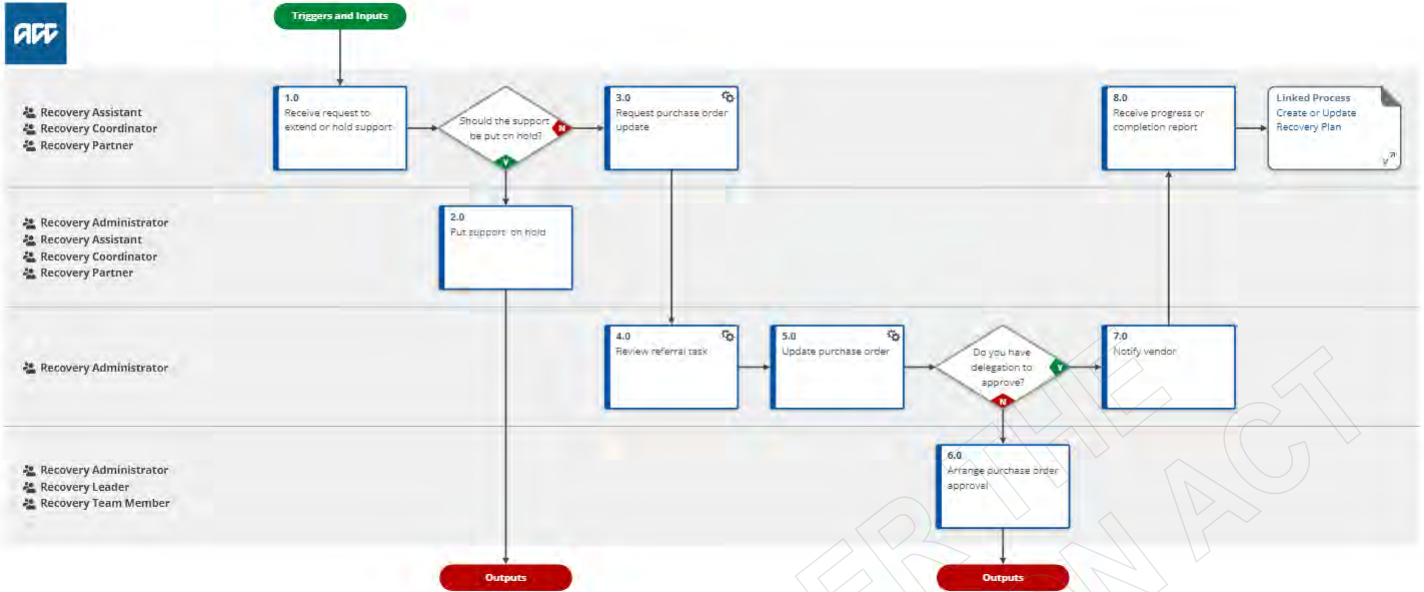
Lean

None Noted

Process Approval

Date	Approver	Type
27-11-2018 (GMT)	[Out of Scope]	Process Group Approver
Approval bypassed	[Out of Scope]	Process Owner
27-11-2018 (GMT)	[Out of Scope]	Promaster

Published on 27-11-2018 (GMT) by [Out of Scope] via Publish Now (some approvals bypassed)



Summary

OBJECTIVE

To maintain Vocational Support for making any required changes to supports after they have been established.

A support can be updated for a variety of reasons, eg if the client recovers quicker or more slowly than expected.

BACKGROUND

Vocational Rehabilitation Services (VRS) is a range of services that are designed to assist a client to return to work or where this is not possible, prepare the client for employment and independence.

The contracted VRS portfolio covers the following primary services:

- Stay at Work (SAW) service – supports clients to return to their pre-injury job
- Back to Work (BTW) service – supports clients who are no longer employed to become work ready.

Procedure

1.0 Receive request to extend or hold support

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a Determine the type of support to be extended, the reason for the extension and the required timeframes for extension. Refer to the relevant service pages below for further information, including stages, funding and purchase order codes.
 - [WEB LINK](#) Back to Work (BTW) Service Page
 - [WEB LINK](#) Stay at Work (SAW) Service Page
 - > **NOTE** When do you receive requests to extend vocational support?
 - > **NOTE** What if the request is for an exceptional circumstance?
- b Review the progress report and/or the request to extend support ensuring that there is a clear rationale and goal for the requested extension. (Note: This must be no more than 12 weeks from the service commencement date.)
 - > **NOTE** Do any goals require updating?

