Understanding ACC cover

For physiotherapists and hand therapists

Learning module

Introduction

This learning module will help you consider whether an injured client qualifies for ACC support, especially when their injury or symptoms are difficult to judge.

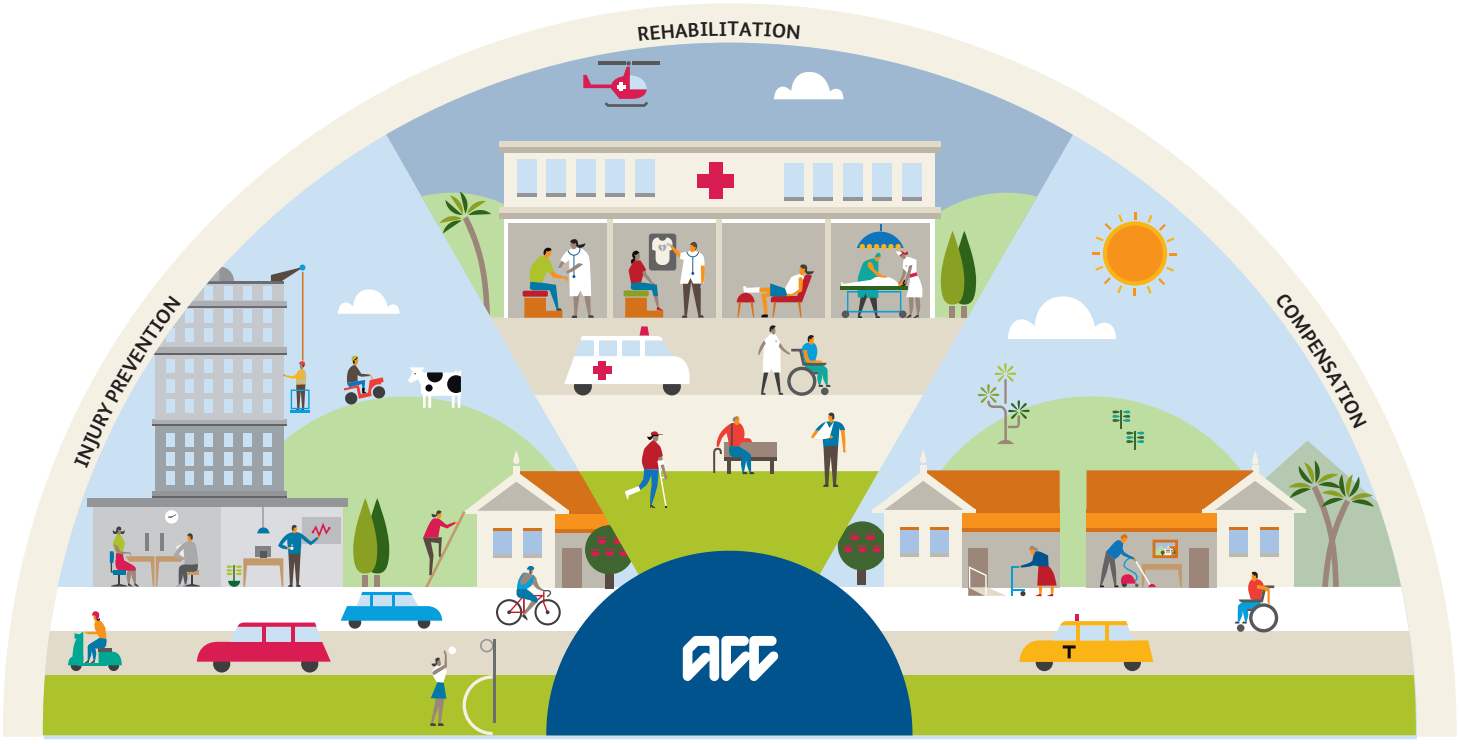
We developed this module's content and discussion session format in response to feedback from physiotherapists and hand therapists nationwide. It's a requirement of the ACC Physiotherapist and Hand Therapist Services contract to complete this module. It also provides you with a useful tool to consider if your client has an injury that ACC may cover.

The session qualifies for professional development, so once you've completed it please take the time to sign and submit the acknowledgement on page 11.

How the session works

In this session you'll work as a group with a facilitator – a senior physiotherapist or hand therapist. Using case studies of injured clients (see pages 6 to 10), you'll answer six questions for each one, with the aim of deciding whether those clients' injuries are likely to be covered by ACC.

