PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

Accident Services

A guide for DHB and ACC staff

2018

Contact details

For operational queries and queries about ACC invoices and schedules:

Provider contact centre: 0800 222 070

Email: providerhelp@acc.co.nz

Provider order line: 0800 802 444 (for ACC forms)

ACC32 Treatment Extension Requests:

Phone: 0800 222 070

Email: ACC32@acc.co.nz

Online web form: https://forms.acc.co.nz/ACC32

Website: https://www.acc.co.nz/for-providers/treatment-recovery/prior-approval-treatment/

Sensitive claims:

PO Box 1426

Wellington 6140

Phone: 0800 735 566 select option 1

Treatment Injury Centre:

ACC

PO Box 430

Dunedin 9054

Phone: 0800 735 566 select option 2

For queries regarding content of this guide:

ACC contact details

Provider Service Delivery

ACC Corporate Office

PO Box 242

Wellington 6011

Phone: 04 816 7400

Website: www.acc.co.nz

Ministry of Health (including Disability Support Services for people under 65) contact details:

Ministry of Health

PO Box 5013

Wellington 6140

Phone: 04 496 2000

Website: www.moh.govt.nz

Disclaimer

This is a joint Ministry of Health (MoH)/Accident Compensation Corporation (ACC) guide and has been developed in collaboration with District Health Boards (DHBs)

The following interpretations of ACC legislation are designed to serve as a guide for DHBs and relevant agencies in determining where services are provided under the Public Health Acute Services Agreement and where ACC directly purchases particular treatment and rehabilitation services provided in public hospitals. For financial and legal purposes, the Accident Compensation Act 2001 and the Annual Service Agreement between the Minister of Health and the Minister for ACC, and contractual agreements between funders and providers, take precedence over this guide.

Table of Contents

Introduction

Purpose

This guide has been developed by the Accident Compensation Corporation (ACC) and the Ministry of Health (MoH) primarily for health and disability providers working for District Health Boards (DHBs) and, in some instances, working for other agencies, and for ACC staff and Accredited Employers working with those providers.

This guide will assist in determining who is responsible for funding the treatment, rehabilitation and related services required by an injured person, when that person has a personal injury for which they are covered under the Accident Compensation Act 2001 (AC Act 2001).

Background

This guide replaces previous versions; *Accident Services A guide for DHB and ACC Staff* (January 2014), *Accident Services – Who Pays?* Edition One (July 1999), Edition Two (March 2001) and Edition Three (July 2002). It also replaces *Purchasing ACC Treatment Services,* Edition One (1998) and Edition Two (1998). This guide will be updated if there are changes in legislation or policy that affects the accuracy of the guide's content.

We recognise that further work is required in developing robust procedures for interfaces between agencies, for example ACC, DHB hospital and community services, and MoH. In the absence of such procedures, this guide attempts to highlight where such interfaces may occur.

This guide does not attempt to provide solutions to issues relating to the accident/illness boundary, as these usually relate to clinical judgements on individual cases. However, there is guidance for hospitals, other funders and ACC to assist with some boundary issues, particularly in respect of the move from acute medical treatment to rehabilitation. A pathway for dispute resolution is provided – the guiding principle in such cases is for services to continue until these boundaries have been clarified by ACC and MoH.

Terms used in this guide in relation to arrangements for the provision of services

ACC pays for the provision of services for injured persons through DHBs via two mechanisms:

a. Public Health Acute Services (PHAS): These services are funded by Vote: Health through an annual service agreement between the Minister of Health and the Minister for ACC. DHBs receive funding for these services from the MoH as part of their annual funding package with distribution to each DHB according to the population based funding formula (PBFF). ACC's reimburses the Crown for PHAS via a monthly payment to the MoH, which is paid into the Crown Account. ACC's annual PHAS contribution is calculated by MoH which includes any annual changes to the contribution. The change in contribution represents a mix of price and demographic changes against the previous year's allocation. In this guide, acute treatment/services for ACC clients through the public health care system is referred to as **'covered by PHAS'**.

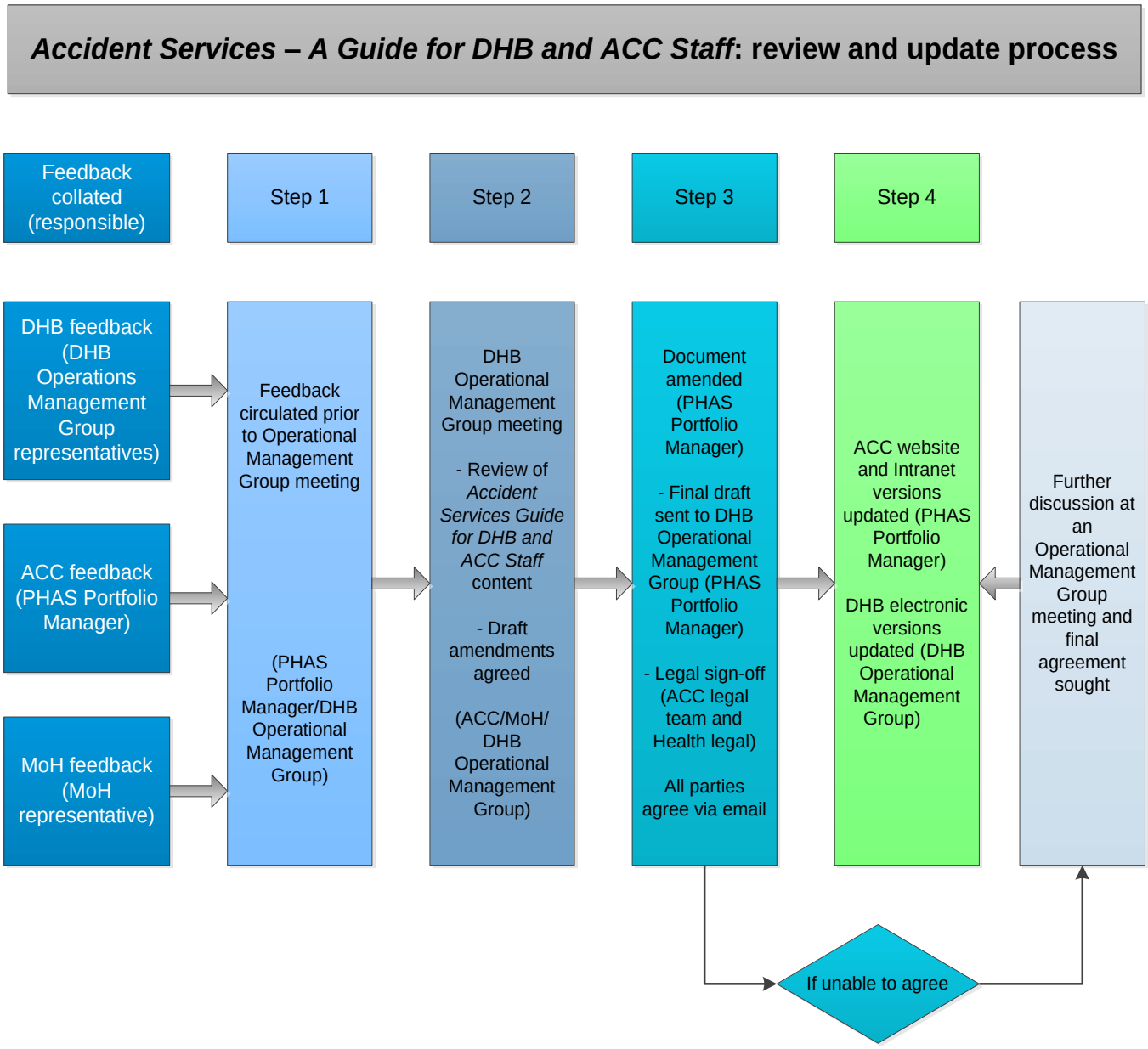
b. Direct purchases of other services[1] by ACC[2]. In this guide, this type of service is referred to as **'purchased directly by ACC'**.

The terms patient, client and claimant are used interchangeably throughout this guide, depending on context. 'Claimant' is used in legislative references and 'client' and 'patient' in describing operational references.

[1] Conditions relating to prior approval may apply
[2] Throughout this guide

Update process

This guide will serve as a 'living document', designed to be used electronically, with updates made as required and agreed by both parties as per the process map below:



The intent is that changes to processes/policies will be updated annually using the above process. Legislative changes and/or major service/contract/policy changes may need to be updated prior to the annual review. Updates required prior to the annual review will be made using a similar process to the one outline above, will be agreed by ACC/MoH in consultations with the DHB Operational Management Group, and will be signed off by ACC Legal team and Health Legal.

Structure of the guide

Section 1 **Outlines the AC Act 2001** and gives an overview of the ACC system.

Section 2 Discusses general categories of service and **how ACC legislation translates into operational use**. In particular, it discusses PHAS timeframes as set in regulation.

Section 3 Discusses examples of services that may require **interfaces between agencies**.

Section 4 Covers **ancillary services** that support treatment and rehabilitation services.

Section 5 Describes key **administrative processes** to be used by DHBs in relation to services for ACC clients, and includes a section on **treatment injury**.

Information on **frequently used forms** is included in this section.

Section 6 Outlines the **process for resolving ACC/MoH boundary issues**.

Section 7 Discusses **provider performance**.

Glossary

Appendix 1 A guideline for transfer of funding responsibilities from DHBs to ACC.

Section 1: The Accident Compensation Act 2001

The AC Act was passed in September 2001.The majority of the provisions in the Act came into force on 1 April 2002.

Prior to March 2010, this Act was known as the Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRC Act 2001). The Accident Compensation Act Amendment Bill 2010 changed the name of the Act to the Accident Compensation Act 2001. Some regulations and past amendments retain their IPRC titles.

1.1 ACC legislation currently in force

The AC Act 2001 (Note: There are a number of amending Acts to the principal legislation. The most current 'version' of the AC Act should always be sourced, and is available online). Regulations to the AC Act can also be sourced online, for example:

a. Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 (IPRC (PHAS) Regulations 2002)

b. Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (Cost of Treatment Regulations 2003 (CoTR 2003)

c. Accident Compensation (Ancillary Services) Regulations 2002 (Ancillary Services Regulations 2002).

1.1.1 Main features of the AC Act 2001

The AC Act 2001 aims to provide a fair and sustainable scheme for managing personal injury, and reflects the Government's key goals of:

a. injury prevention through the promotion of measures to reduce the incidence and severity of personal injury

b. timely rehabilitation – including social and vocational rehabilitation, treatment (including physical and cognitive rehabilitation) and ancillary services

c. fair compensation – including the reinstatement of lump sum compensation, and changes to rehabilitation, weekly compensation and death benefits

d. the development of a Code of ACC Claimants' Rights – specifying clients' rights and service standards for ACC.

1.2 Coverage of the AC Act 2001

1.2.1 Who is covered?

The AC Act 2001 covers everyone in New Zealand.

1.2.1.1 New Zealanders

New Zealanders who are 'ordinarily resident' in New Zealand are covered by the Act, even if, in some circumstances, they are injured while temporarily overseas.

1.2.1.2 Overseas visitors and foreign diplomats

Overseas visitors and foreign diplomats are covered for personal injury sustained in New Zealand. They are considered to be in New Zealand once they disembark from the aircraft or boat bringing them to New Zealand, and have the same eligibility for acute treatment services for injury as New Zealand residents.

In all cases of an overseas visitor sustaining a personal injury by way of accident in New Zealand, the DHB, or first treating health provider if not a DHB, should lodge an ACC claim on behalf of the client. This claim must be signed by the client or their authorised representative. ACC will determine whether the injury is covered by the AC Act 2001.

The AC Act 2001 takes precedence over any other funding arrangements (including reciprocal agreements). If a visitor refuses to submit a claim they should be advised that they may be liable for payment. An overseas visitor may only be charged if:

a. they refuse to submit a claim, or

b. a claim is declined, or

c. they are not otherwise covered by a reciprocal agreement.

Information on eligibility for publicly funded health and disability services (including those for injured persons) can be found on the MoH website. This also has information on the reciprocal agreements with the United Kingdom and Australia.

1.2.2 What is covered?

People who sustain personal injuries caused by accidents – whether in the home, during recreation, on the sports field, on the road, at work or in certain other circumstances – are eligible for ACC cover. Cover can only be granted when an ACC45[3] Injury Claim form is completed by a treatment provider, signed by the client or their authorised representative[4] and accepted by ACC.

a. There are several key terms used in defining coverage under the AC Act 2001, including:

b. accident

c. personal injury: this cover includes damage (other than wear and tear) as a result of an accident to dentures or prostheses that are replacing a part of the human body at the time of the accident. (It does not include hearing aids, spectacles or contact lenses)

d. mental injury

e. work-related personal injury.

The legislative definitions for these terms are provided in section 6 of the AC Act 2001.

The AC Act 2001 also contains details of the cover provided for particular types of personal injury and circumstances, for example:

a. New Zealanders injured overseas (section 22, AC Act 2001)

b. exclusions for visitors while on aircraft or ship (section 23, AC Act 2001)

c. specific instances of mental injury covered by ACC (section 21 and Schedule 3, AC Act 2001)

d. treatment injury (section 32, AC Act 2001)

e. hearing loss (section 26, AC Act 2001).

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[3] The ACC46 injury claim form is also used by some DHBs to assist with gathering information to lodge ACC claims. The order of questions on the ACC46 is designed to assist providers with entering data into a Practice Management System (PMS) or the ACC web-based eLodgement system. The ACC46 cannot be used to lodge claims directly with ACC.

[4] In the case of electronic lodgement of forms, providers need to keep signed copies in paper or image form that show the claims were authorised by the client or their authorised representative.

1.2.3 Who manages injury claims?

1.2.3.1 ACC

ACC manages claims for personal injuries, including work-related personal injuries. The only exceptions to this are work-related injuries to employees of accredited employers within the ACC Accredited Employer Programme.

1.2.3.2 Accredited employers

Accredited employers take on the role of ACC and are responsible for providing statutory entitlements in relation to their employees' work-related (as opposed to non-work-related) injuries that occur from the date of the employers' accreditation (the earliest date for any accreditation is 1 July 2000). Accredited employers have the same legislative/regulatory and contractual obligations as ACC. However, it should be noted that employees of accredited employers are covered by PHAS for both work-related and non-work-related personal injuries[5].

Accredited employers must meet specific criteria for entering and maintaining their participation in ACC's Accredited Employer Programme. They are obliged to pay at least the regulated costs of their employees' claims for an agreed claim management period[6]. At the end of this period, open claims are transferred back to ACC for further management. Accredited employers are entitled to the same level of work-related injury information as ACC, to enable them to manage their workplace injuries effectively. The usual privacy requirements apply to the provision of personal and non-work injury information.

For information on lodging a claim for an employee of an accredited employer, see section 5.2.1.2 of this guide.

1.2.3.3 Accredited employer third party administrators

Under the ACC Accredited Employer Programme, accredited employers may, subject to ACC's approval, contract 'third party administrators' (TPAs) to deliver injury and claim management services to their employees. While TPAs act as payment agents and day-to-day point of contact for some accredited employers, the claim and injury management responsibilities for injured employees remain the responsibility of the accredited employers.

1.2.3.4 Accredited employers – useful resources

a. ACC web page 'Lodging a claim if your patient works for an Accredited Employer'.

b. 'Managing employees injuries' web page

c. Telephone the ACC Provider Contact Centre – 0800 222 070.

[5] Accredited employers pay levies to ACC to cover the provision of PHAS to their employees.

[6] Time periods are individual to each accredited employer and should be identified in instances of employees of accredited employers requiring longer-term treatment.

1.3 Treatment under the AC Act 2001

1.3.1 Treatment conditions that need to be met under the AC Act 2001

The AC Act 2001 states that the purpose of treatment is to restore a claimant's health to the maximum extent practicable. The term 'practicable' is defined in section 6 of the AC Act 2001.

Schedule 1, clause 2 of the AC Act 2001 states:

"(1) The Corporation is liable to pay the cost of the claimant's treatment if the treatment is for the purpose of restoring the claimant's health to the maximum extent practicable, and the treatment –

(a) is necessary and appropriate, and of the quality required, for that purpose; and

(b) has been, or will be, performed only on the number of occasions necessary for that purpose; and

(c) has been, or will be, given at a time or place for that purpose; and

(d) is of a type normally provided by a treatment provider; and

(e) is provided by a treatment provider of a type who is qualified to provide that treatment and who normally provides that treatment; and

(f) has been provided after the Corporation has agreed to the treatment, unless clause 4(2) [of Schedule 1] applies. See also section 1.4.3 of this guide.

(2) In deciding whether sub clause (1)(a) to (e) applies to the claimant's treatment, the Corporation must take into account –

(a) the nature and severity of the injury; and

(b) the generally accepted means of treatment for such an injury in New Zealand; and

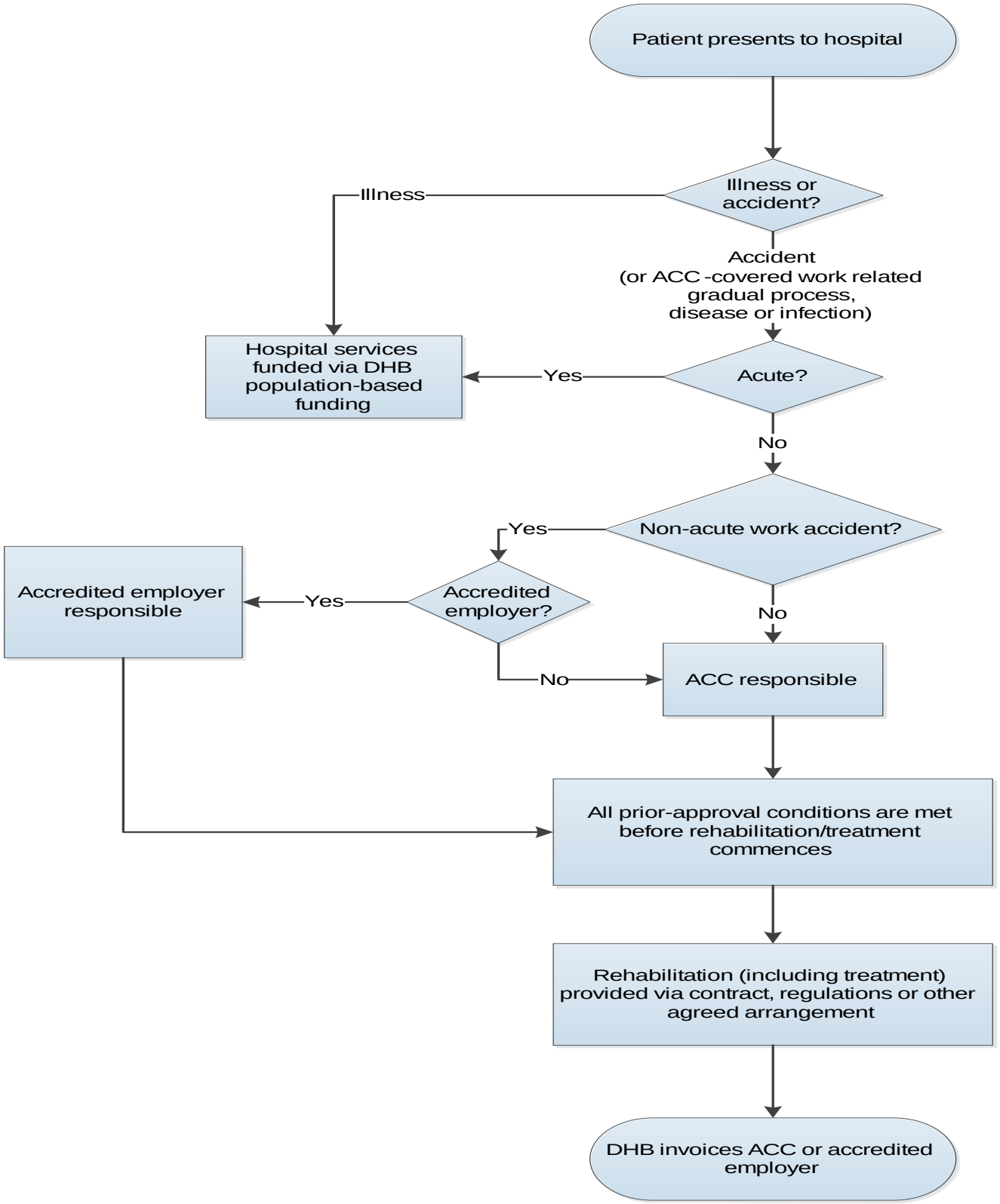
(c) the other options available in New Zealand for the treatment of such an injury; and

(d) the cost in New Zealand of the generally accepted means of treatment and of the other options, compared with the benefit that the claimant is likely to receive from the treatment."