2.0 Put support on hold

Recovery Administrator, Recovery Assistant, Recovery Coordinator, Recovery Partner

a To put the purchase order on hold:


- Add to the Purchase Order, entitlement type: VRSTOP. Enter the period for which the Vocational Rehabilitation service is on hold. You do not need to add any costs to this entitlement type.

- Add the VRGO entitlement type with the start date of when the Vocational Rehabilitation is expected to come off hold. The end date should be the date the Vocational Rehabilitation service is expected to end. You do not need to add any costs to this entitlement type.

b To place the support on hold:

- If you agree to put the support on hold, follow up with an email to the Provider stating the date the support will be put on hold and the timeframe for how long the support will be put on hold.

> **NOTE** How do you place the support on hold?

 **INFORMATION** Placing vocational rehabilitation services on hold (CHIPS)


3.0 Request purchase order update

Recovery Assistant, Recovery Coordinator, Recovery Partner

a Find the relevant information and codes required to update the purchase order. All required information is within the Vocational Rehabilitation contract available on the ACC website.

b In Eos, from the Recovery Plan sub-case, select 'Add Activity' and Choose Activity, NGCM - Admin Request. Update task with the relevant information.

> **NOTE** What information do you need to include in the task?

 **INFORMATION** Referring Tasks to Recovery Administration - Principles

> **NOTE** What if the request is for a driving assessment?

 Eos


4.0 Review referral 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?

 **INFORMATION** Principles of Working in the Administration Team

 Eos

 SalesForce


5.0 Update purchase order

Recovery Administrator

a In Eos, locate the purchase order for the specified referral.


b Update the purchase order accordingly.

> **NOTE** What if you need to put a VRSTOP code onto an existing purchase order for a Stay at Work or Back to Work service?

 **SYSTEM STEPS** Edit an entitlement associated with a PO

c Approve the purchase order.

> **NOTE** What if you do not have the delegation to approve the purchase order?

 **SYSTEM STEPS** Request Authorisation for a Purchase Order - System Steps

> **NOTE** When are approvals required by Recovery Leaders?

 Eos


6.0 Arrange purchase order approval

Recovery Administrator, Recovery Leader, Recovery Team Member

- a Recovery Team member:
 - receives a Request Authorisation task for purchase order approval.
 - updates the Requesters Comments box in the Add.Info tab in the task with a reason why the support is required and needs approval.
 - transfers the task to their Recovery Leader.
- b Recovery Leader:
 - receives a Request Authorisation task for purchase order approval.
 - opens the task using 'do task'. This will open the task in one window and the purchase order in a new window.
 - reviews the reason for the service in the Add.Info tab.
 - approves or declines the purchase order.
 - > **NOTE** What if you approve of the vocational support?
 - > **NOTE** What if you decline the vocational support?
- c Recovery Administrator:
 - receives the task back
 - completes the purchase order set up or cancels the updates they have made if the service is being declined.




7.0 Notify vendor

Recovery Administrator

- a Create an email using the Purchase Order Approval/Extension Email template and advise the costing sheet has been approved.
Select the most appropriate email address.
TIP: It is common for the applicable email address to be listed under General Purchasing.
 **SYSTEM STEPS** NGCM - FINAL Emailing from Eos using a Template - System Steps
- b Send the email, on behalf of the Recovery Team member, to the vendor to confirm that the purchase order value has been increased and approved.
 - > **NOTE** Do you need to include the costing sheet?
- c Close the Admin task.

8.0 Receive progress or completion report

Recovery Assistant, Recovery Coordinator, Recovery Partner

- a When you receive the progress or completion report, it will be attached to the claim. You will be notified.
- b Review the report. Refer to the relevant service page below for guidance.
 -  **WEB LINK** Service Page: Back to Work (BTW)
 -  **WEB LINK** Service Page: Stay at Work (SAW)
- c Perform Privacy and Relevancy checks on the report.
 -  **WEB LINK** Inbound and outbound document checks
- d Check the quality of the report. If required, discuss with the Provider any questions you have, request further information and agree on a timeframe for completing an amended report.
 - > **NOTE** What if the quality of the report is still unsatisfactory?
- e Provide a copy of the report to the client, and key stakeholders.
- f Update the Recovery Plan as required.