In working through the questions, it's important to note that it can be challenging to assess a complex case – and often there's no clear-cut answer. The key is to consider all the factors for or against an accident being the cause of the injury.



Let's start

The session will go like this:

- Individually, you'll read one of the case studies on pages 6 to 10.
- As a group you'll discuss the following six questions in order, using the case study and the information provided with the questions to decide whether the case study client is likely to qualify for ACC support.
- You'll repeat the above process for the remaining case studies. If there's not enough time for this, you might like to do the exercise on your own.

Question 1: Does the client have a personal injury?

To be covered by ACC, the client must have a personal injury caused by an accident or a work-related gradual process, disease or infection.

The Accident Compensation Act 2001 defines **personal injury** and **accident**, and the **link between a personal injury and an accident**. This first question asks you to use the Act's definitions to consider whether the client in the case study has a personal injury.

Under the Act, a personal injury is:

- a physical injury/s suffered by a person
- a mental injury suffered by a person that's secondary to a physical injury/s
- a mental injury suffered by a person that's caused by certain criminal acts
- damage (other than wear and tear) to dentures or prostheses that replace a part of the human body
- a physical injury/s suffered as a result of treatment from a registered health professional (a 'treatment injury')
- the death of a person.

ACC does not cover injuries caused wholly or substantially by:

- gradual processes, diseases or infections that are not work related
- the ageing process
- pre-existing developmental/biomechanical factors.

Question 2: Did the client have an accident?

This question asks you to consider whether the client had an accident, as defined by the Accident Compensation Act.

Under the Act, an accident:

- involves the application of force or resistance external to the human body, or a sudden movement of the body to avoid a force or resistance
- is not a gradual process, disease or infection (unless it's work related)
- can be a specific event that's clearly identifiable, occurs at a precise point in time and meets the above two criteria

OR

- can be series of events that arises from a clearly identifiable repetitive action in a defined short period of time (usually less than 48 hours), which is not a usual action for that person. For example, a person can be said to have had an accident if they spent five hours chopping and stacking their annual consignment of firewood, then woke up the following morning with stiffness and pain.

Question 3: Could the client's injury be due to a work-related gradual process, disease or infection?

This question asks you to consider whether the client has suffered an injury caused by a **work-related gradual process**, **disease** or **infection**.

To be covered by ACC:

- the client must have a personal injury, not just 'pain'
- the personal injury must have been caused or contributed to by an employment task the client was undertaking
- the task can't have been undertaken to any material extent in the client's non-employment activities or environment
- the risk of suffering the personal injury must be significantly greater for people who undertake the employment task than it is for those who don't.

For example, a carpet layer presenting with pre-patellar bursitis would likely be covered as long as their injury wasn't caused by a non-work activity or a known pre-existing disease.

Note that claims for work-related gradual processes, diseases or infections must be lodged by a client's GP. If you suspect that a client's injury is work related, refer them to their GP.

Question 4: Did the accident cause the client's personal injury?

Having considered whether the client has a personal injury and if they had an accident, it's time to consider whether their accident caused the injury.

To answer this question, you need to establish a causal link between the accident and the injury. This involves considering seven factors:

1. Timeframe: How much time has passed between the accident and the client's first presentation for assessment? If there's been a significant delay in their seeking treatment, what are the reasons?
2. Mechanism of injury: What was the degree and type of force involved in the accident? What were the initial consequences as described by the client? How have those signs and symptoms evolved since the accident?
3. Past history: What's the client's relevant medical history, including comorbidities, past medical history and family history? What's their relevant occupational history, including work, sporting activities and hobbies?
4. Initial presentation: What are your objective findings at the initial presentation, including the findings of a clinical examination and specific tests?
5. Imaging: Is relevant imaging available? What are the findings?
6. Progression of condition: Is there a revised diagnosis and what information influenced it? Does the history you've taken align with earlier histories taken by other providers? How do the current examination findings compare with the initial assessment findings?

7. Natural history: What's the natural history of the condition, including background prevalence, demographics and the nature/quality of evidence?

Question 5: On balance, do you think there's a causal link between the accident and the injury - could the client qualify for ACC support?

Weigh up your answers in relation to the seven factors in question 4 to determine if there's a causal link between the client's accident and their injury.

If the client has persistent symptoms over time, is the causal link ongoing or is there a cut-off point for the accident-injury link? This is important to consider, as ACC support continues only as long as ongoing symptoms are caused by the covered injury.

Question 6: What information should be included in your clinical notes?