Patients with wilfully self-inflicted personal injuries are covered by ACC and are entitled to treatment and ancillary services for treatment. However, for suicide and wilfully self-inflicted injuries that occur on/after 1 July 2010, ACC does not provide other entitlements for these patients/clients, except in limited circumstances (see sections 119 and 122A of the AC Act 2001).

1.4 What are the funding arrangements for treatment under the AC Act 2001?

Figure 1: Diagrammatic representation of funding streams



1.4.1 Public Health Acute Services (PHAS)

The IPRC (PHAS) Regulations 2002 define PHAS in relation to the treatment of a client for a covered personal injury. A summary of that definition, with examples of the durations of PHAS (as defined in the Regulations), is given in section 2 of this guide.

PHAS funding agreements are set out in the AC Act 2001, section 301. ACC's annual PHAS contribution is calculated by the Ministry of Health (MoH) and agreed by ACC. This covers the cost of ACC clients receiving acute services in publicly funded hospitals.

The AC Act 2001, section 303, prohibits ACC from purchasing PHAS directly from DHBs or other publicly funded providers.

Tracking actual injury-related events requiring acute inpatient hospital admission relies on

a. coding of accident details for discharge records loaded into the National Minimum Data Set (NMDS)

b. DHBs lodging claims for all accidents with ACC (or accredited employer claim managers).

This allows the identification of injury treatments associated with accepted claims, to determine frequencies and costs.

1.4.1.1 The Annual Service Agreement for Public Health Acute Services, Pharmaceuticals and Laboratory Tests

Section 301(2) of the AC Act 2001 states that the Annual "Service Agreement must−

(a) provide for the payment of money to the Crown in return for the Minister of Health–

  (i) funding the provision of public health acute services, and any other services (including pharmaceuticals and laboratory services) agreed by DHBs or other providers, under Crown funding agreements on behalf of the Corporation; and

  (ii) arranging the funding of that provision; and

(b) provide how the Minister of Health's implementation of the agreement is to be monitored; and

(c) contain the terms and conditions that the Minister of Health and the Minister [for ACC] agree on; and

(d) specify service levels for the delivery of such services; and

(e) specify the level of payment from the Corporation to the Crown; and

(f) specify the mechanism for calculating the sum payable by the Corporation and the method of payment."

Note:
PHAS funding covers laboratory tests referred by private providers.

1.4.1.2 Requirements of providers of PHAS

DHBs must:

a. identify and track service provision for people who are being treated under multiple purchasing arrangements

b. complete the appropriate claim forms (i.e. the ACC45 for all ACC and accredited employer patients), and ensure that they are signed by the patient or their authorised representative. They must ensure that these details are recorded against all the patient's accident events

c. use clinical coding to assign diagnosis, procedure and external cause codes via acceptable classification systems such as International Classification of Diseases-10 (ICD-10) or Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT)

d. invoice ACC (or accredited employers) for approved treatment that is not included within the definition of PHAS.

1.4.2 Assessment and rehabilitation services that fall outside PHAS (non-PHAS)

ACC is responsible for directly purchasing any services outside PHAS to which a patient/client is entitled[7]. ACC is prohibited by the AC Act 2001 (section 303) from entering into contracts for PHAS with DHBs or other publicly funded providers.

However, ACC can enter into direct contractual arrangements with providers of its choice for specified elective surgery, or any other treatment[8] that is not included in PHAS. These providers include DHBs, Community Trust Hospitals and private providers.

When a DHB provides assessment and treatment services that fall outside PHAS or regulations or specific contract arrangements, the DHB must, where appropriate, seek and obtain prior approval, and invoice ACC or the accredited employer.

The cost payable by ACC for non-PHAS is an amount:

a. agreed in a contract between ACC and the provider
For those services where ACC has entered into a contract or agreement for the purchase of non-PHAS, ACC is liable to pay the amount specified in the contract or agreement with the provider for the service. Examples of contracts between ACC and DHBs include elective surgery and non-acute inpatient rehabilitation assessment contracts, and social rehabilitation assessment contracts; or

b. specified in regulations
For example, the CoTR 2003 cover the costs of treatment provided by counsellors, dentists, radiologists, medical practitioners (including registered specialists), specified treatment providers and practice nurses, or services; or

c. covering the cost of treatment
Where there is no contract or agreement or regulations that specify the amount ACC must pay, ACC is liable to pay the cost of treatment for eligible clients provided by a 'treatment provider' (see section 2.4.1 of this guide); and
Schedule 1, Clause 1(2) of the AC Act 2001 states:
"(2) … cost means the cost –
  a. that is appropriate in the circumstances; and
  b. as agreed by the Corporation and the treatment provider."

Prior-approval conditions may apply to treatment; see section 1.4.3 below.

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[7] In respect of a personal injury for which they have cover under the AC Act 2001.
[8] The AC Act 2001 defines rehabilitation as comprising treatment, social rehabilitation and vocational rehabilitation

For mental health services please see section 3.4 of this guide

1.4.3 Prior approval for treatment

Non-acute care is purchased via contracts and regulations that may carry their own entry criteria, such as prior approval. In addition, in some instances (e g physiotherapy) prior approval may be required after a certain number of treatments for a particular injury.

The requirement for a treatment provider to obtain ACC's prior agreement to treatment *does not* apply if the treatment is:

a. acute treatment; or

b. PHAS; or

c. of a type specified in Regulations made under the AC Act 2001 as treatment that does not require ACC's prior approval; or

d. of a type specified in or under an agreement or contract between ACC and a treatment provider as treatment that does not require ACC's prior approval, and the treatment is to be provided by that treatment provider.

ACC may seek a professional second opinion to validate a patient's/client's treatment condition.

ACC is not liable to pay for any services provided by other types of health care providers (eg dieticians, social workers) unless such treatment has been agreed by ACC as part of a rehabilitation plan, *or* the DHBs have the prior approval of ACC (see section 5.2.2 of this guide).

1.4.4 Using an agency to purchase non-PHAS

ACC and accredited employers may use other organisations to purchase services on their behalf, eg TPAs, or other agencies that purchase treatment services.

In some instances, MoH may act as an agent and purchase services that are non-PHAS on behalf of ACC or accredited employers, eg private laboratory services, pharmaceuticals, or residential care for elderly victims of crime.

Section 2: How the AC Act 2001 translates into operational use

This section lists the general categories of service provided to injured people and describes the services and payment responsibilities. Table 1 gives an introductory overview of the provision of these services.

Table 1: Hospital service categories

(This table should be used in conjunction with 'PHAS and how to calculate the PHAS period' overleaf)

Note:
Non-PHAS specialist clinical mental health services for people with ACC cover are funded by ring-fenced, population-based mental health funding. Please see section 3.4 of this guide for more detail.

Service category	Service type	Covered by PHAS	Purchased directly by ACC[9]
DHB hospital admissions (including day cases)	Acute admissions through to discharge from the acute event (to home or non-acute services)	✓	
	Elective admissions through to discharge		✓
	Non-acute inpatient or residential rehabilitation services		✓
DHB emergency department (ED) attendances (see section 2.1.1 of this guide)	Initial presentation	✓	
	Subsequent service within seven days from initial presentation for that injury	✓	
	Subsequent service post seven days after initial presentation for that injury		✓
DHB hospital medical specialist outpatient services (see section 2.1.1 of this guide)	Services[10] provided by a medical practitioner **within six weeks**: (i) after the day of discharge from acute admission; or (ii) after ED presentation	✓	
	Services provided by a medical practitioner **post six weeks**: (i) after the day of discharge from acute admission; or (ii) after ED presentation		✓

[9] Through regulations or contract, subject where appropriate to any prior approval conditions being met.
[10] 'Services' include all radiology services required by patients or ordered during acute admissions or ED attendances and as part of medical outpatient services for up to six weeks from discharge or treatment, unless requested privately by a medical practitioner.

Service category	Service type	Covered by PHAS	Purchased directly by ACC[9]
DHB hospital medical specialist outpatient services (see section 2.1.1 of this guide) *(continued)*	Services provided by a medical practitioner **less than seven days** after the date of referral by another medical practitioner[11]	✓	
	Services provided by a medical practitioner **post seven days** after the day of referral by another medical practitioner		✓
Other services – medical specialist	Elective surgery procedure costs include pre-assessment and six weeks post-surgical outpatient attendances, orthotics and equipment		✓
Other services – non medical specialist (see section 2.1.1.4 of this guide)	Services provided by other health professionals, eg physiotherapy, occupational therapy, outpatient nurse-led clinics, provided after discharge from an acute admission, or ED attendance, or on referral from a General Practitioner (GP). Additional information on mental health services is available in section 3.4 of this guide.		✓
	Non-acute outpatient rehabilitation services		✓
DHB community health services (see section 2.3 of this guide)[12]	District/community nursing services and all other services (eg physiotherapy, occupational therapy) provided after discharge from an acute admission, or ED attendance, or on referral from a GP, or from ACC Elective surgery		✓

[11] Referrals to radiologists by medical practitioners are not included in PHAS if the referral is made as part of providing non-public health acute treatment.
[12] Non-hospital treatment services provided by 'treatment providers' (eg GPs, nurses, physiotherapists, osteopaths, dentists, counsellors etc.), and other rehabilitation services, are purchased directly by ACC under regulations when an ACC45 is lodged and accepted.

2.1 PHAS and how to calculate the PHAS period

The AC Act 2001 defines PHAS as services (as defined in Regulations made under section 322(2) that are funded by the Minister of Health (via the PHAS levy) and provided by publicly funded providers.

The following examples have been developed in consultation with legal experts to clarify PHAS timeframes. It should be noted that some descriptions appear to contradict each other. This is because they reflect the actual legislation. In order to manage this, each situation should be calculated in its own right, eg acute and elective admissions, calculated with their own date explanations.

Table 2: How to calculate PHAS using the IPRC (PHAS) Regulations 2002

Note:
These apply only to services purchased through the Minister of Health and provided by publicly funded providers.

Regulation 4 IPRC (PHAS) Regulations 2002	Duration	Example
(a) Services provided as part of an acute admission[13]	PHAS covers all services related to the acute admission until the date of discharge (see definition in Glossary)	**For example:** Decision to admit made on Monday. Person must be admitted before midnight the following Monday to be an acute admission
(b) Services provided as part of an ED presentation and any subsequent services provided by the ED within seven days after that presentation	Where day zero is the day of the initial ED presentation. The following one to seven days (up to midnight on the seventh day) are included in the provision of subsequent services under PHAS	**For example:** Person initially presents to ED on Monday. Should the person require subsequent ED services, the following seven days – Tuesday to midnight the following Monday – are included in the PHAS period
(c) Outpatient services provided by a medical practitioner and associated with services described in paragraph (a) if those outpatient services are provided within six weeks after the date of discharge from acute admission	Where day zero is the day of discharge from acute admission, the day after the day of discharge is day one and the final day of PHAS is day 42 of the provision of outpatient services	**For example:** Person initially discharged from an acute admission on Monday. The following 42 days (or six weeks Tuesday to midnight Monday) are included in the PHAS period should the person require outpatient services
(d) Outpatient services provided by a medical practitioner and associated with services described in paragraph (b) if those outpatient services are provided within six weeks after the day of treatment (i.e. from ED presentation)	Where day zero is the day of final treatment in ED (within seven days of the initial presentation). Day one is the day after the day of final treatment in ED and the final day of PHAS is day 42 of the provision of outpatient services	**For example:** Person receives final ED treatment for injury on Monday. The following 42 days (or six weeks Tuesday to midnight Monday) are included in the PHAS period should the person require outpatient services

[13] That is, admission to a publicly funded hospital or agreed facility within seven days of a medical practitioner's decision to admit the person to hospital, unless otherwise specified in the regulations (see the definition of acute admission in the Glossary).

Regulation 4 IPRC (PHAS) Regulations 2002	Duration	Example
(e) Services that are provided by a medical practitioner less than seven days after the date on which the client is referred for those services by another medical practitioner, other than: (i) services associated with services described in (a) or (b); and (ii) referrals to a radiologist by a medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 or under Schedule 1, clause 1 of the Act	Where day of referral is day zero and day one is the day after the date the referral is made and PHAS ends at midnight seven days after the making of the referral	**For example:** Referral is made on Monday. The following seven days – Tuesday to midnight the following Monday – are included in the PHAS period should the person receive services that are provided by the medical practitioner to whom the referral was made
(f) Services that are ancillary to any of the services described in paragraphs (a) to (e), including non-emergency travel and accommodation for the client, and an escort or support person for the client, but excluding emergency transport (Emergency transport means transport that— (a) starts within 24 hours of a client suffering a personal injury or being found after suffering a personal injury, whichever is the later; and (b) is necessary for the purpose of obtaining treatment urgently for the client's personal injury)	Duration as for (a) to (e) above	
(g) Services that relate to the provision of treatment described in paragraphs (a) to (f), including, for example, the provision of consumables, diagnostic imaging and equipment	Duration as for (a) to (f) above	

Table 3: Examples of what is included within PHAS (for example during ED attendance)

Note: refer to Appendix 1 - 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

	ED treatment provided under PHAS includes related services directly associated with visit. **Services include:**	**Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services.** **Services include:**	**Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner.** **Services include:**
Trauma management services	Required during the attendance	Encompass ED care and intensive care	Nil required
Diagnostic support services[16]	Ordered during the attendance	As required	Ordered by DHB medical practitioners and related to attendance
Therapeutic support services[17]	Provided in the ED	As required	Provided during the attendance, including allied health (where multidisciplinary clinics are involved. For example, a specialist visit that includes a physiotherapist attending the session)
Procedures required	During the attendance, eg suturing, plastering, fracture manipulation, urgent dental treatment	As required, eg skin grafting, Open Reduction and Internal Fixation (ORIF), tissue repairs, urgent dental treatment	As required during the attendance, such as wound dressing, plastering, fracture manipulation, urgent dental treatment
Pharmaceuticals	As required	As required	As required
Medical supplies	Used during the attendance eg plasters, dressings	As required, eg plasters, dressings, incontinence products. (For medical consumables required by patients	Used during the attendance, eg plasters, dressings

[14] An acute admission may be from an ED, an outpatient department or a GP/private specialist referral.
[15] PHAS covers attendance at a DHB-facility-based medical practitioner, not involving an admission to a DHB, for up to six weeks from the date of discharge from acute inpatient, day patient and ED services.
[16] Examples: diagnostic imaging, laboratory services, audiology, electro-diagnostic imaging, optometry, spirometry and urodynamics.
[17] Examples: nursing, allied health, pharmacy, blood transfusion, counselling and interpreter services.

	ED treatment provided under PHAS includes related services directly associated with visit. Services include:	Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services. Services include:	Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner. Services include:
		immediately upon discharge, see section 4.7 of this guide)	
Aids and appliances eg orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (ACC responsible after six weeks from ED attendance or discharge from acute admission)[18]	Assessed by ED as required by the patient during the attendance or immediately on discharge (see section 4.5.1 of this guide)	As required during the admission, eg orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (aids and appliances required upon discharge are discussed in section 4.5.3 of this guide)	Assessed by clinic staff as required by the patient during the attendance or for the six weeks following discharge from acute admission or discharge from outpatients
Administrative support services eg information systems, clerical support, medical records	As required	As required	As required
Hotel services eg accommodation, food, cleaning	Nil required	As required	Nil required (unless attendance is required out of client's area eg National Burn Centre)
Ancillary services including transport and accommodation	Nil required	As required (See Table 23, section 4.12)	As required (see Table 24, section 4.12)

[18] For information on persons with pre-existing equipment needs, see section 4.5.3.1 of this guide.

	ED treatment provided under PHAS includes related services directly associated with visit. Services include:	Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services. Services include:	Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner. Services include:
Notes and exclusions from PHAS	N/A	N/A	**Exclusion:** visit to a health service (eg physiotherapy), community nursing, non-acute outpatient rehabilitation service or nurse-led outpatient service **that is not part** of a visit to a medical specialist outpatient service visit is directly billable to ACC. Provision of any follow-up DHB medical specialist outpatient services or associated services provided by the DHB following the six-week period after discharge from acute admission or date of last presentation at ED, is directly billable to ACC. Exclusion: Medical referrals do not include radiology referrals related to non-public health acute treatment. ACC is responsible for directly purchasing these services for eligible clients.

2.1.1 Specific examples of treatment and how they are funded

The following tables give specific examples of what is included within PHAS and what is purchased directly by ACC under contract or regulation.

Table 4: Fracture treatment and removal of metal

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB, including decision to admit within seven days, dependent on clinical need	✓ DHB inpatient or ED treatment (eg removal of plaster or metal for reasons of infection)	
Treatment by a medical practitioner at DHB outpatients within six weeks of discharge from acute admission or ED attendance	✓	
Elective treatment		✓ Providing any contractual/ legislative requirements for prior approval have been met

Table 5: Hyperbaric oxygen treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission, ED attendance or acute outpatient attendance	
Acute treatment at private provider	✓ Acute admission, or acute outpatient	
Non-acute treatment		✓ Under contract arrangement or (if no contract exists) under CoTR 2003

2.1.1.1 General dental treatment

General dental treatment is provided by registered general dental practitioners[19] within the scope of practice as determined by the Dental Council.

Forms to be used when lodging dental claims

An ACC42 Dental claim registration form must be completed and signed by the client (or their authorised representative) for every dental claim. The ACC42 details the nature and severity of the damage to the affected teeth[20]. Supporting information such as X-rays and patient/client records can be included with the ACC42 to speed up the claim decision.

The initial non-dental medical practitioner who identifies a personal injury may have completed an ACC45 in line with the established process for other injuries. If this occurs ACC lodges the claim using the ACC45, but requires the ACC42 to be completed by the assessing/treating dentist before any prior approval can be given for long-term management of the dental claim. The ACC42 and ACC45 claim numbers are linked in ACC's claim management system.

How ACC purchases dental services

Dental services are purchased at CoTR 2003 rates. There are instances when a person with an accepted ACC claim is unable to receive general dentistry in a dental chair or is unable to comply with treatment without general anaesthetic, due to conditions such as traumatic brain injury or birth injury. In these cases, prior approval from ACC is required for the theatre and anaesthetic services (including when delivered on an outreach surgical bus). However, ACC does not pay for general dentistry that is not injury related.

Table 6: General dental treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment a provided by the DHB in ED or DHB dental department on day of ED presentation or during an admission because general anaesthetic is required	✓	
Acute self-referral directly to DHB dental department for initial treatment as an outpatient		✓ Regulations
DHB outpatient follow-up treatment (general dentistry)		✓ Regulations

General dentistry and specialist needs such as endodontic, periodontic, paedodontic, orthodontic, restorative, prosthetic, public health and special needs are expected to be managed by a patient's own community dental provider and should be referred on for ongoing management at the earliest opportunity.

