

ACCIDENT SERVICES – WHO PAYS?

**The Impact of the Injury Prevention, Rehabilitation, and
Compensation Act 2001 on District Health Boards**

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July 2002

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Foreword

This guide has been developed by the Accident Compensation Corporation (ACC) and the Ministry of Health for health and disability providers working in the public hospital and health services sector. Its purpose is to provide information that will assist these providers to determine which agency is responsible for purchasing treatment, rehabilitation and related services required by an injured person, for personal injury for which that person has cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001.

This guide replaces *Accident Services – Who Pays?*, Edition One and Edition Two (July 1999, March 2001) and *Purchasing ACC Treatment Services*, Edition One and Edition Two (1998, 1998).

ACC administers New Zealand's accident compensation scheme, which provides personal injury cover for all New Zealand citizens, residents and temporary visitors to New Zealand. In return people do not have the right to sue for personal injury.

The Injury Prevention, Rehabilitation, and Compensation Act 2001 is the principal Act under which ACC operates (see Appendix A for a definition of terms and key sections of this Act). While this Act came into force on 1 April 2002 the main impact on the purchasing of public health acute services occurred from 1 July 2002 when:

- New purchasing arrangements for public health acute services applied (ie ACC purchases these services through the Minister of Health under a Service Agreement between the Minister for ACC and the Minister of Health).
- Services included in 'public health acute services' are the services specified in the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 (see Appendix B).
- ACC no longer purchases directly from Community Trust Hospitals, any services that are specified in regulations as being 'public health acute services'. ACC and the Ministry of Health have agreed that all acute services will again be funded as part of the public health acute services payment and therefore Community Trust Hospital acute services became a Ministry of Health/DHB responsibility from 1 July 2002.

The Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 which came into effect on 1 July 2002, include the services listed in

s.14(2) of the Accident Insurance Act 1998 with the following key changes:

- Includes a definition of 'outpatient'.
- Excludes nurse-led outpatient clinics.
- Clarifies that referrals from community registered medical practitioners to DHB/Community Trust Hospital radiologists are excluded from public health acute services.
- Clarifies that ancillary services including travel and accommodation for claimants, escorts, and support persons are part of public health acute services.
- Clarifies that services related to provision of public health acute treatment (such as consumables and short-term loan equipment) are part of public health acute services.

Appendix C provides a summary of the impact of the Injury Prevention, Rehabilitation, and Compensation Act 2001 on the purchasing of public health acute services between 1 April 2002 and 1 July 2002.

Accredited employers will continue to manage their employees' work-related personal injury claims under the terms of the ACC Partnership Programme, which is also outlined in this guide.

This guide does not attempt to provide a solution to resolving issues relating to the accident/illness boundary, as these usually relate to clinical judgements around individual cases. However, there is guidance for hospitals and ACC to resolve some boundary issues, particularly in respect of the move from acute medical treatment to rehabilitation. The guiding principle in such cases is for treatment to continue until these boundaries are defined.

Ministry of Health contact details

- Ministry of Health, PO Box 5013, Wellington, phone 04 496 2000, fax 04 496 2340.
Website: www.moh.govt.nz

ACC contact details

- ACC Corporate office, PO Box 242, Wellington, phone 04 918 3975, fax 04 918 3975. Website: www.acc.co.nz
- Northern medical fees (covers all of the North Island from Horowhenua north), PO Box 90341, Auckland Mail Centre, phone 09 915 8300, fax 09 915 8301
- Southern medical fees (covers the area from Kapiti south and all of the South Island), PO Box 408, Dunedin, phone 03 417 9000, fax 03 471 9847

- The ACC Provider Helpline 0800 222 070
- Medical misadventure claims 0800 735 566
- Sexual abuse claims (sensitive claims) 0800 735 566

Disclaimer

This information is intended to serve only as a general guide to purchasing arrangements under the Injury Prevention, Rehabilitation, and Compensation Act 2001 and regulations. For any legal or financial purposes, this Act, and contractual arrangements between funders and providers, take precedence over the contents of this guide.