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



Objective

This document outlines the considerations and steps for Recovery Support to determine whether there is a need to refer for an MCR. It will assist in identifying the need at the right time or whether alternative steps could be taken to negate the need for one.

Background

An MCR can be used to obtain an opinion from a non-treating medical provider to clarify the current condition and/or determine the cause of a client's injury/condition or need for an entitlement. It is to be used where there is a clinical or medico-legal reason to obtain an independent expert opinion.

Key Principle – In most cases, clinical guidance should be able to be provided internally or addressed with the treating provider, without the need for independent expert opinion. Where an MCR is obtained, the accompanying opinion will carry significant weight.

Consideration Steps

The following steps are to be considered as part of the decision-making thought process leading to a recommendation to refer for an MCR. These steps are not rigid and do not replace good decision making given a specific scenario. They represent a guideline to assist the internal advisor to be consistent in when an MCR should be utilised.

- 1) Identify scenario and review clinical documents
- 2) Determine if need for MCR can be identified early
- 3) Determine need to write to treating provider
- 4) Consider whether additional internal opinion is appropriate
- 5) Consider whether need for MCR is based on clinical or medico-legal grounds

1) Identify scenario and review clinical documents *(Clinical Advisor, Medical Advisor)*

Confirm whether the task referral relates to a request for cover/entitlement (accept/decline decision) or to investigate the cause of need for an ongoing entitlement (suspension decision). This will identify where the burden of proof lies in reaching a decision (i.e. with the client for the former and ACC for the latter).

There are cases where both a cover and a suspension decision will need to be considered.

Briefly review the clinical records to familiarise yourself with the clinical aspects of the claim.

2) Determine if need for MCR can be identified early *(Clinical Advisor, Medical Advisor)*

The need for an MCR can be identified early in certain circumstances. This will result in avoiding unnecessary time being spent on providing a clinical opinion and/or delaying a referral.

Examples of appropriate circumstances where an MCR may well be required include -

- a) Requests or consideration for cover where specialist opinion is required, however, no treating specialist available. Cover request is for -
 - pain disorder
 - complex concussion / Traumatic Brain Injury (TBI) / head injury
 - client's with relevant non-accident related co-morbidities
- b) Client is receiving an entitlement (e.g. weekly compensation) and the cause of ongoing symptoms or unfitness for work is unclear, or diagnosis is clinically complex. Client has no treating specialist.

- c) Client is receiving an entitlement (e.g. weekly compensation) and has ongoing unexplained symptoms beyond expected healing timeframes. Client does not have treating specialist with required expertise. Cover is accepted for –
 - pain disorder
 - complex concussion / Traumatic Brain Injury (TBI) / head injury
 - complex treatment injuries
- d) Client is receiving an entitlement (e.g. weekly compensation) and the treating specialist has expressed an opinion, with strong* supporting rationale, for an ongoing injury or accident related cause which you disagree with.

* beyond a non-plausible or temporal link only

Note – An MCR is not required when seeking an opinion or report on causation from a treating provider. Only where a non-treating provider opinion is required is an MCR used.

If the need for an MCR is not identified early, provide your clinical opinion and consider the next steps.

Key Principle – Identifying the need for an MCR early should negate the need for the Clinical or Medical Advisor to spend time completing an in-depth analysis of the clinical information and formulating their own opinion. Referring for MCR essentially outsources the clinical advice required.

3) Determine need to write to treating provider *(Clinical Advisor, Medical Advisor, Technical Specialist)*

In determining whether to write to the treating provider consider the following –

- a) The treating provider has provided a confusing opinion, contradictory information or has not indicated their opinion.
 - Where the burden lies with ACC (i.e. for a suspension decision), it is likely necessary to seek further comment or opinion from the treating provider
- b) Does the treating provider have the relevant expertise? For example -
 - Treating provider is the GP and specialist opinion is required
 - Treating specialist does not have the needed medical expertise given nature of issue
- c) If investigating a request for cover / entitlement, who has made the request (e.g. provider vs client/advocate)? For example –
 - If the request is from a client/advocate and the issue can be addressed with internal clinical opinion, then writing to the treating provider may not be necessary.
- d) The complexity of the issue and/or injury history. For example -
 - There is significant and relevant background documentation that requires review and consideration to inform an opinion. This might be beyond the availability of the treating provider.
- e) Is further comment or clarification from the treating provider likely to negate the need for an MCR?

