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FAQs

ACC Pain Service Webinar One

Last update : 4th March 2026

Contents

Current Service

Q: Can you be specific about which 4 hospitals

A: Health NZ - Auckland via TARPS, Health NZ - CDHB via Burwood, Health NZ - Wellington (CCDHB and Hutt Valley)

Eligibility

Q: Is there a proforma or list of requirements that a patient needs to meet to be accepted onto a pain management plan.

A: Yes, there is an eligibility criteria in the contract.

Q: Are there changes to the eligibility criteria for the community services?

A: No,it remains the same

Q: Are there specific referral criteria? And how do we expedite referral e.g. for CRPS?

A: Yes, we have an eligibility criteria. To expedite referral you would document urgency to the relevant RTM with a clearly documented rationale.

Q: Any changes to the eligibility criteria for pain services within the new contract?

A: No, it remains the same.

IDT

Q: How is it envisaged that services will integrate with the client's medical care home?

A: We would expect the core IDT who are looking after the client and a nominated key person to provide liaison and updates with the client's GP/care team

Q:

Q: Is a pain medical specialist review required by ACC, or can providers decide whether a client needs one? Under the current contract, Community Level 2 requires a pain medical assessment—does this still apply, and are PN411 (or equivalent) codes still available?

A: Yes, there codes equivalent to the PN411 code in the new contract. In the new contract there isn't a requirement for SPMP to be involved in the Community level Services. The referral to a SPMP can till occur at stage 1 or stage 2 in the community services but it is based on need/choice. The new contract makes allowance for other medical practitioners to support the client.

Q: What are the updates to the experience and professional development criteria likely to be - broadly?

A: We have lifted the number of years of post-graduate experience to 5 years for allied health and psychology. For the core IDT, all team members are required to have a minimum of three years' experience working in a pain management interdisciplinary team.

Q: Does Triage still require IDT and pain specialist review?

A: Triage still required input from an IDT and a medication practitioner specified in the contract.

Q: Will key workers also need to have the 5 years' experience?

A: Yes, in line with their clinical practise listed in appendix one of the service schedule.

New Service Approvals

Q: Confirmation that triage and L1 are preapproved?

A: No triage and community service stage 1 will not be pre-approved. Suppliers/Providers can refer into the service by notifying ACC, ACC will pre-approve the request providing a PO that will allow service commencement. The pre-approval will be for triage and Community Service stage 1, allowing our providers to commence stage 1 without the need for further approval.

Q: Is only ACC going to be able to send referrals, or can referrals still be accepted from other sources?

A: Yes, ACC will be making and approving the referrals into Pain Services. Providers can recommend clients to enter this service but will need ACC approval to commence triage.

Q: Can health providers still refer in for the triage assessment, or does it have to come from ACC?

A: No. ACC will be making and approving the referrals into Pain Services. Providers can recommend clients to enter this service but will need ACC approval to commence triage.

Q: Does that mean providers are no longer able to refer for pain triage?

A: Yes. You will require ACC pre-approval to commence triage.

Q: Will there still be access to triage from clinicians? E.g. GP able to refer for triage - or will this now need to go via ACC?

A: No. ACC will be making and approving the referrals into Pain Services. Providers can recommend clients to enter this service but will need ACC approval to commence triage.

Q: Is ACC removing Triage No Prior approval - now requires referral from ACC?

A: Yes. You will require ACC pre-approval to commence triage.

Q: Who will be able to refer for the community Pain Service?

A: ACC will be making and approving the referrals into Pain Services. Providers can recommend clients to enter this service but will need ACC approval to commence triage.

Q: So, then there may be delays at start rather than between triage and prog approval? So still delays just at different time likely? So what difference is this making?

A: Yes, there may be a delay at service commencement. ACC are currently working actively to reduce delay by increasing the number of frontline and clinical staff. We also intend to make some workflow improvements as part of this role out so hope that this will minimise the delay at our end.

Q: How will ACC ensure it will not become a bottleneck for access to these services?