[19] Clinical dental technicians and dental therapists who work within dental services and are registered with the Dental Council are not currently on the list of registered treatment providers to ACC.
[20] The Dental Trauma Guide is a web-based tool to evidence based dental traumatology developed by the University Hospital of Copenhagen and the International Association of Dental Traumatology. The Dental Trauma Guide can be accessed via the Dental Trauma Guide Organisation for a small fee.

Table 7: Oral and maxillo-facial surgery

Oral and maxillo-facial surgeons are considered as **specialist medical practitioners** who, when working in a DHB, provide services within the scope of their specialty targeted at those patients who have a clinical need for specialist care.

This may include mandibular maxillary zygomatic arch reconstruction, repair of lacerations and treatment for complex trauma to the face and oral cavity.

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment a provided by the DHB in ED or DHB dental department on day of ED presentation or during an admission because general anaesthetic is required	✓	
DHB outpatient treatment by oral or maxillo- facial surgeon within seven days after the day of referral by a medical practitioner *or* within six weeks of discharge from acute admission or most recent ED attendance	✓	
DHB outpatient treatment after seven days following referral by a medical practitioner *or* after six weeks of discharge from acute admission or most recent ED attendance		✓
Elective treatment at DHB		✓ Providing requirements for prior approval are met. Purchased at regulation rate unless otherwise specified in contract

Table 8: Renal treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission or ED attendance	
Non-acute treatment at DHB	✓ DHB	

Table 9: Mental health services

The following table gives specific examples of what is included within PHAS, what is provided by DHBs with population-based mental health funding, and what is purchased directly by ACC under direct contract or regulation. For full details of mental health services, please see section 3.4.

Service to injured person	Covered by PHAS	Those most severely affected by mental injury covered by population-based mental health funding	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission or ED or crisis team attendance		
Non-acute treatment at DHB		✓ Clinical services provided by outpatients or community mental health team	If not under 3% with lower level need: mild to moderate mental health need go to GP or ACC-registered/contracted psychiatrist, psychologist, psychotherapist or counsellor
Community residential or home-based non-clinical support		✓ With dual mental health needs, joint funding between ACC and DHB considered	✓ Where mental health need is only directly linked to covered ACC mental injury claim

2.1.1.2 Date of discharge from acute admission

The treatment of a client comes under PHAS until the requirement for 'safe discharge' can be met. The date of discharge is the date the client is safely discharged from the acute admission to their home or to non-acute inpatient rehabilitation services – see section 5.6 of this guide.

Exclusion:
A client returning home 'on leave' from a hospital does not constitute a permanent discharge (eg weekend leave for a seriously injured client).

2.1.1.3 Medical referrals

PHAS covers urgent consultations with a DHB medical practitioner that have been provided within seven days after the date on which the patient/client was referred for those services by another medical practitioner. Services covered include services directly associated with the visit – see Table 3. DHBs should note that the seven-day rule applies from the date when the referral is made – the date of the client's injury only provides an indication of the urgency of the need for referral.

Exclusion:
Medical referrals *do not* include radiology referrals related to non-public health acute treatment. ACC is responsible for purchasing these services directly for eligible clients.

2.1.1.4 Other outpatient services (non-medical specialist)

All other outpatient services are purchased directly by ACC, including services such as allied health attendances, non-urgent referrals from medical practitioners, referrals from other treatment providers and medical follow-ups beyond the six-week and seven-day periods outlined above. Prior-approval conditions may apply (see section 5.2.2 of this guide).

DHB hospital treatment providers *may* also refer the client to the private sector for these 'other' services. When making such a referral, the DHB hospital treatment provider must ensure that:

a. the ACC45 injury claim form has been completed and signed by the patient/client or an authorised representative, and sent to ACC

b. a written referral is made to the private sector treatment provider that includes all the information required to ensure continuity of care (this could be in the form of a letter that includes treatment and claim details, a copy of the discharge report, or a copy of the completed ACC45).

Note:
The private provider is responsible for ensuring that any prior-approval conditions have been met before the commencement of treatment.

2.1.1.5 Self-referrals to DHB outpatient services

Patients/clients who self-refer to DHB outpatient services, other than ED services (see section 2.1.1 of this guide), may be treated by any of the non-medical specialist treatment providers listed in section 2.4.1, subject to the correct ACC prior-approval conditions being met. ACC is liable to pay for any such acute treatment, by paying the:

a. amount specified in the DHB's contractual arrangements with ACC; or

b. amount specified in the CoTR 2003; or

c. the cost of the treatment if no contract/agreement or regulations applies.

Prior approval is required for any treatment provided by health professionals who are not 'treatment providers'.

2.1.1.6 Follow-up from other treatment providers (excluding medical specialists)

Clients who are referred to DHB outpatient services (excluding medical specialists) following treatment by a non-DHB-owned provider should be treated as new referrals.

ACC is responsible for directly purchasing this treatment unless the client is referred to a medical practitioner by another medical practitioner and is clinically required to be seen within seven days of referral (see section 2.1.1.3 of this guide).

Note:
The number of treatments provided by a 'referring' provider must be included in the total number of 'allowed' treatments, before prior approval for additional treatment is sought through the ACC32 Treatment extension request for prior approval of treatment form (for example, referrals from private physiotherapists).

2.2 Elective surgery

Elective surgery is surgery performed outside the PHAS period. PHAS funding covers any acute surgery within the PHAS period. Elective surgery requires prior approval from ACC, to ensure cover is confirmed and the treatment plan is in accordance with entitlements. A Surgical Assessment Report and Treatment Plan (ARTP) must be completed and forwarded to the Treatment Assessment Centre for approval **before** surgery or any preparation for surgery is commenced. ACC is not liable and will decline to pay for elective surgery performed without prior approval unless it is performed as an unanticipated requirement in the course of approved elective surgery.

ACC is responsible for all elective surgery where the admission date is not within seven days of the date the decision was made by the specialist that the admission was necessary. The date of the decision to admit is counted as day zero. Therefore, if the decision to admit is made on a Monday, any admission *after* midnight on the following Monday is an elective admission. In exceptional circumstances, this may be negotiable with ACC.

A decision to admit for elective surgery purchased by ACC can be made during an inpatient admission, outpatient attendance or ED attendance (excluding diagnostic procedures required to support the outpatient assessment or treatment).

Details of ACC's responsibilities for elective surgery costs are contained in the CoTR 2003 (section 18). ACC may enter into contractual agreements with providers (including DHBs) for elective surgery on terms superior to the Regulations for most providers.

Where a client chooses to have elective surgery (contracted or regulation) performed at a DHB, ACC pays 100% of the contracted fee for the treatment to the DHB (as outlined in the Elective Surgery contract), and the client is not liable for any co-payment or part-charge.

If a transport need arises following ACC approved Elective Surgery, ACC pays for this as non-emergency transport under Ancillary Services Regulations 2002. When considering non-emergency transport by air, prior approval is required from ACC.

2.2.1 Other treatment

Occasionally clients require treatment that is not surgical, for example work-related asbestosis requiring chemotherapy, or treatment for infertility that has arisen as a result of a covered personal injury.

In these instances, PHAS rules apply and ACC funds non-PHAS treatment and services. Prior approval must be sought via the Treatment Assessment Centre for any non-PHAS services using the ARTP process.

2.3 DHB community services

All community health services required in relation to a personal injury[21] are purchased directly by ACC, as are any related services[22] **during a community health visit**, such as diagnostic services, equipment and consumables.

This provision includes clients referred to DHB community health services by primary care service providers.

[21] Includes district/community nursing, allied health domiciliary services, home help and personal care services.
[22] Or identified as required and referred in accordance with appropriate practice.

2.3.1 Self-referrals to DHB community health services

Clients who self-refer to DHB community health services may be treated by any of the 'treatment providers' (listed in section 2.4.1 of this guide). ACC is liable to purchase treatment for patients/clients with a covered injury.

Prior approval is required for most non-acute treatment as well as any rehabilitation provided by health professionals who are not 'treatment providers' (see section 5.2.2 of this guide).

2.4 Community-based (or non-hospital) treatment and rehabilitation services

Acute treatment in the community is provided under regulation and rehabilitation is provided under contract. The same disciplines may be provided under both frameworks, for example occupational therapists.

2.4.1 Non-hospital-based acute treatment in the community

Treatment providers can exercise their clinical judgement as to the urgency of need for treatment. However, this is only if they are appropriately qualified to make clinical judgements of that kind. If not, they must refer the patient/client to an appropriately qualified treatment provider.

ACC's Provider Claim Lodgement Framework details which providers can give the initial treatment and lodge an ACC45 for the injury. In some cases, treatment providers, eg acupuncturists, can give the initial treatment and populate the ACC45 but the patient/client must be referred to a provider who can lodge the ACC claim to complete lodgement before ACC can determine cover.

Table 10: Non-hospital-based acute treatment providers in the community

Provided an ACC45 is completed and signed by the patient/client, the following treatment providers can provide acute treatment for the patient/client for the personal injury for which they have cover under the AC Act 2001, (see the Glossary for a definition of acute treatment).

Non-hospital-based acute treatment providers	
Acupuncturist[23]	Audiologist
Chiropractor	Counsellor[24]
Dentist	Medical laboratory technologist
Nurse	Occupational therapist[23]
Optometrist	Osteopath
Physiotherapist	Podiatrist
Medical practitioner	Speech therapist

Note:
The treatment conditions listed in section 1.3.1 of this guide apply.

[23] Under ACC's Provider Claim Lodgement Framework, acupuncturists and occupational therapists cannot lodge claims (ACC45s) – they can provide acute treatment where the client already has an approved claim that has been lodged by another provider.
[24] Defined in the Accident Insurance ("Counsellor") Regulations 1999.

2.4.2 Rehabilitation entitlements (including non-acute treatment)

A person who has sustained a personal injury is entitled to rehabilitation purchased by ACC to the extent outlined in the AC Act 2001, to assist in restoring their health, independence and participation to the maximum extent practicable (see section 70 of the AC Act 2001). The injured person is also responsible for their own rehabilitation to the extent practicable, having regard to the consequences of their personal injury (see section 72 of the AC Act 2001).

Table 11: Types of rehabilitation assistance

Where applicable, ACC purchases rehabilitation services (including treatment) from a range of treatment and rehabilitation providers. A client may be entitled to any of the following types of rehabilitation assistance, in addition to acute treatment.

Types of rehabilitation assistance	
Non-acute treatment	Aids and appliances
Attendant care	Child care
Education support	Home help
Modification to the injured person's home	Training for independence
Transport for independence	Vocational rehabilitation assistance

However, a client with a wilfully self-inflicted injury is not eligible for rehabilitation assistance (other than treatment or ancillary services for treatment) unless the injury results from a mental injury covered by the AC Act 2001 (see section 1.3.1 of this guide). Different types of assistance may be funded by other agencies, eg MoH, and each will have its own eligibility criteria.

2.4.3 Individual rehabilitation plans

Under section 75 of the AC Act 2001, ACC is required to develop an Individual Rehabilitation Plan (IRP) in consultation with the client within 13 weeks of the acceptance of the claim for cover if the client is likely to need social or vocational rehabilitation after the 13 weeks have ended. Prior to that plan being developed, ACC is liable for the provision of social and vocational rehabilitation in accordance with the provisions of the AC Act 2001 (Schedule 1, Part 1).

The IRP must identify the patient's/client's need for rehabilitation, the assessments to be done, the services appropriate to meet those needs, and which of the services ACC will provide, pay for or contribute to.

The development of the IRP will require access to relevant information, eg Individual Education Plans and/or a support plan from a Needs Assessment and Service Coordination organisation. ACC will require liaison with the patient's/client's health providers and with disability service providers if there is a pre-existing disability, condition or mental illness. These relationships may need further clarification.

Those seriously injured clients who were assessed as eligible to receive social rehabilitation entitlements under the (now revoked) Accident Rehabilitation and Compensation Insurance (Complex Personal Injury) Interim Regulations 1994 will continue to receive their social rehabilitation entitlements provided for in Individual Rehabilitation Programmes made under those Regulations.

2.5 Non-acute inpatient rehabilitation service

This service is for ACC clients who require inpatient rehabilitation within a specialist unit and is purchased directly by ACC. Providers must have a contract with ACC to be able to provide non-acute inpatient rehabilitation for ACC clients. The process for transfer of patients/clients from acute services (PHAS) to non-acute inpatient rehabilitation is outlined in more detail in section 5.6.1.1 of this guide.

These patients/clients must meet specific clinical criteria, including prior approval. When patients/clients transfer from acute to non-acute inpatient rehabilitation, DHBs should discharge them from their acute admission and admit them to the rehabilitation facilities with the appropriate health service purchase codes.

Note:
Where a client has a dual diagnosis/multiple diagnoses or concurrent medical condition, ACC is liable if admission to a post-acute inpatient rehabilitation facility is a result of the personal injury. Additional information will normally be required to support the injury-related need.

Refer to Appendix 1: 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

2.6 Services provided by Community Trust Hospitals

The AC Act 2001 includes Community Trust Hospitals as providers of PHAS when they are funded by the Minister of Health or DHBs to provide those services (see the definitions of 'public health acute services' and 'publicly funded provider' in the Glossary).

As with DHBs, ACC is only responsible for paying for treatment provided by a Community Trust Hospital when:

a. the treatment is not part of PHAS
b. the patient/client qualifies for the treatment for personal injury
c. the treatment is provided by an appropriate treatment provider.

See section 1.4.2 of this guide for more information about purchasing arrangements for non-public health acute services including treatment conditions, what ACC pays, and prior-approval requirements.

2.7 Work-related gradual process, disease or infection

ACC covers personal injury caused wholly or substantially by a gradual process, disease or infection in certain circumstances (eg work-related personal injury) as defined in section 26 of the AC Act 2001.

Work-related gradual process claim can only be lodged by a medical or a nurse practitioner by completing an ACC45 form and ticking the gradual process box on the form. Any other provider who believes a person has a gradual process, disease or infection should refer them to a medical or nurse practitioner. Upon receipt of the completed ACC45 form, ACC sends three questionnaires to the patient. The patient must complete their questionnaire and ensure the employer and medical practitioner fills in theirs (medical practitioner completes ACC271 Medical practitioner cover questionnaire). All questionnaires must be returned to ACC so that a cover decision can be made.

Section 3: Interfaces between agencies

This section discusses examples of services and situations that may require interfaces between agencies, for example, where an injured person has an existing medical condition or disability. Some of these services remain the subject of discussion and resolution between ACC and MoH (which includes disability support services for people under 65).

Where responsibility is unclear, services should be provided while funding responsibility is resolved. Section 6 of this guide, specifically discusses the process for resolving Health/ACC boundary issues. Section 4 covers the services that support the provision of specific treatment and rehabilitation (eg pharmaceuticals).

3.1 Acute/Elective treatment for concurrent medical conditions, pre-existing disabilities or mental conditions or dual/multiple diagnoses

Where patients/clients with an underlying or pre-existing medical condition or disability require an accident-related intervention, the acute treatment is covered by PHAS taking into account the clients' needs.

ACC is responsible for purchasing elective surgery and related services directly for eligible patients/clients, taking into account the patient's/client's individual circumstances and providing any prior-approval conditions have been met. In general, ACC does not purchase treatment for the underlying or pre-existing medical condition.

If an injured person has been receiving ongoing support, for example from MoH for an existing condition, this support should continue to the level it was required before the personal injury occurred. Additional support required because of the personal injury is the responsibility of ACC.

In terms of ongoing care after acute discharge, the personal-injury-related component of care is funded by ACC. DHBs/MoH have responsibility for the non-accident-related health and disability support component of care.

When such a case is identified, the DHB should contact the client's case owner and, if necessary, other involved agencies (eg MoH/Needs Assessment and Service Coordination service) to discuss the process for identifying shared funding responsibilities.

Some common scenarios for ACC, MoH and DHB responsibilities are outlined in Table 12 – it is recognised that these are not exhaustive.

Table 12: Management of injured person with an underlying or pre-existing condition(s)

If the person has an accident…	Acute phase	Ongoing treatment
…in the community and is admitted to an acute facility, and it is identified that the person has significant medical/mental health issues, or pre-existing impairment or disability	• Covered by PHAS for the injury-related component (health component funded by DHB) until the person meets the clinical criteria • A rehabilitation specialist enters the person into a rehabilitation facility	• ACC funds relevant rehabilitation bed day price (*except mental health)* as long as the rehabilitation is related to the injury; and *DHB funds inpatient mental health rehabilitation* • DHB funds ongoing medical/mental health issues that pre-date that injury event of any new medical condition
…and is discharged home following acute/rehabilitation admission and has ongoing needs	• Not applicable	• DHB funds ongoing disability supports that pre-date that injury event where the person is 65 or over[25] (other than MoH-funded environment support services) • MoH funds ongoing disability supports that pre-date that injury event where the person concerned is *under 65*[26]; • ACC funds ongoing needs that are related to the covered injury
… in the community and they are not admitted acutely for their accident but do require acute admission for a medical condition	• They are admitted and funded by the DHB for their medical treatment	• DHB funds
…in the community and they are admitted for ACC elective treatment, and prior to discharge require acute treatment for a medical condition, eg admitted electively for removal of metal and has cardiac arrest while still admitted	• ACC funds the injury/elective component • PHAS covers the medical acute component[27]	• ACC funds ongoing treatment related to the elective admission • DHB funds ongoing treatment for medical health issues

[25] Or people who are between 50 and 64 but have disability needs that are similar to those who are 65 and over.
[26] Including MoH-funded environmental support services.
[27] This may be reported to the NMDS as two events if the patient meets the facility or the specialty or funding criteria for ending the event (see the NMDS data dictionary – event end type code). If the event does not meet these criteria, report as one NMDS event and the PHAS component will be agreed between ACC and MoH.

If the person has an accident…	Acute phase	Ongoing treatment
…while in hospital and they suffer a minor personal injury	• DHB funds. The person remains in the same ward and under the same specialist because the injury does not affect the existing clinical treatment plan. An ACC45 number should be reported in the NMDS and details of the accident included in the discharge clinical coding along with external cause codes[28]	• DHB continues to pay
…while in hospital and their injury is major	• PHAS covers the injury component of admission if it is significant enough to affect the complexity of care or length of stay • An ACC45 should be lodged and details of the accident reported in the discharge clinical coding (along with external cause codes)[29] • Note: If treatment injury, an ACC2152 Treatment injury claim form should also be completed	• DHB funds ongoing medical/mental health issues • ACC funds ongoing treatment related to the injury

3.2 Acute admission of persons with existing specialised community care needs

There are ACC clients with long term impairments as a result of a personal injury who receive highly specialised personal care in the community. For example, specialised bowel cares for a person with tetraplegia. In such exceptional circumstances and for client's safety; where it has been determined that a client requires support from their regular community provider to safely deliver specialised care when admitted to hospital, the client needs to raise the need for this support via their ACC case manager. The ACC case manager will request DHB to provide supporting information.

If approved by ACC, the cost of support provided by a community provider will be paid by ACC. DHBs need to have their own policies and procedures to ensure obligations of the DHB are met in relation to patient safety, health and safety, privacy and security. Where community support is not approved and during the period of time ACC takes to make a decision to approve support, the DHB must meet the client's health and support needs. Any requests for assistance must clearly specify the level of support required and why this cannot safely be delivered by the DHB.

Note:
The DHB is expected to communicate early with ACC and involve the relevant case manager in the discharge planning to ensure that the client receives appropriate care to meet their identified needs and entitlements in a timely manner – see section 5.6 of this guide.

[28] In the NMDS the ACC45 number is reported and the accident flag is set to 'N'.
[29] The ACC45 number is reported in the NMDS and the accident flag is set to 'N'. If the patient meets the criteria for a statistical discharge from the admitting event (see the NMDS data dictionary – event end type code), report as two NMDS events. If the patient does not, then report as one event.