CONTENTS

1	INTRODUCTION	7
1.1	Purpose	7
1.2	Definitions	7
1.3	Legislative provisions	10
1.4	Payment arrangements for DHB services	11
1.4.1	DHB purchasing arrangements	12
1.4.2	Purchasing arrangements for non-public health acute services	13
1.4.3	User part-charges	16
1.5	Coverage	17
1.5.1	Who is covered?	17
1.5.2	What is covered?	18
1.5.3	Who manages injury claims?	19
2	GENERAL CATEGORIES OF SERVICE	20
2.1	Public health acute services	21
2.2	DHB acute admissions	21
2.3	Elective admissions	22
2.4	DHB emergency department attendances	23
2.5	DHB outpatient services	24
2.5.1	Medical follow-up from public health acute services	24
2.5.2	Medical referrals	25
2.5.3	Other	25
2.6	DHB community services	26
2.7	Community-based (or non-hospital) treatment and rehabilitation services	27
2.7.1	Acute treatment	27
2.7.2	Other rehabilitation (including non-acute treatment)	28
3	SPECIFIC SERVICES	30
3.1	Fracture treatment and removal of metal (ROM)	30
3.2	Hyperbaric oxygen treatment	30
3.3	Dental treatment	30
3.4	Treatment for concurrent medical conditions	31
3.5	Treatment complications requiring acute admission to a public hospital	32
3.6	Blood and blood products	32
3.7	Medical consumables	32
3.8	Rehabilitation and disability support services	33
3.9	Elderly victims of crime	34
3.10	Non-acute inpatient rehabilitation	34
3.11	Equipment (aids and appliances)	35
3.11.1	Short-term loan equipment	35
3.11.2	Long-term or permanent equipment (eg. wheelchairs)	36
3.11.3	Orthotics	36

3.12	Artificial limbs and eyes	37
3.13	Other prostheses	37
3.13.1	Implants	37
3.13.2	External prostheses	37
3.14	Hearing aids	37
3.15	Fertility services	38
3.16	Respite services (carer support)	38
3.17	Transport and accomodation	38
3.17.1	Emergency transport	38
3.17.2	Non-emergency travel and accomodation assistance	39
3.17.3	Escort costs	40
3.17.4	Support person costs	40
3.17.5	Table 3: Summary of agency responsibility for determining travel/transport assistance	42
3.18	Pharmaceuticals	43
3.19	Laboratory services	44
3.20	Radiology services	44
3.21	Treatment provided by Community Trust Hospitals	45
3.22	Mental health services	45
3.23	Sexual assault services	48
4	ADMINISTRATIVE PROCESSES	49
4.1	Notification	49
4.2	Forms and invoicing	49
4.3	Prior approvals	50
4.4	ACC payment arrangements and prior approval requirements	50
4.5	Discharge planning	52
4.6	Information supply and coding	55
4.6.1	Public health acute services	55
4.6.2	National Minimum Data Set (NMDS)	55
4.6.3	Codes used on ACC forms	56
4.7	Audit and monitoring	57
4.8	When other providers have initiated claims	57
5	PROCESS FOR RESOLVING HEALTH/ACC BOUNDARY ISSUES	58
Appendix A		60
	Definitions of Terms in the Injury Prevention, Rehabilitation, and Compensation Act 2001	60
Appendix B		69
	Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 (2002-71)	69
Appendix C		73
	Public health acute services: 1 April 2002 to 30 June 2002	73

Appendix D	75
Clinical criteria for transfer from acute to non-acute inpatient rehabilitation	75
1. Generic criteria	75
2. Specific clinical criteria	76
Clinical team agreement to transfer care	77
Appendix E	78
Clinical criteria for transfer from a non-acute inpatient rehabilitation to a community setting	78

1 INTRODUCTION

1.1 PURPOSE

This guide helps determine whose responsibility it is to pay for services provided to injured persons who have cover for personal injury under the Injury Prevention, Rehabilitation, and Compensation Act 2001.