A: We intend to monitor the waitlists and continue to make continuous improvement to ensure we can minimise impact to timeliness.

Q: Will group programme require approval or will it be included in the initial triage + level 1 approval?

A: As we are moving to service caps, group programmes can be utilised at stage 1 or stage 2.

Q: Combined Question
If providers believe a client is suitable for the Pain Management Service (PMS)

- **which ACC contact or team should they approach to discuss and refer the client for a triage referral**

- **are there dedicated contact details or a specific section of ACC responsible for approving these referrals, particularly when there is no assigned case manager?**

A: If a client has an allocated ACC Recovery Team Member (RTM), the request would be directed to them. If there is no allocated RTM, a request will need to be made via our general contact lines and the request will be allocated to Recovery team for action

Q: With the removal of direct access to triage by clinicians - is there a pathway for urgent review of suspected CRPS without delay?

A: No, a specific pathway. You would make a referral, follow the referral pathway, and notifying RTM and clearly detailing this in the care plan of urgency.

Q: Are you able to let us know how ACC will make decisions about who to refer into the pain service. Who would we contact at ACC to recommend a pain service referral be made?

A: ACC staff will look at the eligibility criteria and recommendation by our providers where applicable when referring clients into pain services.

Q: With the combined approval of triage and Level 1 - is there still a requirement to do a specific triage or can the programme just start?

A: Triage is still required, care plan required as part of that for ACC review.

Q: Is Group Education pre-approved?

A: No all referrals will need ACC prior approval, group programmes are built into each stage.

Q: Can you confirm how ACC are making decision of when the client requires pain management? who is recommending pain contract as necessary; still primary care, GP, NP, physios etc?

A: The service schedule sets out an eligibility criteria, ACC teams will consider this when recommending pain services for clients. Referrals can be made by ACC, GP, another Health professional or Rongoā practitioner.

Q: Will ACC CM be making decisions on approval for triage? Or will they need technical claims or medical advice?

A: ACC team members will have delegation to approve some and will require guidance for others, it will be dependent to the claim type.

Q: If ACC are referring for services as client already deemed suitable, why triage? why that step, why not straight to Stage 1?

A: We require a standardised clinical review of the request to ensure client is entering into the most suitable service.

Q: Do you want patient or clinician to request a pain referral?

A: Both can refer to ACC for the approval.

Q: What is the rationale for removing provider referrals for a pain triage?

A: ACC brought back prior approval for pain triage to ensure appropriate use of services, manage demand and costs, prevent service gaps between triage/stage one and provide stronger oversight of pathway entry.

Q: If entry to the pain contract requires ACC approval, surely ACC would know if the client is off work and needing VRS input?

A: Yes, our teams should be reviewing the whole of claim and informing suppliers of this.

New Service General

Q: What are the core changed deliverables ACC is aiming for with this change?
Q: Can you talk more around what the work part of the new contract is?

A: We are trying to roll out a service that is achieving rehabilitation outcome for our clients and provide better visibility of what is needed to support this. We want to ensure our service priorities are also better aligned with ACC's strategic priorities. Client's off work and on weekly compensation is our highest priority and liability as a scheme, having a KPI around this and introducing early vocational rehabilitation support ensures clients who are off work are given the right management techniques and strategies to return to work.

Q: Will you have a Pain Triage Request form we send in to ACC similar to the TI request form? Or is it just an email request?

A: We are working through operational details, we planned for it to be a email or phone call. But can explore the option of a standardised form like TI.

Q: Will the pathway for pamidronate infusion for early CRPS still be in place?

A: Yes

Other

Q: Will the new changes allow for acupuncturist to provide ACC 45's?

A: No. Not part of this contract.

Q: Will Springboard still be available and pre-approved?

A: There is no requirement in the new service for group programme to be approved by ACC. Providers can provide group programme as they see fit, within the parameters outlined in the service schedule

Q: Is this service intended to sit within secondary care, primary care or both?

A: This service will sit in our Moderate complexity portfolio.