Once you've answered the questions and established whether the client might qualify for ACC cover, it's important to document your thinking process in your clinical notes. This will provide both a written justification for your decision, and important information for ACC (see www.acc.co.nz/for-providers/provide-services/understanding-your-responsibilities).

What key information would you expect to document?

Case studies

Case study 1: Steve – a sore wrist

Steve presents to your clinic with pain and a crackling sensation in his right wrist. The pain has worsened in the past couple of weeks but he's not sure why – maybe it was the heavy lifting he did in his garden a couple of weeks ago. The pain gets worse when he lifts and carries objects.

Steve is 56 years old and works as an accountant for a large firm. He reports that:

- he has no pain in his neck, shoulder, elbow or left wrist
- he's sleeping well, but wakes in the morning with wrist stiffness
- he's coping reasonably well at work, although the pain means he's not enjoying golf as much as he would normally
- he's generally in good health and doesn't normally take medications (in the past couple of days he's taken paracetamol)
- two years ago he broke a bone in his wrist. He didn't have surgery and he thinks his wrist was in a cast for a couple of weeks. He remembers his wrist was sore and stiff for quite a long time after the original accident.

Steve's GP recently ordered an X-ray and he has brought the report to the assessment. He has joint space narrowing, osteophyte formation and subchondral sclerosis at the radio-carpal joint. The report indicates a history of intra-articular distal radius fracture.

Examination and testing reveals:

- a small amount of swelling over the wrist, and tenderness over the radio-scaphoid joint on the right
- a loss of wrist flexion, extension, ulnar deviation and radial deviation. Steve reports that each of these movements is painful at the end of movement
- full and pain-free motion of the elbow, shoulder, neck and left wrist
- a grip strength of 38 kilograms on the right, with pain, and 45 kilograms on the left pain-free.

What's your provisional diagnosis, based on Steve's history and radiology and your examination findings?

Case study 2: Jane – a sore wrist

Jane is 67 years old and presents to your clinic on referral from a GP and on a friend's recommendation. She reports aching through her right wrist and fingers, and says she's always had 'bad wrists' but in the past couple of months the pain in her right wrist has worsened. She says she has some low back, neck, knee, shoulder and left wrist pain. However, her right wrist is causing her the most trouble – in the past couple of months she's found it painful to lift shopping bags out of the car and weed in the garden, and the wrist aches at night and when it's cold.

Jane lives at home with her husband. She enjoys gardening, shopping and aqua-jogging. She reports good health, although she had lumbar surgery 10 years ago. She remembers hurting her wrist about five years ago, when she was rolling cheese rolls for a local kindergarten fundraiser. On further questioning, she says she may have seen a physiotherapist about it once or twice, but it wasn't that bad and seemed to come right on its own.

The GP referral notes that Jane has a diagnosis of wrist osteoarthritis, and a GP-ordered X-ray indicates that she has significant joint space narrowing, osteophyte formation and subchondral sclerosis at the radio-carpal joint.

Examination and testing shows:

- swelling and tenderness throughout the wrists and fingers bilaterally, with the right being worse than the left
- a loss of wrist movement bilaterally right > left. Jane reports pain at the end of each movement
- full and pain-free motion of the elbow
- some stiffness with both shoulder and neck movement
- a grip strength of 15 kilograms on the right, with pain, and 18 kilograms on the left.

What's your provisional diagnosis based on Jane's history and radiology and your examination findings?

Case study 3: Anne – hip/groin pain

Anne is a 36-year-old lawyer. She enjoys Pilates and dance classes at the local gym and was once a competitive gymnast.

Anne has right-sided groin pain, which began two weeks ago when she was doing a squatting exercise at the gym. She thought the pain would ease but it hasn't; if anything it's worsened. She's been able to continue in the Pilates and dance classes, but feels a pinching in her groin when she lunges and squats. She also reports pain when getting out of the car and aching when she sits or drives for an extended time.

Anne can't recall any previous history of hip or groin injury. She's fit and healthy, takes no medications and has no previous history of surgery.

Examination and testing shows that:

- Anne has pain in the right groin with end-range squat
- the FABERs and quadrant tests are restricted and cause pinching pain in the groin
- there's pain with end-range flexion and a painful loss of internal and external rotation when compared with the left hip, which is pain-free
- there's no swelling or significant tenderness.

What's your provisional diagnosis based on Anne's history and radiology and your examination findings?

Case study 4: Jack – R knee pain

Jack is a 22-year-old student surveyor. He presents to your clinic with R knee pain, intermittent swelling and giving way in his knee.