3.3 Other government rehabilitation and disability support services

The DHB is the appropriate contact for issues regarding disability support services for

a. people 65 and over

b. people who are between 50 and 64 but have disability needs that are similar to those who are 65 and over[30].

Where a person requires treatment/rehabilitation but is not entitled to services provided by ACC because they do not have ACC personal injury cover, they may be eligible for either:

a. MoH support if they have a long-term disability and are under the age of 65; or

b. DHB older persons' services if they are 65 years and older or are close in age and interest and between 50 and 64 years of age (see section 3.7, paragraph two of this guide for additional information on this definition).

Acute period – the acute component of related specialised services, such as traumatic brain injury and spinal injury services, is provided by DHBs as part of PHAS (acute medical/surgical services) when there is an accepted ACC claim. The acute period ends when the patient is safely discharged home or into non-acute inpatient rehabilitation services.

Post-acute period – in some instances a person will have ACC cover for personal injury but be disentitled to rehabilitation services in terms of sections 118-122[31]of the AC Act 2001. In the case of disentitlement, a person may be eligible for other rehabilitation and disability support services, but must meet the same access criteria as people with health/disability needs for that service.

Any matters of doubt or difficulty should be referred through a boundary issues resolution procedure (see section 6 of this guide). If there is a delay in deciding an ACC claim (for example in cases of treatment injury) and the injured person receives services from another agency, ACC may require that agency to send supporting information with an invoice for reimbursement within 12 months of the claim being accepted (see section 5.7.4 of this guide).

3.4 Mental health services

3.4.1 Eligibility

ACC provides cover and entitlements for people who have a clinically significant mental health condition diagnosed using standardised diagnostic systems and by appropriately qualified mental health practitioners[32], that is:

a. caused by certain criminal acts (sensitive claims, as per Schedule 3 of the AC Act 2001); or

b. a consequence of a physical injury for which a person has ACC personal injury cover, (for example traumatic brain injury); or

c. a consequence of a work-related mental injury for which a person has ACC personal injury cover (for example, a taxi driver traumatised when a knife is used to threaten them while they were working); or

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[30] For issues regarding disability support services for people under 65, contact MoH's Disability Support Services.
[31] Note that section 119, Disentitlement for wilfully self-inflicted personal injuries and suicide, was re-introduced from 1 July 2010 by the Accident Compensation Amendment Act 2010. The new section 119 does not apply to claims lodged prior to 1 July 2010. The Accident Compensation Amendment Act 2010 also introduced a provision that disentitles certain imprisoned offenders (section 122), which applies to claims lodged on or after 1 July 2010.
[32] A 'clinically significant' mental health condition is a mental health condition that requires treatment.

d. a consequence of a treatment injury for which a person has ACC personal injury cover (for example, a person suffering from psychological distress due to a delay in receiving critical treatment and has had to undergo far more invasive treatment than they would have needed if the treatment had been given earlier).

Publicly funded specialist mental health and alcohol and other drug services (mental health services) provided by, or funded by, DHBs are targeted at the 3% of the population most severely affected by mental illness or substance dependence.

ACC clients who meet the eligibility criteria to receive publicly funded specialist mental health services are included in this funding arrangement in the same way as non-ACC clients where they are:

a. provided by a DHB; and

b. are not purchased through the Minister of Health's funding arrangements for PHAS.

Under an agreement between ACC and MoH, non-clinical mental health support services such as residential, home-based support and vocational services will be funded by ACC where the need arises from a covered injury, even though these services are usually funded by MoH for people with severe mental illness who are not able to be supported in their own home[33].

This decision recognises that ACC is responsible for funding services to support the fundamentals of daily living, where a client's need for support with the activities of daily living is a consequence of trauma covered by ACC. The decision is consistent with arrangements relating to mental health services for people whose disability support needs are met by MoH.

3.4.2 Specific services

This section describes the types of services that ACC clients with a mental health condition might receive.

3.4.2.1 ED attendances

Any consultation or treatment delivered by mental health staff for personal injury (physical or mental) at a hospital ED is purchased through PHAS.

3.4.2.2 Acute inpatient admissions to mental health services

These services provide care for people in the acute stage of mental illness, as well as care for people in need of a period of close observation, intensive investigation and/or intervention where this cannot be provided safely in a community setting.

Inpatient services include assessment and treatment provided by psychiatrists, nurses and allied health professionals (eg psychologists, counsellors and social workers). Acute inpatient mental health services are purchased through PHAS for the period of the acute admission.

3.4.2.3 Consultation/liaison services (inpatient)

Mental health consultation/liaison services are provided by mental health staff to staff and patients in non-psychiatric inpatient services. These services are provided to people with ACC cover and are funded by PHAS during acute admissions or mental health funding for non-PHAS admissions.

3.4.2.4 Post-acute inpatient mental health services provided by DHBs

The expectation is that patients will return to community living. In very exceptional cases the most appropriate long-term arrangement is in a DHB-operated facility (for example, when clients are unable to be discharged from inpatient MoH facilities because there is a lack of appropriate community-based residential facilities to safely meet the client's needs). In these cases, DHBs can request ACC to purchase

[33] Access to the support services will be arranged by agreement with ACC.

(or contribute to the cost of) ongoing inpatient services. It is expected that a DHB will advise ACC of any potential issues requiring a joint funding approach as early as possible, so that both organisations can work together to develop a plan to find the best solution in each situation.

3.4.2.5 Post-acute community-based residential rehabilitation for mental health patients

ACC purchases post-acute community-based residential rehabilitation via contract for patients/clients who have cover for a sensitive claim or physical injury, such as traumatic brain injury, which results in the need for support provided in a mental health setting.

If a DHB identifies a need for a person to receive post-acute residential rehabilitation because of a mental injury caused by a sensitive claim event, the DHB must contact the Sensitive Claims Unit on 0800 735 566 to discuss the patient's needs before a placement decision is made.

If the need for post-acute residential rehabilitation arises from physical injury, the DHB must contact the person's case manager if known, or the nearest ACC Branch, to discuss the patient's needs before a placement decision is made.

3.4.2.6 Community clinical mental health services, including follow-up outpatient services

Attendance at an ED, a mental health crisis service or a mental health inpatient unit is purchased under PHAS. Once a person has been discharged from these services they may need a community mental health team or alcohol and drug team to help them in their recovery.

Treatment for personal injury by a DHB community mental health service is purchased through PHAS if a registered medical practitioner provides the outpatient service:

a. as part of the outpatient follow-up to an acute admission or ED attendance, for up to six weeks after the discharge or treatment date; or

b. there is a doctor-to-doctor referral, and the person is seen within seven days of referral.

PHAS covers all services directly associated with the consultation (see section 2.1 of this guide). After the PHAS period, ACC clients who meet the eligibility criteria for publicly funded specialist mental health services are eligible for community clinical mental health services (including alcohol and drug services) funded in the same way as for non-ACC clients.

This means that subsequent medical services and referral to allied health services provided by community mental health teams (including drug and alcohol services) in the community are covered by ring-fenced mental health funding.

If a mental injury is not covered by a DHB's mental health service (i.e. mild to moderate severity) or services would not be provided by the DHB under ordinary circumstances, then the DHB should contact ACC to advise of ongoing treatment needs. In this situation, any follow-up treatment (such as counselling) in the primary or private sector will be purchased by ACC and/or the client.

3.4.2.7 Pharmaceuticals

Please see section 4.2 of this guide.

3.4.2.8 Mental health services for older people

People who are 65 years and over and have a mental health condition which is managed by mental health services will be funded as for people under 65.

3.5 Self-injury

Mental health treatment required by people who have a self-inflicted injury covered by ACC is purchased through the same mechanisms as other mental health services.

The AC Act 2001 does not provide an entitlement to treatment for any underlying mental condition (such as depression) that pre-dates a self-inflicted injury unless the underlying condition is covered by ACC as a prior mental injury.

3.6 Sexual assault services and sensitive claims

See section 3.4 of this guide for more information about mental health services and counselling services for patients/clients who have a diagnosed clinically significant mental injury caused by a sensitive claims event.

MoH, New Zealand Police and ACC fund Sexual Abuse Assessment and Treatment Services (SAATS). This service primarily addresses the medical and/or forensic needs of patients/clients where there is alleged sexual abuse or assault.

Most DHBs are suppliers for SAATS and are responsible for ensuring linkages are created with crisis support agencies. If a patient/client is demonstrating psychological distress in response to a sensitive claims event and support is clinically indicated, then the SAATS clinician should refer the patient/client to an appropriate agency or the Integrated Services for Sensitive Claims (ISSC) contract for the patient/client to access immediate support and treatment via an ISSC supplier located on www.findsupport.co.nz. Other agencies may include Rape Crisis, Victim Support and DHB mental health teams.

3.7 Residential care for elderly victims of crime

Funding arrangements effective from 1 November 1998 have ensured that an elderly person who required long-term residential care as a direct result of being a victim of a violent crime would not be responsible for paying for their long-term residential care.

For these purposes ‘elderly people’ are defined as people 65 years and older or people who are close in age and interest and between 50 and 64 years of age. In the latter case, a clinical decision must be made by a geriatrician/psycho-geriatrician to determine whether a person has similar care needs to a person who is over the age of 65.

In the instance of an elderly victim of crime needing long-term residential care, ACC (through the client’s case manager) works in conjunction with the client’s DHB (usually through their local Needs Assessment Services Coordination agency).

ACC should be advised as early as possible, using an ACC706 Early notification of complex case form, if the DHB believes that long-term residential care is likely to be required for an individual.

Section 4: Services that support treatment and rehabilitation

This section lists ancillary services provided to injured people. It describes when these services are included in PHAS, and outlines funding responsibilities. Where responsibility is unclear, interim arrangements are in place to resolve the issue. Section 6 of this guide specifically discusses the process for resolving Health/ACC boundary issues.

4.1 Blood and blood products

Blood is donated and cannot be charged for by the blood service provider. The provision of blood services (cross-matching, supply of blood and blood products, storage and administration of blood and blood products) outside PHAS is included in the costs of elective services purchased by ACC as a part of treatment. Blood services required within the PHAS period are included in PHAS funding.

If a patient/client receiving treatment for a personal injury also requires blood products for the treatment of an underlying medical condition, eg Factor VIII for people with haemophilia, these blood products will be purchased by the DHB.

4.2 Pharmaceuticals

The AC Act 2001 definition of pharmaceutical is provided in the Glossary to this guide.

ACC is liable to pay or contribute to the cost of pharmaceuticals (prescription medicines, restricted medicines, pharmacy-only medicines and controlled drugs) when:

a. they are prescribed by a treatment provider who has statutory authority to prescribe pharmaceuticals

b. the pharmaceuticals are reasonably required to facilitate a client's treatment for personal injury.

ACC pays or contributes to pharmaceutical costs for ACC clients:

a. through bulk funding payments under the Annual Service Agreement between the Minister of Health and the Minister for ACC for PHAS and community pharmaceuticals and laboratory tests

b. through reimbursements to clients for co-payments on community pharmaceuticals, and in some cases reimbursement of the cost of pharmaceuticals not on the Pharmaceutical Schedule

c. through direct payments to pharmacies/providers who have direct billing approval from ACC

d. via service contracts that are inclusive of the costs for pharmaceuticals.

The bulk funding arrangements for PHAS include pharmacy services and pharmaceuticals that are provided as part of the services that DHBs and other publicly funded providers are responsible for. PHAS includes pharmaceuticals:

a. required by patients/clients during acute admissions or ED attendances

b. administered by a medical practitioner as part of the treatment associated with an outpatient visit for up to six weeks from discharge or treatment

c. required during treatment provided by medical practitioners less than seven days from referral by another medical practitioner

d. for patients/clients that are prescribed and dispensed in the community and that meet the funding criteria of the Pharmaceutical Schedule.

Clients can seek reimbursement of co-payments on community pharmaceuticals from ACC or their accredited employer.

If a prescriber wishes to prescribe a pharmaceutical for use in the community that is not on the Pharmaceutical Schedule (i.e. a pharmaceutical that is not subsidised), they may apply to ACC or the accredited employer on behalf of the client to seek funding for this. The prescriber must complete an ACC1171 Request for pharmaceutical funding form to request funding from ACC for non-subsidised pharmaceuticals. On discharge, DHB prescribers should write prescriptions for subsidised pharmaceuticals to avoid high patient pharmaceutical costs in the community.

DHBs are required to record the accident claim form (ACC45) number against each item when prescribing medicines. A MoH identifier must be recorded for all medical illness prescriptions to distinguish between accident and medical cases.

4.2.1 Overseas residents and pharmaceuticals

Overseas residents who are in New Zealand are considered 'eligible people' for health services if they are covered for injury by ACC. This means they should get the same funding for pharmaceuticals as New Zealand residents if the pharmaceuticals are required to treat an injury covered by ACC.

Table 13: Process for accessing PHAS/ACC directly purchased pharmaceuticals

Injury scenario	Prescription pharmaceuticals	Funding approval	Funding source
Person admitted acutely or treated in ED	All pharmaceuticals included	• Not required from ACC. • Standard hospital prescribing process applies	PHAS
Person being discharged from inpatient stay or ED	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria and **hospital is supplying** the pharmaceuticals. (Clients are eligible for any named patient pharmaceutical applications and discretionary supply guidance)	• Not required from ACC. • Standard hospital prescribing process applies	PHAS
	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria and **hospital is not supplying** the pharmaceuticals	• Not required from ACC. • Standard hospital prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined

Injury scenario	Prescription pharmaceuticals	Funding approval	Funding source
Person not admitted acutely to DHB and seen by community prescriber eg GP, specialist nurse, optometrist	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria	• Not required from ACC. • Standard hospital prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined
Person referred to ACC directly funded service and pharmaceuticals included in service specification eg Residential Support Services	All pharmaceuticals included	• Not required from ACC	Paid for within contracted rate
Person referred to ACC directly funded service and pharmaceuticals are not included in service specification for contract eg home-based nursing	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria	• Not required from ACC. • Standard community prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined

4.3 Laboratory services

The PHAS agreement includes funding for laboratory services provided to clients during acute ED, outpatient and inpatient presentations.

Outside the PHAS period, the agreement covers the cost of community laboratory services provided from community referrals, non-acute medical specialist outpatient services (including private), community nursing services, all allied health outpatient services and services provided as part of elective assessments or admissions. Laboratory tests supporting the above services are covered by the DHB even when private laboratories provide them, and clients cannot be charged for these tests.

DHBs and community providers are required to record the accident claim form number (from the ACC45) on any form requesting laboratory tests.

4.4 Radiology services

PHAS funding includes radiology services. It covers all diagnostic imaging (including high-tech imaging) required by clients or ordered during acute admissions or ED attendances and as part of medical outpatient services for up to six weeks from discharge or treatment.

Radiology referrals to a private provider are the responsibility of ACC to directly purchase even within the acute service timeframes, if the referral is made by an appropriate treatment provider as part of providing non-PHAS services. Clients must meet relevant contract eligibility criteria.

Should a DHB subcontract radiology services during the PHAS period (for example, due to strikes), the DHB is responsible for funding those radiology services.

Outside the PHAS period, ACC purchases radiology services provided as part of services funded directly by ACC. This covers primary care referrals, post-six-week follow-up services, and services provided as part of elective assessments or admissions. This applies whether clients are referred to private or DHB radiology clinics.

DHBs are required to record the accident claim form number (from the ACC45) on any forms requesting diagnostic imaging.

4.5 Equipment (aids and appliances – excluding orthotics)

Equipment (aids and appliances) comprises reusable items that are supplied to assist in restoring clients' independence in everyday activities to the maximum extent practicable.

Note:
Wheelchair batteries and negative-pressure wound therapy units are reusable, and therefore also considered to be equipment.

4.5.1 Eligibility criteria for equipment

A patient/client is eligible to receive equipment if they have an accepted claim and an entitlement to receive funding for rehabilitation equipment (social or vocational).

A patient/client with a wilfully self-inflicted injury is not entitled to receive equipment unless the injury results from a mental injury covered by the AC Act 2001.

ACC is not responsible for providing equipment if the:

a. patient/client already possesses equipment that has a similar function to that recommended in the assessment. Exceptions to this can occur if the piece of equipment is unsuitable due to its age or condition (eg needs renewing or upgrading)

b. piece of equipment is more expensive than an item that is strictly required to meet the patient's/client's identified needs

c. equipment (or any item used in association with the equipment) requires replacement due to the patient/client neglecting, abusing or misusing the equipment

d. patient/client, after injury, disposed of a piece of equipment that had a similar function and was suitable

e. equipment relates to a medical need, pre-existing disability or impairment, rather than a need through personal injury.

Note:
Where a personal injury leads to an increased need for equipment that is already used by a patient/client because of an existing condition or need, ACC is responsible for the provision of appropriate equipment or modifications to equipment to meet the individual's new needs. See section 4.5.3.1 of this guide.

4.5.2 Responsibility for the provision of equipment

Table 14: Provision of equipment

Patient requires:	DHB or rehabilitation provider	ACC
…equipment to assist recovery from a personal injury and is being discharged home from the acute admission	• Assesses the immediate need for equipment supply[34] or loan of equipment for the initial six-week period after discharge from the acute admission. Costs associated with this assessment and supply are covered by PHAS funding • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period
… equipment to assist recovery from a personal injury and is being **discharged home by a DHB different from their DHB of domicile**	• Makes arrangements with the person's DHB of domicile to supply the assessed equipment. Costs associated with this assessment and supply are covered by PHAS funding • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period
… **reassessment within six weeks of discharge** as part of a medical outpatient service	• Remains responsible for providing the equipment until the expiry of the six-week period (PHAS funding) • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period

[34] This includes temporary ramps.

Patient requires:	DHB or rehabilitation provider	ACC
… **transfer from acute admission into (ACC directly purchased) inpatient rehabilitation** and is in rehabilitation for **less than six weeks**	• Rehabilitation provider provides equipment needed during inpatient rehabilitation as part of their ACC contract (inclusive of bed stay charge) • DHB (of domicile) funds (under PHAS) equipment needed for the remainder of six-week post-discharge period if patient is discharged home from inpatient rehabilitation within six weeks of acute discharge date • Advises ACC if ongoing equipment is needed after six-week period	PHAS covers equipment needs for up to six weeks post discharge from acute care. (Note: The six-week period begins upon admission to Non-Acute Rehabilitation (NAR) i.e. the client is discharged from acute care) After this time, ACC is responsible for purchasing equipment where the eligibility criteria above is met
… **transfer from acute admission to ACC directly purchased inpatient rehabilitation**, and requires equipment during rehabilitation, eg wheelchair, **and the need for equipment is being reviewed during inpatient rehabilitation admission**	• Rehabilitation provider provides equipment needed during inpatient rehabilitation as part of their ACC contract (inclusive of bed stay charge) • Advises ACC if ongoing equipment is needed	ACC provides appropriate equipment needed at home post inpatient rehabilitation discharge (unless discharge was still within PHAS period– see above)
…**transfer from acute admission to ACC directly purchased inpatient rehabilitation, and requires the identical specialised equipment during and after rehabilitation**	• ACC must be advised of this need for specialist equipment prior to acute discharge	ACC may provide equipment from the date of discharge from the acute admission

Equipment required by a person who has suffered a personal injury, for which they have cover under the AC Act 2001, is funded through PHAS for the acute period, including the six-week medical specialist outpatient period after acute discharge or ED attendance. Once the six-week period has elapsed, the responsibility for provision of equipment falls to ACC, except in some circumstances eg if cover has not yet been agreed and the MoH becomes the interim funder.