If it is determined that it is necessary to write to the treating provider, decide if it is appropriate to either:

- a) Seek confirmation of your clinical opinion
 - Refer to example template in appendix 1
- b) Provide questions only
 - Refer to example template in appendix 2
 - Consider providing any background information that may be relevant and important to addressing the questions posed

- Consider if any background documentation is required to be provided with this request (e.g. a relevant historical report they may not have available to them)

When received, consider the response from the treating provider.

- If the response confirms or informs the clinical opinion, provide guidance and return the task to either the –
 - Recovery Team Member if the referral related primarily to a request for cover/entitlement (accept/decline decision) or non-weekly compensation suspension decision.
 - Technical Specialist if the referral related to investigating the cause of ongoing incapacity and ACC's ongoing WC entitlement provision (suspension decision)
- If the response is contrary to your opinion, or you disagree with the opinion provided, consider the level of evidence and robustness of the rationale provided -
 - If a temporal link, non-plausible rationale or no rationale has been provided, provide your opinion, confirm the guidance and return the task as in a) above.
 - If the evidence is perceived to be in balance (lay person or 50/50 test), continue to the next step. If you are unsure, consult with technical services.
- If the response raises new and relevant clinical or medical issues, and you consider these require additional or different internal clinical expertise, continue to the next step.

Key Principle – If a treating specialist provides an opinion and supports this with a plausible rationale, their opinion is likely to carry significant weight. Only in cases where a temporal link only, non-plausible or no rationale has been provided, would a well-reasoned internal clinical opinion likely carry more weight.

4) Consider whether additional internal opinion is appropriate

(Clinical Advisor, Medical Advisor, Technical Specialist)

In cases where the evidence is perceived to be in balance, or the clinical issue becomes complex, there are circumstances where seeking additional internal opinion might negate the need for an MCR.

This might include a Clinical or Medical Advisor seeking comment from a Principal Clinical Advisor with a relevant medical specialty.

Reasons for doing so may include –

- The issue falls outside the expertise of the Clinical or Medical Advisor
- For medico-legal reasons, the evidence does not allow for a robust decision (e.g. suspension decision). In this circumstance, consult with technical services on whether this action is likely to support a robust decision and negate the need for an MCR.

Factors to take into consideration may include –

- Whether there is a need for an in person or physical assessment. If so, this step is likely not appropriate.
- The size of the background documentation requiring review. If there is a large volume of documentation requiring review, utilising Principal Clinical Advisor resource may not be appropriate.
- Careful and discretionary use of the additional internal clinical resource

If obtaining additional internal opinion is considered appropriate, the rationale should be made clear and required expertise indicated (i.e. do not refer to a specific individual, rather identify the expertise required).

5) Consider whether need for MCR is based on clinical or medico-legal grounds

(Clinical Advisor, Medical Advisor, Technical Specialist)

Finally, if after having considered or having taken the above steps an MCR is still indicated, determine whether the need is based on clinical or medio-legal grounds.

a) Clinical grounds may include –

- Complicated diagnosis
- Diagnosis still unclear
- Issue outside expertise of internal capabilities

In these cases, the Clinical or Medical Advisor should progress to identifying the appropriate medical speciality required and providing appropriate questions before confirming and returning the guidance.

Please go to appendices 3 and 4 for further resources on provider and question selection.

b) Medico-legal grounds may include –

- Conflicting external opinions
- Conflicting internal verses external opinions

In these cases, seek guidance from Technical Services who will weigh the need for an MCR versus the risks and context of the claim/decision. As required, reach agreement on the need for an MCR, the appropriate medical speciality and questions required.

Please go to appendices 3 and 4 for further resources on provider and question selection.

Key Principle – Where an MCR is to be recommended for medico-legal reasons, technical services should be consulted as part of the decision-making process.

Appendix 1 – Example letter to treating provider

Dear Name of treating provider,

Thank you for providing ACC with the medical certificate / clinical information in relation to Client's name's recent injuries. A Clinical Advisor / Medical Advisor has reviewed the clinical evidence and advised:

1. Client's name's covered personal injuries of List of injuries are no longer a material cause of their presentation and incapacity for work as a Pre-injury role, and
2. Client's name's presentation and incapacity for work as a Pre-injury role is now more likely than not substantially due to Alternative condition, which was not caused by their accident of Date of injury for the following reasons Rationale.