Q: If ACC decline giving a client a pain programme when their treating providers recommend one are clients able to get a review on these decisions

A: Yes, Clients can continue to review decisions they do not agree with.

Q: With ACC generated referrals how are they allocated - case manager choice?

A: They would be allocated to the requested supplier or randomly to one of the suppliers who hold the contract with the TLA.

Performance/KPIs

Q: Any changes to reporting requirements?

A: Yes, we have updated the reporting requirements, detailed for you in the service schedule.

Pricing Structure

Q: Is ACC setting the hourly rate for the service charges?

A: Yes. We are introducing detailed capacity for each service type, within each of those there will be hourly rates for each of those provider groups.

Q: Are the Specialist Pain Medicine Physician assessments similar to the current contract? Is there any provision for follow ups?

A: Yes, there are provisions for Specialist Pain Medicine Physician Assessments in there. There's been a change to how service will be funded, with the introduction of hourly breakdown by provider type and service cap, any follow ups that happen will need to happen within those service caps.

Q: Will ACC provide a breakdown of how you determine the hourly rate charges?

A: No, this information is commercially sensitive however we use our current standard rates across different provider groupings to create the pricings.

Q: Have you considered in your hourly rate that those working in the pain service are often masters or post grad qualified in pain management?

A: Yes, at ACC all of those details are considered when we create pricing structures. They tend to sit behind the formulas we use across the board.

Q: As well as clinical fee, is there an admin code available to bill again

A: No, it does not. There is a code in the service cap there is allowance for additional cost billing but not specifically for admin

Q: Will there be a Clinical Pharmacy referral component in RFP?

A: Yes, within service there is availability for pharmacy involvement. The pricing structure has codes allowing oversight from pharmacy for medications and relevant recommendations.

Q: Will key working and reporting codes be allowed for separately rather than coming out of the funding cap for clinical service provision?

A: No, it's part of the service cap.

Q: Is there a key worker code for funding?

A: No, it is part of the core IDT. Price charge aligned with key worker profession.

Q: Do codes extend to podiatry, dietician/nutritionist?

A: No, they don't have their own code specifically but cap costs have allowances for input.

Q: Is the 'medical rate' the same for all medical practitioners? Or a different rate for the additional qualifications held by SPMP (FFPMANZCA)?

A: Medical rates are for all Medical Practitioners who work under the contract, the only rate specific to SPMP is the specialist assessment in Part A, Table 4 Tertiary Service.

Q: When is the tertiary aspect going to tender?

A: You will find the definition of the tertiary service and the requirements for this in the service schedule published on GETs. We are still in discussions about how we will tender for this service and are not in the position to share any additional information at this point.

Q: Who are the currently available Tertiary providers?

A: APM, Body in Motion, Australis, Te Whatu Ora (Auckland, Christchurch, Wellington - Hutt Valley & Capital Coast)

Q: Combine question

- **If tertiary services are included in the same new contract, why is their discussion being handled separately?**

A: We encourage you to review the contract published on GETS, our definition of the service specifies how we intend to procure the service. However, we are currently in discussion about this and cannot comment further.

ePPOC

Q: Will EPPOC still be used?

A: Yes, we are planning to still use ePPOC to collect information around our clients and their clinical outcomes for pain at this stage. We have work underway internally to review ePPOC, we anticipate there will be small change to what is reported, the variables we view and improving the report we receive. We may look at a more substantial change in the future.

Q: Will the paediatric ePPOC be utilised?

A: We have just set up paediatric ePPOC and the intention is for that to continue.

Q: How will you ensure that the data ACC collects aligns with the data that the providers collect please?

A: We are working with ePPOC to ensure the information we see is the same as what our provider see. We will be providing this report as well as the RTW monitoring data to suppliers so we can ensure the validity of the data we review.

Q: If we continue to use eppoc as a measure are there going to be contingencies made for English as a second language or neurodiversity?

A: The ePPOC questionnaires are currently not available in different languages.