ACC's responsibilities for equipment cover: self-referrals, primary referrals, post-six-week outpatient services, allied health outpatient services (eg occupational therapy and physiotherapy), and services provided as part of non-PHAS, including elective assessments and elective surgery.

4.5.3 Processes when equipment is needed after discharge

On discharge from hospital (post-acute/ED discharge and post-elective-surgery discharge) or inpatient rehabilitation, the client may require equipment after the six-week period for which the DHB is responsible. In the case of directly purchased inpatient rehabilitation**,** there may also be a need for equipment after inpatient rehabilitation has ended.

If after the six-week period the client still requires the equipment, ACC provides it from the six-week 'cut-off'. ACC may provide the equipment from the point of acute discharge if it is required for more than six months. In both cases:

a. the DHB should give ACC one month's notice of the need for this service

b. ACC should supply the equipment through a Managed Rehabilitation Equipment Service (MRES) supplier.

The scenarios in Table 15 may apply depending on the DHB's/rehabilitation provider's recommendation.

4.5.3.1 Replacement or modification of pre-existing equipment

Where a person already has equipment because of a pre-existing disability or medical condition and this equipment needs replacement or modification as a result of a covered personal injury, the DHB or relevant disability support service should contact the client's case manager to discuss options for equipment replacement or modification.

4.5.4 Deposit for loan of equipment

A DHB may charge the patient/client a refundable deposit for the supply or loan of equipment. Such deposits are not considered to be a user charge. The patient/client may not be required to pay a deposit if they can demonstrate resultant financial hardship.

Table 15: Equipment provision scenarios

<table>
<tr><th colspan="5">If the DHB/rehabilitation provider recommends that equipment is required:</th></tr>
<tr><td>…for less than six weeks</td><td colspan="4">the DHB is required to provide all equipment at no additional cost to ACC. Under no circumstances will ACC fund any part of any equipment on discharge of a client from hospital. ACC has already paid for this equipment as part of other agreements</td></tr>
<tr><th colspan="5">If the DHB/rehabilitation provider recommends that equipment is required:</th></tr>
<tr><th>...for more than…</th><th>the DHB should…</th><th>the ACC case owner…</th><th>then…</th><th>and…</th></tr>
<tr><td rowspan="2">… six weeks</td><td>use the ACC705 “Referral for support services on discharge” or the ACC706 “Early notification of complex case” form pre discharge; or post discharge use the ACC4249 “Short-Term Equipment (needed post six weeks discharge) request” form if the client needs equipment for a PHAS period of more than six weeks</td><td>either places an online equipment order with the MRES supplier[35]; or

if more information is required, organises a Social Rehabilitation Assessment, from which an online equipment order is sent to the MRES supplier</td><td>ACC equipment is delivered to the client by the MRES supplier[36]</td><td>the DHB collect their equipment.</td></tr>
<tr><td>Note: If the equipment is:
required for just a short time longer than six weeks
difficult to install or remove and doing this would disrupt the client
cost effective to continue to supply through the DHB</td><td>determines how much longer equipment is required, generates a purchase approval authorising the DHB to extend the equipment loan beyond six weeks, and sends this to the DHB</td><td>the DHB equipment remains with the client</td><td>the DHB collect their equipment at the end of the approved timeframe</td></tr>
<tr><td>…six months</td><td colspan="4">ACC starts funding the equipment from the point of discharge. If the hospital assessment is sufficient to satisfy a purchasing decision for the equipment, the case owner orders the equipment. The MRES supplier can consider purchasing the equipment items from the hospital if equipment has been customised for the client. Otherwise the case owner arranges a Social Rehabilitation Assessment and follows the equipment supply process</td></tr>
</table>

[35] The MRES supplier manages ACC’s rehabilitation equipment on behalf of ACC. ACC owns the equipment that is loaned to clients and the MRES supplier manages the process of loans and collection.
[36] Where there is an overlap in equipment provision, because equipment loaned by a DHB for a six-week period has not been collected by the DHB (even though ACC has provided equipment to the client), ACC is not responsible for loan costs incurred during the overlap period.

4.6 House modifications and transport for independence

4.6.1 Housing modifications

Housing modifications are funded by ACC to assist a client to live as independently and safely as possible given the limitations imposed by their injury; this is achieved by removing structural barriers and/or adding fixed features. Entry is via an appropriate assessment conducted by ACC-contracted occupational therapists specialising in housing modifications.

In deciding whether to provide or contribute to the cost of modifications to a person's home, ACC needs to consider:

a. the rehabilitation outcome that would be achieved by providing the modifications
b. the difficulties faced by the person in doing the following without the proposed modifications:
    i) gaining access to their home
    ii) enjoying reasonable freedom of movement within the home
    iii) living independently in their home
c. the likely duration of the person's residence in the home
d. the cost, and the relevant benefit, to the person of the proposed modifications
e. whether the property owner agrees to the proposed modifications being undertaken
f. the likely cost of reasonable alternative living arrangements
g. the likely duration of the person's limitations arising from the personal injury for which they have cover.

It is important that early discharge planning consider any housing modifications that may be required by the person on discharge and that these are communicated to ACC to initiate a housing modification assessment.

ACC's contracted Housing Assessor will identify the limitations encountered by the person in their home environment given their injury-related needs and, in collaboration with ACC's Housing Modification Service, identify the most appropriate and cost-effective equipment or housing modification solutions to address those needs.

4.6.2 Transport for independence

Transport for independence aims to restore a client's independence to the maximum extent practicable, particularly their ability to access transport safely and be mobile. Entry is via an appropriate assessment conducted by an ACC-contracted transport for independence assessor.

Table 16: Transport options

ACC can consider supporting transport for independence in several ways. The AC Act 2001 requires that ACC considers all possible transport options. These include making a contribution towards:

Transport Option	Meaning
Funded transport i.e. public transport, taxi or escort in a private vehicle. Note: This is not used for transport to treatment, rehabilitation, or to visit an ACC office	Funded transport can include a contribution for additional travel costs incurred by the client because of their injury-related needs, over and above the costs they would normally incur, eg the additional costs of taking a taxi to the supermarket if they are unable to drive themselves
Vehicle modifications Essential modifications to a client's vehicle to enable them to drive independently	Vehicle modification means adding or removing features of a vehicle so that the client can: • gain access to vehicle and have freedom and safety of movement while in it • drive or operate the vehicle safely • travel safely as a passenger • transport essential mobility equipment
Vehicle contribution	To assist a client in obtaining a suitable motor vehicle with assessed injury-related features
Driver licence retraining	To assist a client to regain their driver licence

The type of assistance or support that ACC can provide depends on the client's individual transport needs and the rehabilitation outcomes to be achieved.

Any requests for funded transportation should be referred to ACC to discuss with the client the activities that they need transport for and the frequency of those requirements.

4.7 Medical consumables

A medical consumable is a medical product, or a product used for a therapeutic purpose, that:

a. is not a pharmaceutical
b. is not reusable
c. a patient/client has an assessed need for
d. is required as a result of the patient's/client's personal injury, to assist in restoring the patient's/client's health, independence and participation to the maximum extent practicable
e. is cost effective
f. has evidence to justify its use.

Table 17: Medical consumables terms and meanings

The definition includes the following terms and meanings:

Term	Meaning
Medical products	Products used for a therapeutic purpose on humans or related products.
Therapeutic purpose	Used for the purpose of treating or preventing disease.
Not reusable	The product is single use, disposable or non-recyclable.
Assessed	The process by which the need for medical consumables are determined by a contracted assessor or provided within treatment regulations.
Required	Products that are essential as a consequence of the injury.
Covered personal injury	That only the 'covered' injury is being addressed and not any pre-existing condition. **Note:** It is not always possible to differentiate between the two, and some joint funding arrangements may apply.
Restoring (in relation to client)	Returning to the client's original condition or maintenance so that their condition does not deteriorate.
Practicable	Practicable after considering and balancing: the nature and consequences of the injury; the achievement of rehabilitation outcomes; cost; cost effectiveness; the availability of other forms of rehabilitation; and other relevant factors (from section 6 of the AC Act 2001).
Cost effective	The best-quality product for the best price.
Evidence based	There is good clinical literature available concerning the efficacy of the product.

Table 18: Medical consumables

Examples of medical consumables include:	
incontinence sheets and pads	hearing aid batteries
wound care/prevention products	tracheostomy brushes, tubes and holders
syringes and needles	dressing and catheter packs
ventilator disposables – humidifiers and oxygen	tubing, swivel connectors and filters
feeding tube sets	catheters (urinary and suction) and irrigation solutions for bladder irrigations
urine bags and associated tubing	ostomy bags
connectors and tapes	gastrostomy and nasogastric tubing

Table 19: Medical consumables – funding responsibility

The responsibility for funding medical consumables is as follows:

Medical consumables used during PHAS[37] period of treatment	Medical consumables used outside PHAS period (when ACC is funding the service to the injured person)
Funded under PHAS. (Note: Nurse visits after acute discharge are purchased directly by ACC)	Funded by ACC via contract arrangements, eg community nursing contracts, including ACC-purchased community-based services (eg for changing of dressings) during the six-week period when the client is attending medical outpatients

Prior to a patient's/client's discharge, the DHB needs to assess the patient's/client's immediate need for medical consumables. In cases where discharge planning with ACC is not possible, the DHB should arrange a reasonable supply for the patient/client, sufficient to cover the period until ACC can organise medical consumables (about a week).

It should be noted that treatment covered under the CoTR 2003 include the costs of medical supplies associated with that treatment. For example, plaster costs are included in the payment for fracture treatments.

4.8 Orthotics

Orthotics must be prescribed by an approved health practitioner, eg Orthopaedic surgeon, Rheumatologist, Sports medicine specialist, General Practitioner, Podiatrist or Physiotherapist, and the orthotic device must be required as a result of a covered personal injury[38].

Table 20: Funding responsibility for orthotics

	Funded under PHAS	Purchased directly by ACC
Orthotics required for less than six weeks	The hospital is required to provide these orthotics at no additional cost to ACC. Under *no* circumstances will ACC fund any part of orthotics on discharge of a client from hospital	ACC has already paid for this equipment as part of other agreements[39]
Orthotics required for longer than six weeks and less than six months	First six weeks after ED attendance or discharge from acute admission. ACC should be informed one month prior to 'handover' if orthotic use will extend beyond the six-week period	From six-week period
Orthotics required for more than six months		From point of discharge from acute admission, or ED attendance. Note: Prescription required from appropriate health practitioner

[37] Including consumables used during medical specialist outpatient visits within six weeks of acute discharge or ED attendance.

[38] A client with a wilfully self-inflicted injury is not entitled to receive orthotics unless the injury results from a mental injury covered by the AC Act 2001. The current provisions of section 119 of the AC Act 2001 only apply to suicides or wilfully self-inflicted injuries that occur on or after 1 July 2010. See the Accident Compensation Amendment Act 2010, section 53. However, if funding for orthotics is covered under PHAS (eg orthotics required for less than six weeks) or under an agreement for treatment such as elective surgery, then orthotics may be supplied if there is no additional cost to ACC.

[39] The elective surgery contracts cover post-discharge/post-procedure care including, but not limited to, any orthotics (and any associated orthoses) required for up to six weeks post discharge.

4.9 Prostheses (eg artificial limbs and eyes, breast prostheses)[40]

Table 21: Funding responsibility for prosthetics

	Funded under PHAS	Purchased directly by ACC
Prosthetics required for less than six weeks (eg temporary wigs)	The hospital is required to provide *all* prosthetics at no additional cost to ACC. Under *no* circumstances will ACC fund any part of prosthetics on discharge of a client from hospital	ACC has already paid for this equipment as part of other agreements
Prosthetics required for longer than six weeks (and less than six months)	First six weeks after ED attendance or discharge from acute admission. ACC should be informed one month prior to 'handover' if prosthetic use will extend beyond the six-week period	From six-week period
Prosthetics required for longer than six months	Treatment is covered under PHAS until acute discharge. This would include the cost of any prostheses provided prior to discharge	ACC purchases permanent prostheses provided to a client from the point of discharge. Note: amputees who require prostheses as a result of war action remain the responsibility of Work and Income, Ministry of Social Development

4.10 Implants (eg hip prostheses, cochlear implants, spinal stimulators)

Table 22: Funding responsibility for implants

	Funded under PHAS	Purchased directly by ACC
Injury-related implants	Insertion, maintenance or replacement of implants during acute inpatient admission	Insertion, maintenance or replacement of implants provided during elective surgery

[40] A client with a wilfully self-inflicted injury is not entitled to receive prosthetics unless the injury results from a mental injury covered by the AC Act 2001. However, if funding for prosthetics is covered under PHAS (eg prosthetics required for less than six weeks) or under an agreement for treatment such as elective surgery, prosthetics may be supplied if there is no additional cost to ACC.

4.11 Hearing aids

Table 23: Funding responsibility for hearing aids

	Funded under PHAS	Purchased directly by ACC
Hearing aids where there is an accepted claim for hearing loss due to personal injury	Treatment is covered under PHAS until acute discharge. This would include the cost of any hearing devices provided prior to discharge	ACC is responsible for contributing towards the costs of hearing aids from the point of discharge

Hearing aids where there is no accepted claim for hearing loss due to personal injury

Options for funding assistance are:

a. where a person meets specific criteria, hearing aid funding may be available via the MoH hearing equipment provider (Enable New Zealand)

b. if an individual is not eligible under the above criteria, they may be eligible for the MoH hearing aid subsidy[41]

c. if eligible, funding may be available through Veterans' Affairs. (Veterans' Affairs also pays an allowance to cover battery costs.) Phone 0800 483 8372

d. some people on benefits may be eligible for a loan through the Ministry of Social Development. Phone 0800 559 009.

4.12 Transport and accommodation

Transport and accommodation can be provided through different funding mechanisms, for example the Emergency Ambulance Services agreement (see the Nationwide Service Framework Library, the Ancillary Services Regulations 2002 and the National Travel Assistance (NTA) policy). The responsibility for determining eligibility to access transport assistance is split between DHBs and ACC depending on the scenario, as detailed in the table below.

As a general rule, DHBs are responsible for decisions on transport and accommodation associated with treatment provided as part of PHAS. This excludes emergency transport within 24 hours of a person being injured or the discovery of the injured person (where ACC determines eligibility). An exception to this exclusion is where transfer within 24 hours is required because the DHB's normal services are not available (eg if the intensive care unit [ICU] is full or the specialist is on leave).

ACC is responsible for decisions on the provision of transport and accommodation required by accident patients outside the PHAS period, as well as emergency transport required within 24 hours[42].

[41] Information on MoH subsidies for hearing aids can be accessed via Enable New Zealand website.
[42] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).

Table 24: How is transport purchased/funded?

Table 24 shows which agencies are responsible for determining travel assistance eligibility in different scenarios. Eligibility is always on a case-by-case basis. The NTA policy and ACC may have different criteria to determine eligibility for assistance and different levels of assistance available.

Type of hospital-related attendance	Type of transport	How transport is purchased/funded[43]
DHB ED attendance	Emergency transport of injured person within 24 hours[44]	ACC
	Non-emergency transport (non-ambulance)[45] prior to admission	ACC
	Non-emergency transport of a client travelling home after an ED attendance or discharge from an acute admission	DHB[46] (must meet NTA policy criteria)[47]
DHB acute admission	Emergency transport of injured person within 24 hours[48]	ACC
	Inter-hospital transfers within 24 hours because of specialist treatment requirements (i.e. specialist level of treatment required that is not normally available at DHB)	ACC
	Inter-hospital transfers within 24 hours because normal services are not available (eg lack of ICU beds)[49]	DHB
	Any inter-hospital transfers after 24 hours	DHB
	Non-emergency transport prior to admission	ACC
	Non-emergency transport of a client transferring to a non-acute inpatient rehabilitation facility after discharge from an acute admission	DHB
	Non-emergency transport for family/support person to travel between their home and the DHB[50]	DHB (must meet NTA policy criteria)

[43] Where the DHB is responsible for purchasing transport assistance, it is the injured person's DHB of domicile (the DHB of the area in which the patient usually resides).
[44] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).
[45] ACC does not consider it necessary, or appropriate, to pay for non-emergency transportation in an ambulance to an ED.
[46] DHBs do not normally pay for transport for patients to discharge home from an acute admission or ED attendance.
[47] NTA funding is only available if the person meets the eligibility criteria of the NTA policy.
[48] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).
[49] Funding comes from the DHB that is transferring the patient.
[50] It is the situation of the patient that determines eligibility for the NTA, not the situation of the supporters. If an injured person is eligible for the NTA, their specialist must approve funding for a support person.

Type of hospital-related attendance	Type of transport	How transport is purchased/funded[43]
DHB outpatient services – medical follow-up: • provided by a doctor within six weeks of ED attendance discharge or six weeks following an acute admission • provided within seven days of GP referral	Non-emergency transport for the injured person (and family/support person) to travel to and from the DHB for treatment at medical outpatients	DHB (must meet NTA policy criteria)
DHB other outpatient services: • all non-medical outpatient services (eg physiotherapy, occupational therapy) • medical outpatient services outside the six-week PHAS	Non-emergency transport for the injured person (and escort) to travel to and from the DHB for treatment at outpatients	ACC
DHB elective admissions	Non-emergency transport and other travel assistance for the injured person (and support person/escort) for hospital visits associated with elective admissions	ACC
Services provided by non-DHB hospital treatment providers[51]	All non-emergency transport and travel assistance	ACC

[51] Treatment must be from a treatment provider specified in the AC Act 2001.

4.12.1 PHAS and National Travel Assistance (NTA) Policy 2009

The NTA provides some financial assistance towards meeting the expenses associated with travel that may be a barrier to a person accessing the specialist care they require. During the PHAS period, injured persons have the same access to the NTA's travel and accommodation assistance as persons with a medical condition or a disability. Outside that period, ACC's own policies with regard to travel and accommodation assistance apply.

NTA Policy 2009 is targeted at those people who:

a. have to travel long distances to access specialist health or disability services
b. incur high travel costs as a result of frequent visits to specialist health or disability services
c. have significant financial needs that might otherwise prevent them accessing necessary specialist health or disability services.

Any person who is referred by a publicly funded health and disability specialist to another publicly funded health and disability service (as described in section 2.1 of the NTA Policy 2009) may be eligible for travel assistance under the NTA scheme, provided they meet one or more of the distance/frequency criteria. People can find out more about the eligibility criteria by:

a. calling MoH's Sector Operations (the NTA payment agency) on 0800 281 222 (option 2) or
b. emailing travel@moh.govt.nz or
c. visiting http://www.moh.govt.nz/travelassistance.

People can confirm eligibility to register for travel assistance by contacting a DHB's patient transport coordinator.

4.12.1.1 Overseas visitor

Overseas visitors[52] are generally not eligible for travel assistance, as they do not meet the criteria of 'home' defined in the NTA policy[53].

4.12.2 Emergency transport

Regulation 3 of the Ancillary Services Regulations 2002 states Emergency transport means transport that:

a. starts within 24 hours of a claimant suffering a personal injury or being found after suffering a personal injury, whichever is the later; and
b. is necessary for the purpose of obtaining treatment urgently for the claimant's personal injury.

ACC is responsible for emergency transport (air, and road including water) within 24 hours of a patient/client being injured or being found after being injured. This includes emergency inter- hospital transfers (that is, within 24 hours) where the patient's/client's condition has deteriorated or the hospital is not able to provide the level of specialist care required[54]. All emergency transport, including emergency inter-hospital transfers, must be dispatched by an ambulance communications centre.

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[52] Some overseas visitors (eg some students and New Zealand citizens whose usual place of abode is in the Cook Islands, Niue or Tokelau) may qualify for the NTA because they are entitled to access public health services. See MoH website for details on the publicly funded health services eligibility criteria.
[53] 'Home' is currently defined in the NTA policy as the person's normal place of residence, where the person has been living continuously for more than three months.
[54] Inter-hospital transfer because of space constraints within the acute period are funded via PHAS.