Please let me know by return correspondence if our understanding of the clinical evidence and opinion is correct, and if not, please point ACC to the clinical evidence and provide your rationale for any alternative position to ACC's understanding above.

Thank you for your further time in responding to us.

Kind regards,

Appendix 2 – Example letter to treating provider

Dear Name of treating provider,

Thank you for providing ACC with the medical certificate / clinical information in relation to Client's name's recent injuries.

Provide background information as appropriate

With regard to this client and claim, please can you provide ACC with additional clinical information including your clinical rationale in answer to the following questions –

- 1)
- 2)
- 3)

Thank you for your further time in responding to us.

Kind regards,

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

Appendix 3 – Provider Selection

The required medical specialty of the MCR assessor should be clearly communicated in the written guidance.

In some cases, depending on the nature of the issue, there is more than one speciality that might be able to provide the assessment.

For example, confirming a diagnosis and opinion on the cause of a non-complex musculoskeletal issue might be adequately addressed by an orthopaedic specialist, sports physician or musculoskeletal physician.

In other cases, there might only be one medical speciality that can provide the required opinion. I.e. a neurologist for a complex neurological issue.







Consider the circumstances of the case and consider whether to –

- 1) Identify the preferred medical speciality and provide a list of suitable alternatives. Provide a comment noting that if the next available appointment with the preferred specialist type is not reasonably available (I.e. within 3 months) then the alternative options can be considered.
- 2) Provide the single medical speciality required in cases where only one is suitable.

Appendix 4 – Question Selection

The purposes for obtaining an MCR can be varied. Providing a background summary highlighting the need for the referral can often be valuable and important in ensuring the assessor understands the context in which their opinion is sought. It also provides an opportunity to highlight any important or relevant facts that are specific to the case.

In general, there are three circumstances from which we are seeking opinion –

		Diagnosis	Causation
1)	We need confirmation, or expert opinion, of the diagnosis and its cause.		
2)	The diagnosis is confirmed; however, we need expert opinion on its cause.		
3)	Both the diagnosis and its cause are confirmed; however, we need to distinguish between the relevant contribution of injury versus non-injury conditions.		

Below is a template background and base set of questions specific to each circumstance. Where appropriate, these questions reflect the requirements as per the Clinical Service contract.

***Reminder** – when an MCR is sought for medio-legal reasons, a technical specialist should be consulted and proposed questions agreed upon.

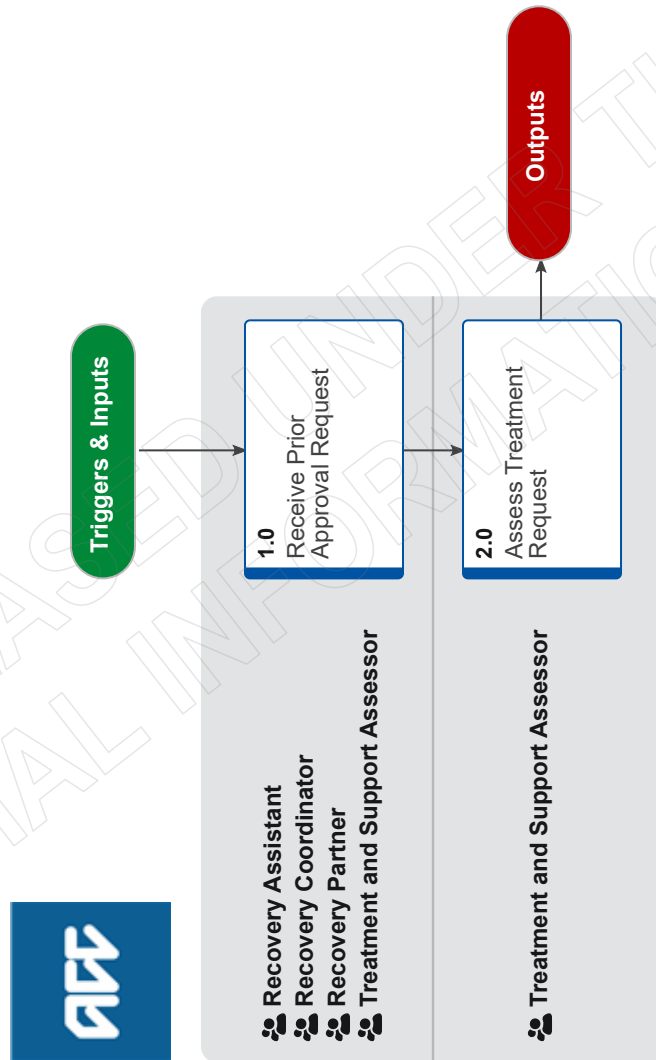
(click arrows to expand headings)