It is addressed mainly to District Health Boards (DHBs) which arrange the provision of some services purchased for ACC claimants through the Minister of Health's funding arrangements for public health acute services, and others that are purchased directly through arrangements with the Accident Compensation Corporation (ACC)¹.

Section 1 outlines the **key issues** arising from the Injury Prevention, Rehabilitation, and Compensation Act 2001.

Section 2 defines **services that** the Ministry of Health and ACC have a responsibility to purchase for injured persons.

Section 3 covers examples of **specific services** that often require clarification.

Section 4 describes key **administrative processes** to be used by DHBs in relation to the services purchased through the Minister of Health's funding arrangements for public health acute services, on behalf of ACC.

Section 5 outlines the **disputes resolution** process for ACC/Health boundary issues.

1.2 DEFINITIONS

Throughout this document the following terminology is used:

ACC – the Accident Compensation Corporation, is the Crown entity responsible for providing treatment, rehabilitation and other entitlements for claimants with personal injury for which they have cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001. ACC makes payments to the Crown to enable the Minister of Health to arrange the purchase of 'public health acute services', and by directly purchasing treatment and rehabilitation services that are not part of public health acute services.

Accredited employer – an employer (or group of companies) who, after meeting defined criteria, has signed a contract with ACC to become part of the ACC Partnership Programme. The accredited employer accepts responsibility for managing and directly funding most of the statutory entitlements of their employees who suffer a work-related personal injury. *ACC remains liable for making payments to the Crown for the costs of public health acute services required by these employees.*

¹ There may also be some arrangements with accredited employers.

Acute admission – means an admission within seven days of the making of the decision to admit unless otherwise specified in regulations. (See s.74(4) in Appendix A).

Acute treatment is defined in s.7 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see Appendix A) and, in relation to an injured person, means:

- the first visit to a treatment provider for treatment for a personal injury for which the injured person has cover
- further visits to that first treatment provider for the same injury if, in the treatment provider's reasonable clinical judgement, the need for the treatment is urgent (given the likely clinical effect on the patient of any delay in treatment)
- referral by the first treatment provider to another provider for that same injury, if the first provider believes the referred treatment is urgent (given the likely clinical effect on the patient of any delay in treatment).

Ancillary services regulations – the Injury Prevention, Rehabilitation, and Compensation (Ancillary Services) Regulations 2002, which specify the contribution towards the cost 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.

District Health Board (DHB) – organisations established under s.19 and named under Schedule 1 of the New Zealand Public Health and Disability Act 2000.

Injured person or **Patient** or **Claimant** – a person who has cover for a personal injury, under the Injury Prevention, Rehabilitation, and Compensation Act 2001.

Minister of Health's funding arrangements for public health acute services – the term used in this document to refer to the arrangements whereby public health acute services for accident patients are purchased through the Minister of Health's funding arrangements with DHBs and other publicly funded providers (such as Community Trust Hospitals) for the provision of these services. The Minister of Health funds these services from the payments that ACC makes to the Crown for this purpose.

Outpatient is 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 registered 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 registered medical practitioner intends that the person will leave the facility within three hours after the consultation begins.

Pharmaceutical is defined in s.6 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 to mean –

- (a) a prescription medicine, a restricted medicine, or a pharmacy-only medicine, as listed in Parts I, II, and III of the First Schedule of the Medicines Regulations 1984; or
- (b) a controlled drug as defined in the Misuse of Drugs Act 1975.

Public Hospital – sometimes used instead of DHB to distinguish the hospital provision function.

Public health acute services is defined in s.6 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 as follows: means services (as defined in regulations made under s.322(2)) that are purchased through the Minister of Health and provided by a publicly funded provider. The hospital treatment services covered by this definition are outlined in section 2.