The contracted price for emergency transport includes the paramedic crew. Any additional crew or medical escort(s) provided by a DHB or required as part of an emergency transport service, including inter-hospital transfers within the first 24 hours, is the responsibility of the DHB and is included within PHAS funding.

4.12.3 Inter-hospital transfers within the first 24 hours and clinical crew

a. Emergency ambulance providers (road and air) are funded to cover the cost of paramedic level clinical crew for inter-hospital transfers that are within the first 24 hours of a patient/client being injured or found injured.

b. Inter-hospital transfers may require the patient/client to be escorted by an appropriate hospital clinical team from bed (originating hospital) to bed (receiving hospital). DHBs are funded for this through Regulation 4(1) of the IPRC (PHAS) Regulations 2002.

c. There may be arrangements in place between emergency ambulance providers and DHBs for the operational management of clinical crew for these inter-hospital transfers. However, please note these are outside of obligations under the emergency ambulance service agreements and IPRC (PHAS) Regulations 2002.

4.12.4 Transfer of patients between hospitals

a. Inter-hospital transfers funded by ACC are part of emergency transport. The transfers must be within the first 24 hours only of the patient/client being injured or found injured and they must be dispatched by an ambulance communications centre.

b. A DHB only funds inter-hospital transport within 24 hours if a patient/client requires transferring because the hospital's normal services are not available (eg if the ICU is full or the specialist is on leave).

c. A public hospital to public hospital transfer relating to an acute event, and taking place more than 24 hours after a patient/client has been injured or has been found injured, is covered by PHAS. These are the funding responsibility of the DHB of domicile

d. A private hospital to public hospital transfer is the responsibility of the referring hospital or ACC, depending on whether the transfer to acute treatment is due to a health need or a personal injury/treatment injury need.

Additional information on the transfer of patients/clients is covered in Table 24 in section 4.12 of this guide.

4.12.5 Non-emergency travel and accommodation assistance

The DHB is responsible for funding travel and accommodation assistance for injured patients/clients who are receiving public health acute services. The NTA policy applies to ACC clients on the same eligibility grounds as patients who are ill or have a disability. Assistance by the DHB is not automatic; it is dependent upon criteria such as distance to travel, income levels, age and frequency of treatment.

ACC is not responsible for providing any assistance where the NTA policy does not provide for assistance to an injured person who is receiving public health acute services, until the DHB's responsibility for travel and accommodation ceases. This is when the patient/client is no longer receiving public health acute services, eg after being transferred to a non-acute inpatient rehabilitation facility or after the patient/client has travelled home following the completion of six weeks of medical outpatient services.

ACC is responsible for providing non-emergency transport for its clients to travel to treatment (excluding the majority of public health acute services – see Table 24 in section 4.12 of this guide) and to travel to the specified types of social and vocational rehabilitation listed in the Ancillary Services Regulations 2002.

The criteria for receiving payment from ACC for transport and accommodation costs related to treatment and rehabilitation are specified in the Ancillary Services Regulations 2002:

a. Non-emergency scheduled surface public transport costs (Regulation 7)
b. Non-emergency transport by private motor vehicle (Regulation 8)
c. Non-emergency transport by air (Regulation 9)
d. Non-emergency transport ambulance transport (Regulation 10)
e. Non-emergency other transport (Regulation 11).

It must be noted that the transport to treatment criteria only relates to medical practitioner outpatient appointments as per PHAS rules, and not allied health and nurse consultations or community-referred radiology. ACC's prior approval is required in some cases (eg for non-emergency transport by air and non-emergency ambulance transport).

ACC can also pay the cost of non-emergency ambulance transport and non-emergency transport by air to *rehabilitation* (excluding the majority of public health acute services – see Table 24 in section 4.12 of this guide), which is available to clients where the client's injury is such that no other form of public or private transport is appropriate.

To access one of these services, a client must have obtained a certificate from their doctor that validates the need for an ambulance. The service can be arranged by the requesting treatment provider by contacting the ambulance communications centre. Prior approval from ACC is required.

ACC contracts for the provision of this service with their emergency ambulance providers. It should be noted that non-emergency transport by ambulance is not subject to the same access criteria as apply under the Ancillary Services Regulations 2002 to most other forms of non-emergency transport to rehabilitation.

4.12.6 Escort costs

Under Regulation 12 of the Ancillary Services Regulations 2002, ACC is responsible for decisions on payment for travel and accommodation assistance for an escort, but only when an escort is accompanying the client in non-emergency transport to treatment or rehabilitation that is not part of PHAS (see Table 24 in section 4.12 of this guide for more detail).

ACC is liable for escort costs for non-emergency transport under the following circumstances:

a. the injured person is under 18 years of age; or
b. the medical condition or pre-existing disability of the injured person is such that they need an escort; or
c. the person or organisation providing the transport that is used requires the injured person to be escorted.

ACC pays accommodation costs for escorts for as long as the availability of transport services prevents the escort returning home. ACC does not pay accommodation costs for an escort if they are sharing the accommodation with the client. Prior approval should be sought from ACC to check if escort costs can be paid in a particular case. An individual cannot receive 'double' payment for acting as both an escort and a support person.

4.12.7 Support person costs

Under Regulation 13 of the Ancillary Services Regulations 2002, ACC is responsible for decisions on payment for travel and accommodation assistance for support persons, but only when a support person is visiting a client who is receiving ACC-approved inpatient or residential rehabilitation that is not a public

health acute service. When a client is receiving a public health acute service, any support person's costs are managed under the DHB's responsibility and determined by the NTA criteria.

If the client is aged 18 years or older, ACC pays the regulated amounts for up to one return journey and two nights' accommodation per week, if the support person would have to travel over 80 kilometres in a one-way journey to visit the client. If the client is under the age of 18 years, the client travel rules apply to support person travel.

ACC pays accommodation costs for support persons for as long as the availability of transport services prevents them returning home (or up to a maximum of two nights' accommodation per week if the client is aged 18 years or older). ACC does not pay accommodation costs for a support person if they are sharing the accommodation with the client or escort.

An individual cannot receive 'double' payment for acting as both a support person and an escort. Prior approval should be sought from ACC to check if support person costs can be paid in a particular case.

4.13 Relief care (carer support)

So that a regular carer can take a break, ACC is responsible for the assessment of the need for and the provision of personal care services by another carer – this is known as relief care.

ACC expects that relief care will be needed from time to time as it is not possible for one person to provide 24-hour hands-on care safely by themselves.

There are two types of relief care:

a. family caregiver requires a break
b. crisis care (when a client's safety and health would be at risk without services).

Relief care can be provided in the following ways:

a. the client can be admitted to a residential facility to receive the care
b. an alternative caregiver can go to the family home to provide the care
c. the client can go to an alternative provider's home, such as the home of another family.

An assessment of relief care is done during a support needs assessment. Should a family feel that they require relief care beyond that which is provided for in the assessment, they should contact ACC as soon as possible.

Section 5: Administrative processes

5.1 Notification of acute admission due to personal injury

ACC (or the accredited employer) should be notified as early as possible (through the ACC45 form) when a person is admitted acutely due to a personal injury. If a client's diagnosis changes, the DHB should update ACC via the ACC18 Medical certificate form to ensure that appropriate cover is provided and post-discharge treatment or rehabilitation services can be arranged as required.

5.2 ACC forms

Copies of ACC forms most frequently used by DHBs are available online or by contacting ACC.

Table 25: ACC forms frequently used by DHBs

ACC number	Name of form	When to use the form
ACC18	Medical certificate	If a client is unable to work at their normal employment because of their injury, the medical practitioner completes an ACC18, which describes how the client's injury affects their capacity for work. It can also be used to add to the original injury diagnosis or to clarify the diagnosis
ACC32	Treatment extension request	This is completed by the treatment provider when initial treatments have been provided and the client needs more treatment.
ACC42	Dental injury claim form	This is a specialised form of the ACC45 Injury Claim form that dentists use to provide more specific details about client's dental injury
ACC45	Injury claim form	This form must be completed *and signed* by the person who has had a personal injury (or their authorised representative) for the first attendance or admission. It can be lodged electronically. See section 5.2.1 of this guide
ACC46	Injury claim form	This form contains the same information as the ACC45 form and is used to collect claim information before entering it into a practice management system (PMS). The ACC46 is not sent to ACC to lodge a claim
ACC271	Medical practitioner cover questionnaire	This form must be completed by the treating medical practitioner of a person who has lodged a claim for a personal injury caused by work-related gradual process, disease or infection. This information is used by ACC when deciding whether to accept the claim
ACC705	Referral for support services on discharge	DHBs are to use this form to notify ACC about support needs post discharge. The form should be submitted at least 48 hours before the proposed discharge date. Clients requiring short-term support (up to a maximum of six weeks) can be referred directly to a Home and Community Support Services provider. For eligibility criteria, please see section 5.6.1.2 of this guide.

ACC number	Name of form	When to use the form
ACC706	Early notification of complex case	DHBs are to use this form to provide early notification to ACC of a client who will have complex support needs on discharge, so that joint discharge planning can commence. The form should be submitted to ACC within a week of admission
ACC1151	Referral to TBIRR service form	DHBs are to use this form to request prior approval from ACC when a client with a moderate to severe Traumatic Brain Injury (TBI) requires emerging consciousness rehabilitation services.
ACC1171	Request for pharmaceutical funding	This form is used to seek funding approval for non-subsidised pharmaceuticals
ACC2152	Treatment injury claim form	This form notifies ACC of treatment injury and is filled out by the provider (preferably the provider who provided the treatment concerned). The client *must* be aware of the claim. The form *must* be used in conjunction with the ACC45 form
ACC4249	Short-term equipment (needed post six weeks discharge) request	This form is used to request ACC funding for short-term equipment needed by clients for more than six weeks post discharge.
ACC7422	Early cover application form	DHBs use this form when a client with TBI, multi-trauma or spinal cord injury requires an early cover decision so that ACC can assign a case manager to assist with discharge planning

5.2.1 ACC45 Injury claim form

This form gives ACC the first notification of an injury caused by an accident. It is used to determine ACC cover on a person's claim. In the case of a dental injury an **ACC42 Dental injury claim form** must be completed.

An ACC45 form must be completed and signed by the client (or their authorised representative) for the first attendance or admission, including clients:

a. treated under PHAS

b. whose work-related personal injury cover is the responsibility of an accredited employer.

Where a form is lodged electronically, a copy, signed by the client, must be retained by the treatment provider. Information on how to complete, sign and lodge a claim using the ACC45 form is available on ACC's website.

5.2.1.1 ACC46 Injury claim form

Some DHBs also use the ACC46 form. This form is designed to assist with transferring data from a paper form to ACC's web-based lodgement portal or into a PMS. Although the ACC46 is filled in by the client and provider in much the same way as the ACC45, it cannot be used as a form to lodge claims directly with ACC.

5.2.1.2 ACC45 form initiated by another provider

Where another provider, eg urgent care clinic, has ensured that an injured person has completed an ACC45 form before the person's treatment at a DHB, the DHB should use that claim number.

Where another provider has **submitted** a completed ACC45 to ACC and the **DHB's injury diagnosis is different** from the diagnosis made by that provider, the DHB should advise ACC using an **ACC18** (Medical certificate), quoting the original ACC45 number.

Where a patient is delivered to hospital by ambulance but then is not assessed or treated by the DHB (for example, where a patient leaves before being seen in ED), the DHB cannot complete an ACC45 form for that person.

5.2.1.3 ACC45 forms and Accredited Employers

General information on accredited employers and TPAs can be found in section 1.2.3.2 of this guide.

Accredited employers under the ACC Accredited Employer Programme accept the responsibilities that ACC would accept in relation to the work-related injuries of their employees. Some accredited employers use TPAs to manage their employees' claims. Accredited employers pay ACC a fee to cover the free provision of PHAS to employees, and DHBs cannot invoice accredited employers for these services.

The ACC45 form asks for the name of the injured person's employer. If a DHB or client knows the employer is an accredited employer, the DHB should send the accredited employer (or their TPA) a copy of the ACC45 form. If relevant, any invoices for non-public health acute treatment should be sent directly to that employer.

If a DHB is unsure whether the client's employer is an accredited employer or if they use a TPA, then the DHB should send the ACC45 directly to ACC.

If an ACC45 for an employee of an accredited employer is sent to ACC in error, ACC will forward it to the appropriate recipient.

See section 5.4 of this guide for information on accredited employers and the lodgement of sensitive claims.

5.2.1.4 ACC32 Treatment extension request

Under the provisions of the AC Act 2001, no approval is required from ACC when providing acute treatment (as defined in section 7 of the AC Act 2001) or PHAS. ACC purchases non-acute care via contracts and regulations, which may carry their own entry criteria such as prior-approval requirements. Please refer to the details of the contracts with ACC that your DHB holds.

If prior approval is required, either the appropriate form for entry into a particular service (eg active rehabilitation) or an ACC32 will need to be submitted to ACC before the treatment that requires this approval takes place.

Additional information on the ACC32 form can be found on ACC's Treatment and recovery web page. In some instances, for example physiotherapy, prior approval using the ACC32 may be required after a certain number of treatments for a particular injury.

If contractually required prior-approval conditions are not met, payment may be declined by ACC. In cases where prior approval is not required, ACC monitors service provision and investigates any apparent excessive service provision.

5.3 Treatment injury

5.3.1 What is treatment injury?

Treatment injury is a personal injury caused as a result of treatment from one or more registered health professionals. The person must have been actually injured during treatment, not just suffered symptoms. The personal injury cannot be a necessary part or an ordinary consequence of the treatment provided.

'Treatment' includes diagnosis, the actual treatment itself, a lack of treatment that should have been provided, a failure to obtain consent to treatment, a failure of equipment or the application of support systems. For the legislative definition of treatment injury, see sections 32 and 33 of the AC Act 2001. Section 32 defines treatment injury and section 33 lists what constitutes treatment in terms of treatment injury.

Table 26: Treatment providers covered under treatment injury

Treatment providers whose treatment is covered under treatment injury		Treatment providers whose treatment is not covered under treatment injury
Chiropractor	Midwife	Acupuncturist
Clinical Dental Technician	Nurse	Audiologist
Dental Technician	Occupational Therapist	Counsellor
Dentist	Optometrist	Osteopath
Medical Laboratory Technologist	Pharmacist	Speech Therapist
Medical Practitioner (Doctor, Surgeon, Anaesthetist etc.)	Medical Radiation Technologist	
Physiotherapist	Podiatrist	

5.3.2 When treatment injury occurs and the client requires acute treatment

All treatment injury claims need to be lodged with ACC (using the ACC45 and an ACC2152; see below) as soon as possible after it is identified that a treatment injury has occurred.

If, as a result of a treatment injury, a client requires acute treatment at a DHB, this treatment is funded under PHAS. When the record is loaded into the NMDS, the ACC45 number should be included and the accident flag set to 'N' (the client was not admitted as a result of the accident). Report the treatment injury in the clinical coding along with external cause codes that are dated between the admission and discharge dates.

5.3.2.1 When a treatment injury occurs at a private facility

If a treatment injury has occurred at a private facility section 74(2) of the AC Act 2001 allows acute care to be delivered in a non-public hospital if the clinical decision is that a transfer from the private facility to the DHB for treatment is unsafe due to the client's condition, or it is more clinically appropriate to treat the treatment injury immediately.

The client should be transferred to a DHB within 24 hours of the treatment injury occurring (or being identified as a treatment injury).

ACC will fund the:

a. cost of the acute surgery
b. hospital stay up to the point that it is practicable to transfer the client to a DHB
c. emergency transport from the private facility to the DHB.

ACC will review the funding of the treatment at the private facility when the cover decision is made to accept the claim and a request for funding is received.

5.3.3 Treatment injury claims

Every treatment injury claim needs to be lodged with an ACC45 (or ACC42 for a dental injury) and a provision of an ACC2152 form will assist ACC in making a timely decision. A treatment injury claim can be made by any registered treatment provider able to submit an ACC45 form. However, **the injured person must have knowledge of the claim being lodged and must have given consent**. Treatment providers are paid for the completion of the ACC2152 treatment injury claim form.

Treatment injury claims are considered complicated claims, and section 57 of the AC Act 2001 allows for up to nine months to assess and determine cover, depending on the ease of accessing relevant clinical information. However, in most cases, where clear, relevant information has been provided to ACC, cover can be decided much more quickly (in days or weeks). ACC's intent is to make robust cover decisions as quickly as possible so that the patient/client can access the scheme for treatment, rehabilitation and entitlements.

In some instances, an injured person will require treatment, elective surgery or rehabilitation related to the treatment injury prior to the treatment injury claim being determined. In these cases, the treatment provider or funder, eg MoH, will be reimbursed by ACC once the claim for treatment injury has been accepted. For more information, see section 5.7.4 of this guide.

5.3.4 Review of treatment injury claim decisions

Only the patient/client (i.e. the injured person) or their authorised representative may seek a review of a decision on a treatment injury claim. The review application must be made within three months of the date of ACC's decision on the treatment injury claim. Should a patient/client seek to have a decision reviewed they should contact ACC directly. In some circumstances a patient/client may decide to appeal a review decision through the District Court.

5.4 Sensitive claim lodgement

ACC accepts a sensitive claim when there is a mental injury caused by a certain criminal act, for example sexual abuse or assault. To lodge a claim, a medical practitioner completes the ACC45 injury claim form stating that this is for a sensitive claim following sexual abuse or assault.

ACC doesn't accept cover for a mental injury based on these ACC45 forms, but ACC's Sensitive Claims Unit contacts the patient and discusses what pre-cover and cover assessment services are available for sensitive claims through the Integrated Services for Sensitive Claims (ISSC).

If the patient decides to go through the mental injury assessment process in order to have a covered claim, the Sensitive Claims Unit will request clinical notes from the DHB for the purpose of the assessment.

Note:
Where the injured person is employed by an accredited employer and the injury is a sensitive claim, the patient/client can request that the case be managed by ACC directly. In this case, no ACC45 form or claim details should be sent to the employer; they should go directly to the ACC Sensitive Claims Unit.

5.5 Information supply provisions related to ACC claims

5.5.1 Information supply provisions for PHAS

The MoH incorporates information supply provisions in their funding agreement with DHBs, including:

a. the completion of ACC forms and medical certificates for individuals
b. the submission of data to MoH's Client Insights and Analytical Group for all inpatients, outpatients, day patients and ED patients receiving PHAS
c. reporting on the volume of, and expenditure on, public health acute services provided by DHBs in outpatient and emergency departments:
    i. by the purchase unit
    ii. recording ACC claim information
    iii. whether the injuries were work related or non-work related
d. the supply of copies of relevant audit and monitoring reports related to the purchase of PHAS.

Note:
At present there is no set process for reimbursement by ACC to other agencies (for example MoH), and therefore there is no set format for what information needs to be supplied to facilitate this reimbursement. Generally, the process is managed between MoH's Client Insights and Analytical Group and ACC.

5.5.2 The NMDS

Clinical coding submitted to the NMDS plays a major part in identifying accident cases treated by hospitals and is used in calculating the amount ACC pays for PHAS. Accident cases are normally coded with principal and/or other diagnosis codes within the ICD-10-AM ranges of S00-T98 (injury, poisoning and certain other consequences of external causes) and U50-Y98 (external causes of morbidity and mortality). Note though that not all such diagnoses are covered by ACC and covered cases may also have principal and/or secondary diagnoses outside this range.