Jack says that three years ago his knee "blew up" in a basketball game. He remembers jumping up for a rebound then landing strangely, and his knee felt as if it had exploded. He went to his physiotherapist, saw an orthopaedic surgeon and had an MRI, and was diagnosed with an ACL rupture. Jack says the surgeon wanted to do a knee reconstruction, but he wasn't keen at the time as he was about to go on a three-month holiday to Europe with his girlfriend.

Jack indicates that while his knee settled down a bit in the next few months, it was never quite the same. He has tried jogging and some "gym work" but hasn't been able to manage exercise consistently as his knee just can't take it.

Two weeks ago he went to the gym and played basketball with a couple of mates, but he had to stop after a few minutes because of his knee.

Jack says he has mild asthma for which he occasionally takes Ventolin, but otherwise he's well and takes no other medications.

Examination and testing reveal:

- a clear loss of muscle bulk in the quadriceps, calf and gluteals on the right side
- anterior knee pain with end-range squatting, single knee bends and hopping
- pain with end-range knee flexion and end-range extension, and a small loss of knee extension
- a small amount of medial knee swelling
- positive anterior drawer
- positive Lachman's test
- medial joint line tenderness
- positive McMurray's test medially.

What's your provisional diagnosis based on Jack's history and radiology and your examination findings?

Case study 5: Sam – L knee pain

Sam is a 27-year-old architect from Canada. He reports L knee pain, swelling and giving way.

Sam recalls a massive knee injury 10 years ago, before he came to New Zealand, which required an ACL reconstruction and meniscal repair. He remembers having physiotherapy for about a year after the surgery, but the knee has never been the same as it was before the injury. It often aches and it gives way when he does anything vigorous.

Three months ago Sam twisted his knee while playing touch rugby. He experienced severe knee pain, his knee gave away and it swelled up for a couple of days. After a couple of weeks the knee settled down but it continues to niggle.

Sam's workmates have been urging him to re-join their touch team, but Sam says he doesn't want to stuff up his knee again.

Examination and testing show:

- post-surgical scars on the right knee and a loss of muscle bulk in the quadriceps, calf and gluteals on the left side
- anterior knee pain with end-range squatting, single knee bends and hopping
- pain with end-range knee flexion and end-range extension, with a small loss of knee extension
- a small amount of medial knee swelling
- positive anterior drawer
- positive Lachman's test
- medial joint line tenderness
- positive McMurray's test medially.

What's your provisional diagnosis based on Sam's history and radiology and your examination findings?

Case study 6: Ruth – R shoulder pain

Ruth works as a shelf stacker at her local supermarket. She's 61 years-old, is a keen tennis player and swims occasionally for fitness.

After a smash shot during a game of tennis, Ruth felt pain in her right shoulder. She was able to finish the game despite the pain, but presents to your clinic 10 days later reporting pain when stacking high shelves at work, and some difficulty sleeping. She has had the odd niggle in both shoulders in the past, but no significant injuries.

Examination, testing and X-rays show:

- a full range of movement, but with a painful arc on abduction
- positive impingement testing

- pain/catching on abduction at 110 degrees
- no tenderness over the acromioclavicular (AC) joint, but some arthropathy in the joint and non-specific tenderness over the shoulder
- no demonstrable weakness
- no abnormality of the cervical spine, elbow or wrist/hand
- cortical irregularity
- a minor cystic change of the anterior greater tuberosity of the humerus
- a five-millimetre spur acromial spur.

Ruth's shoulder pain resolves within the next two months, except for the odd occasion when she's stacking high shelves for long periods of time.

Six months later, Ruth falls down two steps in her garden and breaks her fall with her right arm outstretched. She immediately feels pain in the right shoulder region and takes some paracetamol to ease it. She comes to see you after three days off work due to the pain and an inability to lift her arm.

Examination and testing show:

- difficulty in initiating abduction
- an inability to lift the arm beyond 45 degrees of abduction
- rotator cuff testing is significantly limited by pain
- no tenderness over the AC joint
- no peripheral signs of nerve or vascular damage
- a full and pain-free range of movement in the neck.

What's your provisional diagnosis based on Ruth's history and radiology and your examination findings?

Acknowledgement

Practice name:

Provider name:

Provider number:

Signature:

Date: D M Y

Ensure your practice has a signed copy of this acknowledgement.

Disclaimer

All information in this publication was correct at the time of printing. This information is intended to serve only as a general guide to arrangements under the Accident Compensation Act 2001 and regulations. For any legal or financial purposes this Act takes precedence over the contents of this guide.

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