Public health acute services regulations – means the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002, which specify the services included in public health acute services (see Appendix B).

Publicly funded provider – means a provider that, for the time being, is funded by a district health board or the Minister of Health to provide public health acute services.

Rehabilitation is defined in s.6 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 as follows:

- (a) means a process of active change and support with the goal of restoring, to the extent provided under s.70, a claimant's health, independence, and participation; and
- (b) comprises treatment, social rehabilitation, and vocational rehabilitation.

Sensitive claims event – means certain criminal acts (ie, sexual assault) that are described in Schedule 3 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see Appendix A).

Service Agreement – means the current Service Agreement for the Purchase of Public Health Acute Services, Primary-referred Pharmaceuticals and Laboratory Tests between the Accident Compensation Corporation (by and through the Minister for Accident Insurance under s.301 of the Injury Prevention, Rehabilitation, and Compensation Act 2001) and the Minister of Health (on behalf of the Crown).

Treatment costs regulations – the Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999, and its amendments, which specify the contribution towards the cost of treatment that must be made by ACC and accredited employers.

Treatment providers – a range of health providers recognised in the Injury Prevention, Rehabilitation, and Compensation Act 2001 as able to provide acute treatment for personal injuries (see section 2.7 and Appendix A).

1.3 LEGISLATIVE PROVISIONS

The Injury Prevention, Rehabilitation, and Compensation Act 2001 came into force on 1 April 2002. This new legislation replaces the previous Accident Insurance Act 1998 and its amendments.

Main features of the Injury Prevention, Rehabilitation, and Compensation Act 2001

The main features of the Injury Prevention, Rehabilitation, and Compensation Act 2001 are listed below:

- The purpose of the Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury.
- The Act has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs).
- A primary function of ACC is the promotion of measures to reduce the incidence and severity of personal injury.
- Where injuries occur, ACC's primary focus should be on rehabilitation (treatment, social and vocational) with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence, and participation.
- Fair compensation for loss from injury, including fair determination of weekly compensation and, where appropriate, lump sums for permanent impairment.
- A Code of ACC Claimants' Rights to ensure positive claimant interactions with ACC.

Public health acute services

'Public health acute services' required to treat a claimant's personal injury for which he or she has cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001 are purchased through the Minister of Health and provided by DHBs and other publicly funded providers. These services are publicly funded through Vote: Health.

The Crown recovers these costs from ACC through bulk payments made under a Service Agreement between the Minister of Health and the Minister for ACC. The Injury Prevention, Rehabilitation, and Compensation Act 2001 prohibits ACC from purchasing these services directly from DHBs or other publicly funded providers.

Services included in 'public health acute services' are specified in regulations made under s.322(2) of the Injury Prevention, Rehabilitation, and Compensation Act 2001. These regulations came into force on 1 July 2002 (see Appendix C for information about arrangements for the purchase of public health acute services between 1 April 2002 and 1 July 2002).

ACC is responsible for directly purchasing any services outside public health acute services for which a claimant is entitled in respect of a personal injury for which they have cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001. ACC can purchase services from the provider of their choice, including DHBs and Community Trust Hospitals.