Note:
The NMDS is the national collection of inpatient and day-case hospital events. The National Non-Admitted Patient Collection (NNPAC) holds data for ED and outpatient attendances. Both collections include the Accident flag and ACC45 fields. NNPAC does not currently include ICD-10-AM clinical coding. NNPAC data may be used in the future for funding purposes. To enable this to happen DHBs, ACC and MoH will need to work together to agree on the data to be collected and address data quality issues. The current file specification for NNPAC can be found on the MoH website.

5.5.2.1 Identification of potential ACC-covered cases

DHBs are required to identify potential ACC-covered cases by using the following fields:

a. Accident flag
b. ACC claim number
c. Clinical coding – use of diagnosis, procedure and external cause codes.

For further information, see the NMDS Data Dictionary.

The 'principal health service purchaser' code is used to identify the purchaser of treatment. In most cases, accident acute admissions will be coded '35' as they are funded through the Minister of Health's funding arrangements for PHAS (the exception is code '20' for MoH purchasing of services for injured overseas visitors). Principal health service purchaser codes for ACC (code 'A0') and other accident payers, eg accredited employers (code '17'), should be used only for treatment directly purchased by ACC or accident payers (eg elective admissions for elective surgery or non-acute/rehabilitative care).

It is acknowledged that there are inconsistencies in coding cases in the NMDS between different DHBs, but DHBs, MoH and ACC are working together to get a more standardised approach.

Table 27: Reporting of accident cases by DHBs to NMDS

NMDS field	Acute admissions	Elective admissions and non-acute transfers
Accident flag	Y	Y
ACC form number	ACC45	ACC45
Admission type (see NMDS Data Dictionary for further information)	AA or AC	WN or AA
Principal health service purchaser	35 = all accident cases (except specific classes of overseas visitor) 19 = overseas ineligible 20 = overseas eligible	A0 = ACC 17 = Accredited employer

5.5.3 Codes used on ACC forms

5.5.3.1 Injury diagnosis codes

ACC has endorsed the use of common diagnosis codes. Injury diagnosis code information will also be collected by the Government to monitor that ACC is meeting its obligations for treatment.

Read is the diagnosis and procedure coding system to be recorded on ACC45 forms lodged by the primary healthcare sector. The secondary healthcare sector, including DHBs, may choose to use either Read or **ICD-10-AM on the ACC45 form. However, only ICD-10-AM codes can be reported to the NMDS**.

ACC is in the process of migrating from Read coding to SNOMED CT for reporting the diagnosis on submissions to ACC including the claim form (ACC45/6) and the Medical Certificates (ACC18). Implementation will be phased in over a period of time. Stakeholders wanting to move to SNOMED CT coding to replace Read codes should contact ACC.

5.5.3.2 Provider codes

ACC needs a number that identifies each DHB as a health provider. All health and relevant disability providers should use their Health Practitioner Index (HPI) number (including the Common Person Number), which can be sourced from each registration authority. It is acknowledged that further work is required to improve coding standards (eg National Health Index [NHI] and HPI number).

5.6 Discharge planning

Planning for discharge should be continually evaluated along the continuum of care to ensure that:

a. the injured person has care appropriate to their needs
b. the transitions between services are well organised, efficient and effective
c. the injured person and their family/whānau are involved in decision-making wherever possible.

Good communication between the MoH, DHBs, ACC and suppliers is vital in discharge planning, especially where there is a pre-existing disability or dual/multiple diagnosis.

Discharge planning requirements include the provision of a discharge summary sent on the day of discharge to the patient's/client's GP and referring consultant (if different from the operating surgeon/attending physician). The discharge summary should include, as appropriate, the diagnosis, treatment provided, prognosis and recommended treatment plan.

ACC may request a copy of the discharge summary or letter following receipt of the ACC45 form, but does not require a copy routinely.

The funding agreement between the MoH and DHBs require that DHBs grant such access to ACC to information relating to any client receiving treatment in that hospital for a personal injury covered by the AC Act 2001, and to those health professionals necessary for arranging post-discharge treatment, care, rehabilitation or other services. Client consent for this is included on the ACC45 form.

Accredited employers are entitled to the same provision of and access to information as ACC.

Refer to Appendix 1 - 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

5.6.1 Early notification for complex injury/support needs post discharge

Where a patient/client has a complex injury/support needs (eg TBI, burns unit, multi-trauma, or spinal cord injury), and requires either rehabilitation in a residential facility or ongoing support upon discharge, it is important that the DHB:

a. reviews the diagnosis on the ACC45 (and updates via an ACC18 where necessary) to ensure that the patient/client has the appropriate cover
b. provides clinical notes to support the cover decision
c. notifies ACC as soon as possible (within three days of admission) using an ACC706 Early Notification of Complex Case form to allow ACC and rehabilitation suppliers to engage early with the patient/client and their family/whānau. An ACC706 or ACC7422 Early cover application form must be completed and emailed to the nearest ACC Contact Centre.

ACC will liaise with the DHB and, where appropriate, will arrange an assessment of the patient's/client's needs and arrange appropriate post-discharge support.

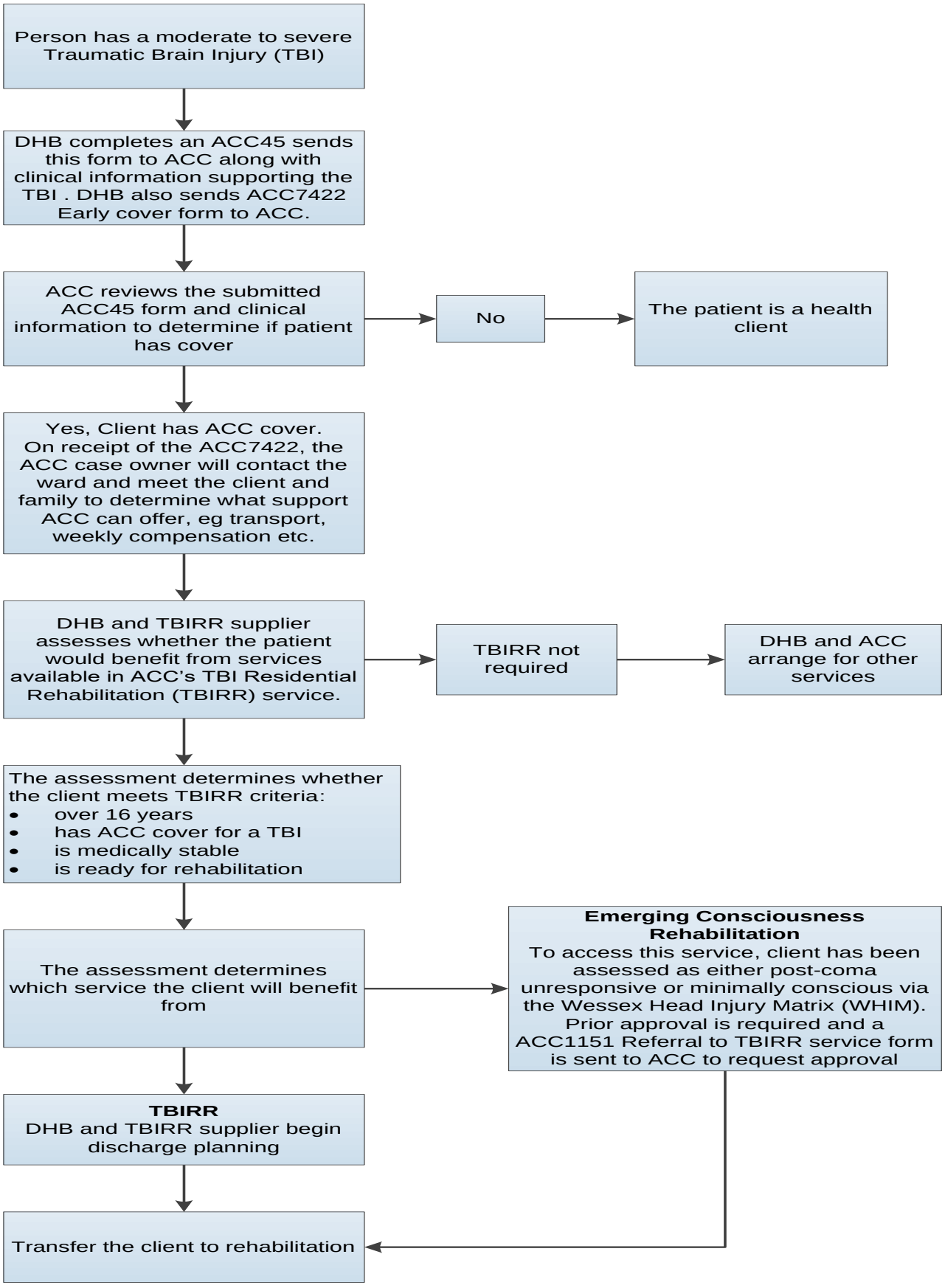
5.6.1.1 Transfer to residential rehabilitation services[55]

In addition to 5.6.1, and where a patient/client requires rehabilitation in a residential setting, the DHB will notify the ACC case owner as soon as the need for residential services becomes apparent.

In some cases, ACC will need to approve residential rehabilitation for a patient's/client's covered injury, and the DHB and rehabilitation supplier will assess the patient/client against the relevant contractual criteria to determine eligibility for the service. The DHB needs to provide the appropriate clinical information to ACC and rehabilitation suppliers to enable good decision-making.

[55] The Traumatic Brain Injury Residential Rehabilitation (TBIRR) contract started on 1 April 2014; the process described here reflects changes to this service.

Figure 2: Process for referring a patient for Traumatic Brain Injury Residential Rehabilitation services

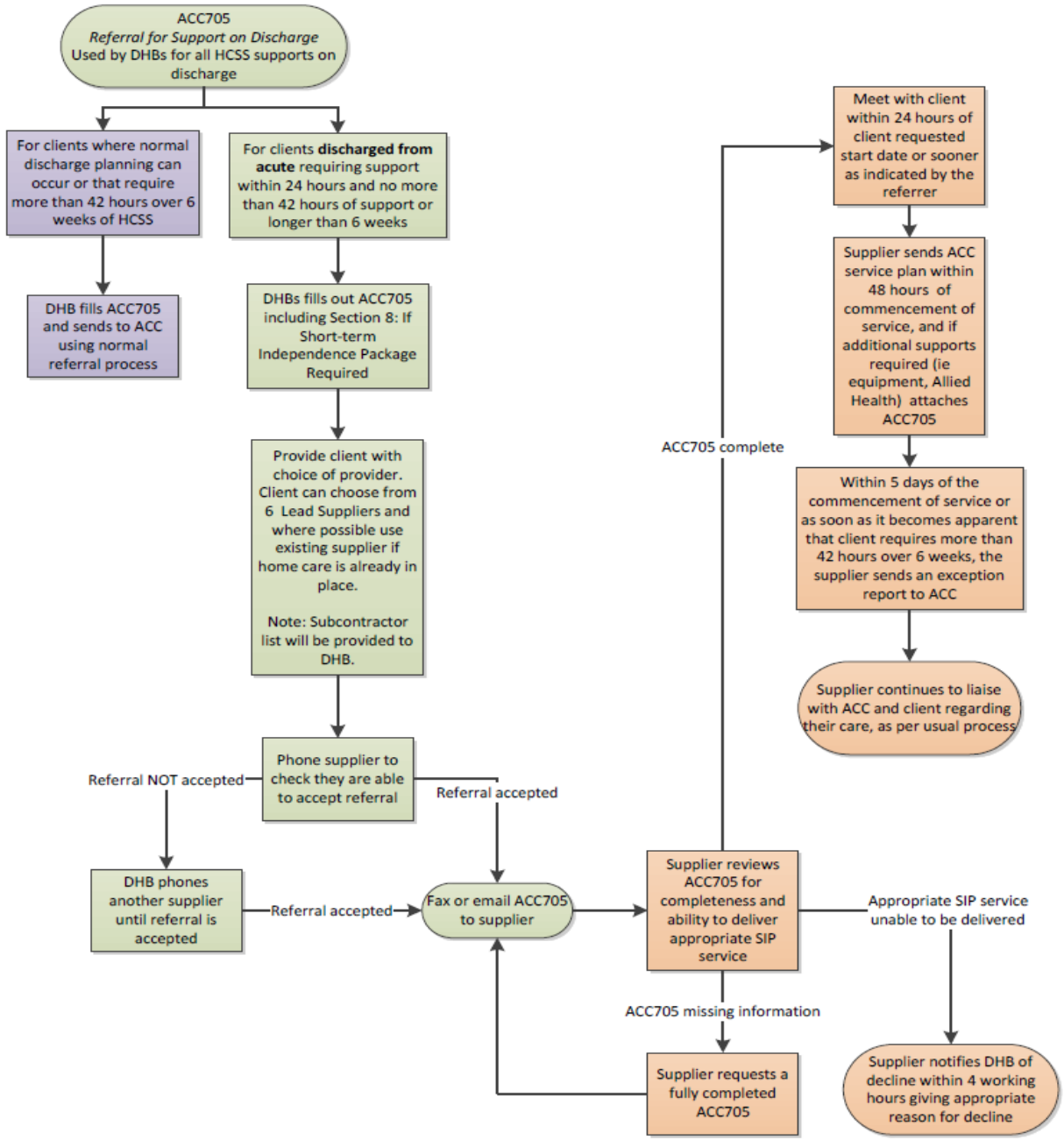


5.6.1.2 Home and Community Support Services

If a client is likely to require more than 42 hours' support or more than six weeks' support, the DHB should complete an ACC705 Referral for Support Services on Discharge form and forward this to the ACC Contact Centre at least 48 hours prior to discharge. The ACC Contact Centre will make the decision on the appropriate action to be taken and will notify the DHB as to whether a package of care can be implemented without a prior assessment, or an assessment is required.

If the client requires less than 42 hours of support over a six-week period, the DHB can make a referral directly to a Home and Community Support Service (HCSS) supplier by completing an ACC705. The Short-term Independence Package is available 24 hours a day, seven days a week – see Figure 3 for further information.

Figure 3: Process for referring a patient for HCSS Short-term Independence Package



5.7 Invoicing for treatment and services

5.7.1 Invoicing ACC for treatment that is not included in PHAS

ACC will only make a payment for treatment of an injury if:

a. a claim has been registered with ACC via an ACC45 injury claim form
b. the claim has been accepted by ACC
c. prior approval has been obtained where required.

Invoicing for non-acute services is via the DHB bulk-billing form or on a case-by-case basis.

Further information is available on ACC website under Invoicing us.

5.7.2 Electronic transactions

eLodgement lets you send your ACC45 Injury Claim forms to ACC using the ACC webpage. eInvoicing lets you invoice ACC for treatment that is not covered by PHAS electronically, either via an application called the XML Builder (ACC provides this for free) or via an upload mechanism on the ACC eBusiness Gateway Invoicing webpage.

You can check the payment status of sent invoices, query the status of a claim (ACC45) and access and download your payment advice details. You can also submit discharge notices, clinical notes and reports to ACC using HealthLink or MMEx. For more information:

a. see the ACC website under Getting set up online; or
b. contact the eBusiness team on 0800 222 994 (option 1).

5.7.3 Invoicing an Accredited Employer

DHBs need to invoice accredited employers for non-acute services provided to employees for work-related injuries (eg allied health outpatient services, rehabilitation, post-six-weeks medical outpatient services and elective surgery).

If an invoice for payment by an accredited employer is sent in error to ACC, ACC will send the invoice back to the DHB, together with a letter advising of the accredited employer's details.

If a DHB has consistent difficulty with an accredited employer or their TPA (eg in receiving timely payments for invoices, obtaining prior approvals for treatment or arranging support services for discharge), the DHB should contact the ACC account manager for assistance.

5.7.4 Invoicing ACC for non-PHAS treatment where funding responsibility is unclear and a decision has been delayed

If there has been a delay of more than 12 months between the commencement of services to a person and that person's claim being accepted by ACC, the agency will need to provide supporting documentation with their invoice to ACC. Delays can happen with instances of complex treatment injury or multiple or dual diagnosis. Queries regarding invoicing should be directed to the ACC Provider Contact Centre.

If sending a late invoice, a provider must include additional information[56] that demonstrates:

a. the ACC45 claim number for the personal injury that the service relates to
b. that the service relates to the personal injury specified on the ACC45 and the service was necessary and appropriate for that personal injury. Information that demonstrates this might include clinical records and treatment notes
c. full management of the personal injury to date (eg assessment reports, clinical records).

[56] It is the provider's responsibility to ensure that the information demonstrates that the service was necessary and appropriate for the personal injury etc. ACC may audit the information at any time.

5.8 Audit and monitoring

The PHAS agreement includes provisions relating to the quality of service provision and audit procedures that apply to the services purchased on behalf of ACC. The MoH and ACC will work with service providers to further develop a compliance regime that will monitor service provision with a focus on quality of delivery and optimal health outcomes, and will identify over-servicing or fraud.

Section 6: Process for resolving Health/ACC boundary Issues

6.1 Principles for resolving boundary issues

The following principles are to be used as a guide:

a. All parties should work together in good faith to resolve issues

b. Disputes should be resolved at the lowest possible level of management that is appropriate given the nature of the dispute and taking into account legislative and contractual requirements.

As a general principle, ACC is responsible for paying (either directly or through PHAS) for services required by a client as a result of personal injury covered by the AC Act 2001. Funding for and the provision of services outside the AC Act 2001 are the responsibility of DHBs and/or MoH.

6.2 Agreed steps where there is a dispute over boundaries

a. **DHB staff** should first talk to the ACC case owner or relevant team manager if possible/appropriate. Where a claim has not yet been accepted, DHB staff should contact ACC's Provider Contact Centre on 0800 222 070.

   If the issue is not resolved (or if the actions above are not possible/appropriate), DHB staff should discuss this with their DHB's ACC Contract Manager. The Contract Manager will work with ACC's Engagement and Performance Manager to resolve the issue.

   ACC staff should, in the first instance, talk to the DHB staff member involved and as necessary, escalate the matter to a Team Leader. If this is not possible or appropriate, contact the Engagement and Performance Manager who will work with the DHB's ACC Contract Manager to resolve the issue.

b. If the dispute is not able to be resolved between the DHB's ACC Contract Manager and ACC's Engagement and Performance Manager, they will escalate the issue to the DHB/ACC Operational Management Group.

c. If the issue remains unresolved, it may be appropriate to follow the relevant agency's escalation pathway.

6.3 Funding while boundary disputes are resolved

Where responsibility for payment is disputed, the following will continue until the issue is resolved:

a. services and, for the avoidance of doubt, items inherent to the provision of the services (eg consumables, equipment, pharmaceuticals) to individuals will be maintained by whichever agency is currently providing the service

b. payment for the above will continue to be made by whichever agency is currently paying.

Section 7: Provider Performance

ACC is committed to guiding providers towards best-practice behaviour and contract compliance to improve client outcomes.

7.1 Engagement and Performance Managers

Engagement and Performance Managers (employed by ACC) work in the community primarily with contracted suppliers and providers, including DHBs, and also those who work under the CoTR 2003, such as general practice staff (medical practitioners, nurses and practice managers), physiotherapists, osteopaths and acupuncturists.

The role of Engagement and Performance Managers includes:

a. working with suppliers and providers in an educative and supporting role

b. implementing monitoring activity in accordance with ACC policy and annual performance plans, and tracking those suppliers and providers whose service provision against their contract causes concern

c. developing, negotiating and implementing performance improvement plans for suppliers and providers as required

d. managing and resolving escalated supplier and provider issues that affect client outcomes.

7.2 ACC Resources available to providers

ACC produces a number of resources for providers. These include:

a. reports summarising the utilisation of ACC-subsidised treatment across treatment provider groups

b. 'frequently asked questions' sheets

c. electronic resources, which are available using the resources section of the ACC website, or by contacting ACC.

Glossary

Accident – For the full definition of 'accident' and types of personal injury, see sections 25-30 of the AC Act 2001.