1) Opinion on diagnosis + causation

2) Opinion on causation only

3) Opinion on contribution of diagnoses to symptoms

Common relevant additional questions



Summary

Objective

The purpose of this process is to determine a client's eligibility for funding for additional treatment beyond those normally required for a specific injury. We're liable to contribute to a wide range of medical and related treatment costs for a client's covered personal injury.

Use this process when dealing with these types of treatment:

The types of treatment we can purchase for clients include, but are not limited to, those listed below.

- Secondary and Tertiary Care Portfolio (eg, Elective Surgery Treatment, Radiology, Dental Treatment)
- Mental Health Care (eg, Counselling, Psychological Services, Psychiatric Services)

Background

Treatment includes, but is not limited to:

- giving treatment
- diagnosing a person's medical condition
- deciding on the treatment to be provided or not provided
- providing or failing to provide, treatment in a timely manner
- obtaining or failing to obtain, a person's consent to undergo treatment
- providing prophylaxis
- the failure of any equipment, device or tool used as part of the treatment process
- applying any support systems, including policies, processes, practices, and administrative systems used by the organisation or person providing the treatment and that directly support the treatment
- physical rehabilitation and cognitive rehabilitation.

A treatment provider must be a Registered Health Professional. The types of treatment provider we can purchase the treatment from are limited.

The processes below are assessed in the centralised Treatment and Supports team, if you are a Recovery Team member please ensure you pass this to the Treatment and Supports team.

Owner

[Out of Scope]

Expert

Procedure

1.0 Receive Prior Approval Request

Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

- a** If you receive one of the below treatment requests (at 2.0) via email, please forward this to prior.approval@acc.co.nz.

NOTE **What if a client's current Pharmaceutical approval is due to expire?**

Send an 'Alert: You Have Mail' task to the 'Elective SC - Pharmaceutical' queue, requesting the current approval be extended.

NOTE **What if the request is for a Non-Subsidised Pharmaceutical (new or continued), from a treating provider or client?**

Send an 'Alert: You Have Mail' task to the 'Elective SC - Pharmaceutical' queue.

NOTE **What if the request is an ACC1171?**

Send an 'Alert: You Have Mail' task to the 'Elective SC - Pharmaceutical' queue.

NOTE **What if the request is to change a Pharmacy or commence direct billing?**

Send an 'Alert: You Have Mail' task to the 'Elective SC - Pharmaceutical' queue, to update change of Pharmacy or commence direct billing (include the Vendor ID details).

NOTE **What if the request is a Pharmaceutical receipt?**

Transfer request to the 'Elective SC - Claimant Reimbursements' queue.

















2.0 Assess Treatment Request

Treatment and Support Assessor

- a** Assess treatment request, the pages below provide an overview of these services.

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
 -  Processing an ACC32 request for extra treatment funding
 -  Assessing a non-standard ACC32 request
 -  Home-Based Podiatry Treatment Service Page
 -  Processing a pharmaceutical reimbursement
 -  Assessing Eligibility For Funding Erectile Dysfunction Interventions
 -  Diagnostic Services Page
 -  Urgent Care Clinic Services Page
 -  Hyperbaric Oxygen Treatment Service Page
 -  Extra-Corporeal Shockwave Therapy Service Page
 -  ACC1855 Burns Outpatient Treatment & Consumables - Prior Approval Request
 -  Considering request for extended discretion for elective surgery when no prior approval obtained
 -  Issuing an elective surgery funding decision
 -  Approving dental claim requests
 -  Paying dental claim invoices
- b** Issue decision letter.
-  Purchase Order - Handy Hints on how to create and edit POs