Requirements on providers of public health acute services

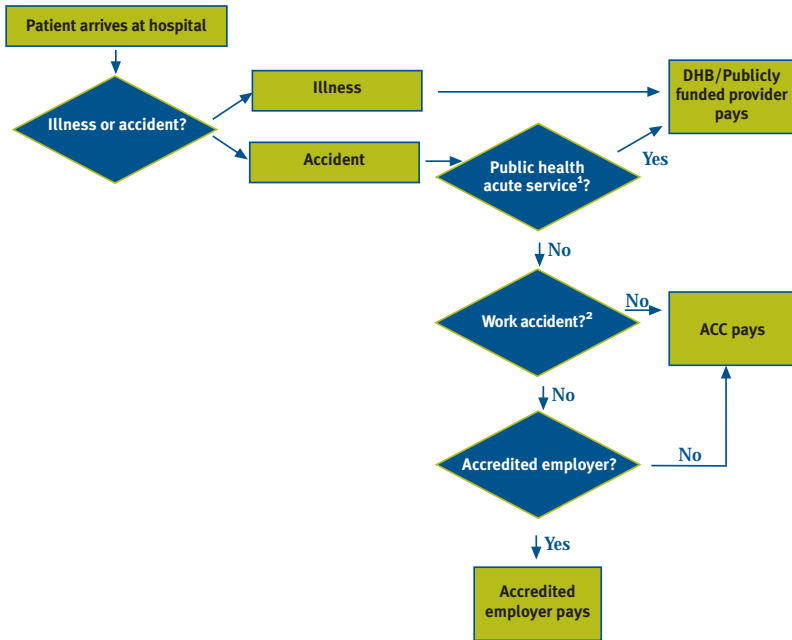
DHBs and other publicly funded providers need to be able to:

- identify and track service provision for people who are being treated under multiple purchasing arrangements
- complete the appropriate claim forms – ie, an ACC 45 for all ACC or accredited employer patients
- invoice ACC (or accredited employer) for treatment that is not included within the definition of public health acute services.

1.4 PAYMENT ARRANGEMENTS FOR DHB SERVICES

The following diagram illustrates payment arrangements for services provided by DHBs. The diagram covers all services, including electives.

Figure 1: Payment arrangements for services provided by DHBs



- 1 *'Public health acute services' are services (as defined in regulations made under section 322(2)) that are purchased through the Minister of Health and provided by a publicly funded provider (see section 2).*
- 2 *Private insurers covered work-related personal injury claims suffered during the period 1 July 1999 to 30 June 2000. These insurers are still liable to cover the costs of these claims.*

1.4.1 DHB purchasing arrangements

The amount that ACC pays to the Crown for public health acute services is agreed in a Service Agreement between the Minister of Health and the Minister for ACC (rather than being set in regulations, as previously occurred). The Service Agreement:

- provides for the payment of money to the Crown in return for the Minister of Health:
 - funding the provision of public health acute services and primary referred pharmaceuticals and laboratory tests; and
 - arranging the funding of that provision; and

- provides how the Minister of Health's implementation of the agreement is to be monitored; and
- contains the terms and conditions that the Minister of Health and the Minister for ACC agree on; and
- specifies service levels for the delivery of such services; and
- specifies the level of payment from ACC to the Crown; and
- specifies the mechanism for calculating the sum payable by ACC and the method of payment.

The Minister of Health enters into Crown Funding Agreements with DHBs to ensure that ACC claimants receive 'public health acute services' through them. The DHB arranges for these services to be provided and funds them with Crown money.

1.4.2 Purchasing arrangements for non-public health acute services

When a DHB provides treatment services that fall outside 'public health acute services', the DHB must invoice ACC or the accredited employer.

The cost of treatment payable by ACC for these non-public health acute services, for claimants entitled to receive assistance from ACC with the cost of their treatment, is an amount:

either

(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-public health acute treatment, ACC is liable to pay the amount specified in the contract or agreement with the provider for the service. Such contracts between ACC and DHBs include elective services and High Tech Imaging services.

or

(b) Specified in Treatment cost regulations

Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999 ('Treatment costs regulations'), covering the costs of treatment provided by counsellors, dentists, radiologists, registered medical practitioners (including registered specialists), specified treatment providers (see section 2.7) or practice nurses, or services such as hyperbaric oxygen treatment or elective surgery where these are not provided for by contract;

or

(c) Cost of treatment

ACC is liable to pay the cost of treatment for eligible claimants when the non-public health acute treatment has been provided by a 'treatment provider' (see section 2.7), and there is no contract or agreement or regulations that specify the amount ACC must pay. Such services include acute treatment provided by occupational health nurses and independent nurse practitioners.