Accident Compensation Corporation (ACC) – The Crown entity responsible for paying for the provision of treatment, rehabilitation and other entitlements for clients with personal injury for which they have cover under the AC Act 2001. ACC makes payments to the Crown to enable the Minister of Health to arrange the purchase of PHAS, and directly purchases treatment and rehabilitation services that are not part of PHAS.

Accredited Employer – An employer (or group of companies) that, after meeting defined criteria, has signed a contract with ACC to become part of the ACC Accredited Employer Programme. The accredited employer accepts responsibility for a specified time period for managing and directly purchasing most of the statutory entitlements of their employees who suffer a work- related personal injury.

Acute admission – As defined in section 4 of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 and section 74 (4) of the AC Act 2001.

Acute treatment – As defined in section 7 of the AC Act 2001 and, in relation to an injured person, means:

a. the first visit to an appropriate treatment provider for treatment for a personal injury for which the claimant has cover
b. subsequent treatments by that treatment provider if, in their reasonable clinical judgement, the need for the treatment is urgent (given clinical safety issues)
c. referral by the first treatment provider to another provider (this provider may not be a DHB) for that same injury, if the first provider believes the referred treatment is urgent (given clinical safety issues).

Ancillary Services Regulations 2002 – The Accident Compensation (Ancillary Services) Regulations 2002, which specify contributions towards the costs of specified ancillary services related to specified kinds of rehabilitation (including treatment) that must be made by ACC and accredited employers. Specified ancillary services are: emergency transport, non-emergency scheduled surface public transport, non-emergency transport by private motor vehicle, non-emergency transport by air, non-emergency ambulance transport, non-emergency other transport, accommodation, escort transport and accommodation, and support person transport and accommodation.

Annual Service Agreement – Section 301 of the AC Act 2001 requires the Minister, on behalf of ACC, to enter into an annual service agreement with the Minister of Health for the purchase of PHAS, pharmaceuticals and laboratory tests for ACC claimants (the annual service agreement). Funding for PHAS is distributed to DHBs via Vote: Health Crown Funding arrangements.

The full title of the agreement is: Annual Service Agreement for the Purchase of Public Health Acute Services, Pharmaceuticals, Therapeutic Devices, Laboratory Tests and Renal Dialysis Services between the Minister for ACC and the Minister of Health (Under Section 301 of the Accident Compensation Act 2001).

Claimant – Patient/Client.

Community Health Trusts (also referred to as Community Trust Hospitals) – are funded through DHBs via MoH funding. These provide some health services to smaller communities, and may provide PHAS.

Complex injury – An ACC term meaning an injury that involves one or more injury and/or factors that could complicate or delay the patient's/client's rehabilitation, eg injury severity, age, non-injury health issues, infection.

Date-time of discharge (within the NMDS; in NNPAC collections this is called event end date-time) – The date and time when a patient/client is safely discharged from a hospital. The date-time of discharge can also be the date-time of discharge home or discharge to non-acute rehabilitation services, for example from a medical/surgical ward to rehabilitation. A patient/client returning home 'on leave' from a hospital does not constitute a permanent discharge, eg weekend leave for a seriously injured patient/client. For more information on the NMDS event end date please see the NMDS data dictionary.

Disability Support Services – Disability services funded by MoH and DHBs.

District Health Board (DHB) – An organisation established under section 19 of, and named under Schedule 1 of, the New Zealand Public Health and Disability Act 2000.

Emergency Department (ED) – There is no definition within the AC Act 2001 or associated regulations of what constitutes an 'emergency department'. It is interpreted in this context to mean any area in a DHB or other publicly funded provider that provides treatment services that would generally be considered part of a normal ED operation of a public hospital.

Individual Rehabilitation Plan (IRP) – As defined in section 6 of the AC Act 2001, a plan that ACC and a claimant develop in consultation with the claimant's family, employer and treatment provider within 13 weeks of the acceptance of the claim for cover. The IRP outlines the injured person's need for rehabilitation, the assessments to be done, the services appropriate to meet those needs and which of the services ACC will provide, pay for or contribute to in order to restore the claimant's health, independence and participation to the maximum extent practicable.

Mental injury – As defined in section 27 of the AC Act 2001. Cover for mental injury caused by certain criminal acts is discussed in section 21 of the AC Act 2001 and the relevant sections of the Crimes Act are listed in Schedule 3 of the AC Act 2001.

MoH Client Insights and Analytical Group – On 1 July 2008 the New Zealand Health Information Service was merged into MoH's Information Group. This group was disestablished in 2012 and the information collection functions largely sit under the Ministry's Client Insights and Analytical Group.

National Minimum Data Set (NMDS) – A national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. Unit record data is collected and stored. All records must have a valid National Health Index (NHI) number. Additional information on the NHI can be found at National Health Index | Ministry of Health NZ. The NMDS is used for policy formation, performance monitoring, research and review. It provides statistical information, reports, and analyses about the trends in the delivery of hospital inpatient and day patient health services both nationally and on a provider basis. It is also used for funding purposes.

National Non-Admitted Patient Collection (NNPAC) – A system introduced on 1 July 2006 that provides nationally consistent data on non-admitted patient activity (eg outpatient and ED events). Unit record data is collected and stored. All records must have valid National Health Index (NHI) number. Additional information on the NHI can be found at National Health Index | Ministry of Health NZ.

The availability and use of the data in NNPAC will improve sector knowledge and enable more informed planning, resource allocation and advice. The collection provides statistical information, reports, and analyses about the trends in the delivery of non-admitted patient services both nationally and on a health provider basis. The collection will be expanded over time and may be used in the future for funding purposes. Further information about NNPAC including the file format, can be found at National Non-Admitted Patient Collection File Specification | Ministry of Health NZ

Ordinarily resident in New Zealand – As defined in section 17 of the AC Act 2001.

Outpatient – As defined in Regulation 3(2) of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 to mean –

"3(2) A person is an **outpatient** in relation to a healthcare facility if –

(a) the person receives from a medical practitioner a pre-admission assessment, a diagnostic procedure, or treatment at the facility; and

(b) the person has not been admitted to the facility; and

(c) the medical practitioner intends that the person will leave the facility within three hours after the consultation begins."

Personal injury – As defined in section 26 of the AC Act 2001. The terms mental injury, work-related personal injury, personal injury that is both work related and motor vehicle injury, personal injury caused by work-related process, disease or infection, and treatment injury are individually defined in sections 26-30 of the AC Act 2001.

Pharmaceutical – As defined in section 6 of the AC Act 2001:

"pharmaceutical means **--**

(a) a prescription medicine, a restricted medicine, or a pharmacy-only medicine, as listed in Parts 1, 2, and 3 of the Schedule 1 of the Medicines Regulations 1984; or

(b) a controlled drug as defined in the Misuse of Drugs Act 1975."

PHAS regulations – The Injury Prevention, Rehabilitation and Compensation (Public Health Acute Services) Regulations 2002 in Public Health Acute Services.

Physical injury – Evidence of actual damage to the body and an actual diagnosis of the injury is needed before it can be said that a patient has sustained a 'physical injury'. A diagnosis of pain is insufficient for establishing there has been physical injury.

Prior approval – When approval from ACC for a service or treatment is required prior to the commencement of the service. If prior-approval conditions are not met, or prior approval is declined, ACC will not pay for the service or treatment. Prior approval is not required for acute treatment or PHAS. Most other non-acute treatment and rehabilitation services require the prior approval of ACC.

Public Health Acute Services (PHAS) – Specialist acute accident services required by clients. These services are purchased by the Minister of Health on behalf of ACC and are provided through DHBs.

Publicly funded provider – A provider that is funded by a DHB or the Minister of Health to provide PHAS. Providers can include Community Health Trusts, also referred to as Community Trust Hospitals.

Purchasing arrangements for public health acute services – The arrangements whereby PHAS are purchased through the Minister of Health's funding arrangements with DHBs and other publicly funded providers (such as Community Trust Hospitals). The Minister of Health funds these services through Vote:

Health, and subsequently ACC makes payments to the Crown for PHAS received by ACC clients. These payments are in the form of an annual regulated levy payment from ACC to the Crown (agreed via an Annual Service Agreement for the purchase of public health acute services and other health services as per section 301 of the AC Act 2001).

The calculation for PHAS is based on a data match between ACC and DHB data.

Registered health professional – As defined in section 6 of the AC Act 2001:

"**registered health professional –**

(a) means a chiropractor, clinical dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, occupational therapist, optometrist, pharmacist, physiotherapist or podiatrist, and

(b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when they are acting in accordance with any conditions of such interim certificate, and

(c) includes a member of any occupational group included in the definition of 'registered health professional' by Regulations made under section 322 of the AC Act 2001."

Rehabilitation – A process of active change and support to assist a person with a covered injury to regain their health and independence and therefore their ability to participate in their usual activities as far as practicable. It comprises treatment, social rehabilitation and vocational rehabilitation. ACC purchases many rehabilitation services by way of contracts with public and private organisations, outside the public health acute services period.

Sector Operations – The group within MoH that is responsible for making and monitoring payments to various health providers. The group used to be known as Health Payments Agreements & Compliance (HealthPAC) until a restructure in 2008. More information is available at Sector Operations | Ministry of Health NZ; see also the glossary entry for MoH Client Insights and Analytical Group.

Serious injury – An internal ACC classification that applies to people who are likely to have long-term requirements for support funded by ACC. This covers those with spinal injury, moderate to severe brain injury or other significant injuries such as severe burns, multiple amputations and comparable injuries.

Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT) - SNOMED CT is the standard international system of clinical terminology used to record precise, structured and actionable information about a person's health and disability status and the care and support they receive. SNOMED CT provides the core general terminology for electronic health records.

Treatment Cost Regulations – The Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003, which specify the contributions towards the cost of specific treatment services that must be made by ACC and accredited employers.

Treatment injury – A personal injury occurring in the context of treatment by one or more registered health professionals – but is not a necessary part or ordinary consequence of the treatment.

Treatment providers – A range of health providers recognised in section 6 of the AC Act 2001 as able to provide acute treatment for personal injuries (see section 2.4 of this guide).

Work-related personal injury – As defined under section 28 of the AC Act 2001. Work-related personal injury involving a motor vehicle is defined in section 29 of the AC Act 2001. Personal injury caused by a work-related gradual process, disease or infection is defined separately under the AC Act 2001 in section 30.

Appendix 1: A guideline for transfer of funding responsibilities from DHBs to ACC

Purpose

This document describes the services, responsibilities and ACC purchasing options that may apply for the transfer of patients/clients from acute care to rehabilitation using scenarios. This document is part of the *Accident Services – a guide for DHB and ACC staff (2018).*

Principles that guide ACC's funding decisions

1. ACC only funds support needs directly related to a covered injury
2. All decisions are made in the client's best interest
3. Discharge destination decision is made by clinicians, but ACC makes the cover and associated funding decisions.
4. Discharge destination decision must support optimal rehabilitation outcome
5. Weight bearing status can be an indicator in some situations that the patient/client is ready to participate in active rehabilitation. However, weight bearing status should not be the only determining factor of the patient's/client's readiness for rehabilitation.
   Note: there is risk of the patient/client deconditioning due to prolonged immobility which subsequently prolongs the recovery period. A patient/client may be able to actively participate in rehabilitation/physical activity despite being non-weight bearing, which should be decided on a case by case basis.

Transfer of funding responsibility from DHB to ACC

The transfer of funding responsibility for patient's rehabilitation and/or additional support needs from DHB to ACC is at the point of a patient's discharge from hospital. Discharge is defined as when the clinical responsibility for the patient is transferred from the DHB Clinician to the patient's General Practitioner.

The timeliness of ACC's cover and entitlement decisions is dependent on the quality of the patient information provided by the DHB.

Note, the PHAS six week rules apply e.g.: equipment, DHB medical outpatient appointments and ancillary services such as non-emergency travel etc. may remain the responsibility of the DHB for six weeks following an emergency department attendance or an acute admission.

Refer to Section 2 of the *Accident Services - a guide for DHB and ACC staff (2018)* to view the PHAS rules and how to calculate the PHAS period.

Process for resolving Health/ACC boundary issues

Where responsibility for funding between DHB and ACC for a client is, unclear or disputed:

- **DHB staff** should contact the ACC Case Owner or relevant team manager. If the claim has not yet been accepted, DHB staff should contact ACC's Provider Contact Centre on 0800 222 070.
  If the issue is not resolved, DHB staff should contact the DHB's ACC Contract Manager. The DHB's ACC Contract Manager will work with ACC's Engagement and Performance to resolve or escalate the issue.

- **ACC staff** should, in the first instance, talk to the DHB staff member involved and as necessary, escalate the matter to a Team Leader. If this is not appropriate or the issue remains unresolved, contact the Engagement and Performance Manager who will work with the DHB's ACC Contract Manger and ACC's Acute Care Services Portfolio to resolve the issue.

Refer to Section 6 of the *Accident Services - a guide for DHB and ACC staff (2018)* for further details.

Acute Care to Rehabilitation Scenarios

The following scenarios are to be utilised as a *guide* to support decision making. Decisions should be made on a case by case basis taking into consideration any entry requirements for a ACC purchased service. There will be occasional exceptions to the patient pathway and purchasing options described below.

Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Home	Ms D is 30 years old and has children under her care. Ms D fractured her arm at home. She was treated non-operatively at ED/Orthopaedics ward and discharged home the same day. Ms D has a follow up appointment at the Orthopaedics clinic post discharge.	✓ **ED through to discharge home from acute ward** ✓ **Outpatient appointment** to see medical practitioner (if within 6-weeks post discharge) If required: ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Outpatient appointment** to see medical practitioner (from 6-weeks post discharge from acute care) ✓ **Home and Community Support** services (domestic support, child care and personal cares) upon discharge home from acute admission. ✓ **Allied Health** services (eg physiotherapy) ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Home 2) Injury only 3) Home	Mr H is 60 years old and has fractured his lower leg at home. Mr H presented to ED and is admitted into an acute ward. Mr H has surgery performed for his lower leg and after a few days, he is clinically safe to be discharged home with crutches. He requires help with personal hygiene, cooking and cleaning. Mr H has a follow up appointment at an outpatient Orthopaedic Clinic four weeks later where it is decided that Mr H will participate in community rehabilitation.	✓ **ED through to discharge home from acute ward** ✓ **Outpatient appointment** to see medical practitioner (if within 6-weeks post discharge) ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Home and Community Support** services (domestic support and personal cares) upon discharge home from acute admission ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)

[57] Scenario outline: (1) describes the patient/client's living situation at time of injury, (2) describes the patient/client's need for hospitalisation is related injury only or injury as well as comorbidities, (3) describes the discharge location

Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Rest home	Mrs B is 67 years old and sustains bilateral wrist fractures at home. Mrs B was taken to ED and is treated with both arms in a cast. She is discharged from hospital but requires rest home level of care as she needs full supports with activities of daily living. She is otherwise clinically stable. Once the casts are removed, Mrs B will receive community rehabilitation (e.g. physiotherapy).	✓ **ED and through to discharge into rest-home** ✓ **Equipment** (up to 6-weeks post discharge from acute care to rest home). × The DHB is not responsible for the rest home stay as patient is clinically stable and only requires supports with activities of daily living due to the injury.	✓ Support services in client's home if additional family members available and able to provide natural supports for security and safety reasons. ✓ **Short-term Residential Supports** if natural supports at home are not available. ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Home 2) Injury only 3) Home but rest home supports requested	Mr C is 80 years old and has sustained a lower leg fracture at home. Mr C was admitted in the acute ward and his fracture fixed externally (in a cast). The DHB clinician has made the decision to discharge Mr C home however, Mr C's family has requested that Mr C is placed in a rest home so that he can be better supported.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC makes a contribution towards rest home care (similar to amount of contribution that ACC would make if patient is discharged home) and the patient/patient's family makes a contribution. ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Rest Home 2) Injury only 3) Hospital level rest home	Mrs K is 76 years old and has sustained a fractured ankle and wrist whilst in her rest home. Mrs K presented to ED and is admitted into an acute ward. Due to her injury, Mrs K requires additional supports for activities of daily living. Mrs K is discharged to hospital level rest home care.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC pays the difference between the rest home level of care and hospital level of care at rest home as the additional supports required are related to the covered injury. ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)

Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Hospital level rest home	Mr R is 96 years old and has sustained a fractured ankle at home. He presented to ED and is admitted to the acute ward. He is treated non-operatively (fracture plastered). Mr R is unable to manage the crutches due to his frailty, which is exacerbating his injury related needs. Mr R is discharged needing a higher level of care (hospital level) at a rest home.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (for up to six weeks post discharge from acute care).	✓ **Short-term Residential Support** services: ACC funds the placement at a hospital level rest home (usually up to six weeks). ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care). Note: ACC will fund the equipment from the point of discharge if the equipment is required for more than 6 months post discharge.
1) Home 2) Injury & comorbidities 3) Non acute rehabilitation	Mrs A is 82 years old with Congestive Heart Failure (CHF) recently discharged from hospital. Mrs A falls and sustains a fractured neck of femur at home. She is taken to ED and is admitted into an acute ward. Her CHF is stabilised over 1 day and she has surgery which is successful. The clinical decision has been made that Mrs A will benefit from inpatient/non acute rehabilitation. However, she requires a period of management of CHF before she is ready to participate in inpatient/non acute rehabilitation	✓ **ED through to discharge into inpatient/non acute rehabilitation** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Non Acute Rehabilitation** service ✓ **Equipment** (from 6-weeks post discharge from acute care) ✓ **Home and Community Support** services (domestic support and personal cares) upon discharge home from non acute rehabilitation service ✓ **Training for Independence Advisory** service

Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Rest Home 2) Injury that requires ongoing clinical/medical management 3) Non acute rehabilitation	Mr E is 78 years old and has fractured his pelvis in three places at the rest home where he lives. Mr E was treated non-operatively in an acute ward. Mr E requires bed rest for the fracture to be fixed and stabilised. He requires four staff to perform cares. After six weeks, a clinical decision is made that Mr E will participate in inpatient/non acute rehabilitation.	✓ **ED through to discharge in to inpatient/non-acute rehabilitation** Note: the DHB may transfer the patient to a DHB contracted rest home for the bed rest period. This remains DHB responsibility as the patient's fracture is not fixed and they remain under the care of DHB clinicians. ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Non Acute Rehabilitation** service ✓ **Equipment** (from 6-weeks post discharge from acute care from the hospital/rest home into Non Acute Rehabilitation service). Note: ACC will fund the equipment from the point of discharge if the equipment is required for more than 6 months post discharge.
1) Home 2) Injury only 3) Hospital level rest home until ready for non acute rehabilitation	Mrs J is 86 years old and has sustained a humerus fracture at home. She receives acute care, with the fracture being fixed externally (in a heavy plaster cast). Pre-injury, Mrs J used a walking frame to aid in her mobility. However, due to her cast she is unable to use the walking frame and requires supports with dressing, bathing and toileting. She also has some dementia, and is admitted for three days for investigations. Due to a lack of natural supports at home (as Mrs J lives alone), the clinician has requested Mrs J is placed under hospital level care in a rest home until the cast is removed. After which, Mrs J may require inpatient/non acute rehabilitation.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC funds the placement at a hospital level rest home for up to six weeks as: - the need is a consequence of the injury and - the need is not due to underlying medical conditions and - the fracture is fixed externally or internally and - the client is safe to discharge under GP care (at rest home) NOTE: If she requires longer-term Residential Support it may not be due to the injury. ✓ **Equipment** (from 6-weeks post discharge from acute care). ✓ **Allied Health** services (eg physiotherapy) ✓ **Non Acute Rehabilitation** service Note: rehabilitation may be provided in the rest home by Non Acute Rehabilitation Community services or Training for Independence for adults with other injuries service.