ACC is not liable to pay for any services provided by other types of health care providers (eg, dietitians, neuro-developmental therapists), 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 4.3).

Treatment conditions

The Injury Prevention, Rehabilitation, and Compensation Act 2001 states that the purpose of treatment is to restore a claimant's health to the maximum extent practicable: (see Appendix A for the Act definition of 'practicable').

ACC is not liable to pay for any treatment unless it meets the following treatment conditions in relation to that purpose²:

- treatment is necessary and appropriate for that purpose; and
- treatment is of the quality required for that purpose; and
- treatment is provided only as often as necessary for that purpose; and
- treatment is provided at a time or place appropriate for that purpose; and
- treatment is of a type of treatment normally provided by a treatment provider; and
- treatment is provided by a treatment provider of a type who is qualified to provide that treatment; and
- treatment is provided by a treatment provider who normally provides that treatment; and
- treatment has been provided after ACC has agreed to the treatment, except in certain cases (see prior approval below).

When deciding if the treatment conditions are met in relation to a particular claimant's treatment, ACC must also take into account:

- the nature and severity of the injury; and
- the generally accepted means of treatment for such an injury in New Zealand; and
- the other options available in New Zealand for the treatment of such an injury; and

² As set out in Clause 2 of Schedule 1 of the Injury Prevention, Rehabilitation, and Compensation Act 2001

- 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.

Prior approval

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

- acute treatment; or
- a public health acute service; or
- of a type specified in regulations made under the Act as treatment that does not require ACC's prior approval; or
- 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 the treatment provider.

ACC may seek professional opinion to validate patients' treatment conditions.

Contracts

ACC may enter into direct contractual arrangements with DHBs for specified elective services, or any other treatment that is not included in public health acute services. However, ACC is prohibited by the Injury Prevention, Rehabilitation, and Compensation Act 2001 (s.303) from entering into contracts for public health acute services with DHBs or other providers.

Agency arrangements

ACC and their agents may use other organisations to purchase services on their behalf, eg, third party administrators or other agencies that purchase treatment services.

In some instances, the Ministry of Health may act as an agent and purchase services that are non-public health acute services on behalf of ACC or accredited employers. Any services purchased by the Ministry of Health as an agent of ACC will be specified as such in this guide.

Payments

Payments by ACC for treatment that is not included in public health acute services may be made on the basis of one of the following:

- A contract or agreement between ACC and the provider, covering a specified service.
 - A claim against payment schedules specified in the Treatment costs regulations.
-

- The cost of service if not covered by any of the above arrangements (including negotiated one-off agreements between ACC and the provider, covering individual cases).

1.4.3 User part-charges

In certain circumstances, DHBs may charge the injured person an amount over and above the amount that ACC pays. The Injury Prevention, Rehabilitation, and Compensation Act 2001, the New Zealand Public Health and Disability Act 2000 and the funding arrangement between the Minister of Health and the DHBs specify the circumstances under which user part-charges may be made. The following table shows the services for which providers may charge injured people.

Table 1: Services for which DHBs may part charge injured people

Type of Service	Type of Provider	
	DHB hospital	Non-DHB hospital
Public health acute services – as specified in the Public health acute services regulations (see Appendix B)	The user part-charge conditions specified in the Service Agreement and relevant Crown Funding Agreement apply.	Not applicable.
Non-public health acute services provided by a ‘treatment provider’ (see section 2.7)	User part-charges may be payable by the injured person, being the difference between the amount payable under the Treatment costs regulations and the treatment providers’ total cost for providing the services.	
	But, if the amounts are <i>not</i> specified in the Treatment costs regulations, ACC must pay the provider the cost of treatment, and therefore no user part-charges can be raised.	
Ancillary services related to treatment that is not included in public health acute services (eg, pharmaceuticals, ambulance services, and escort costs)	ACC pays or contributes to the cost of ancillary services when reasonably required to facilitate a claimant’s rehabilitation. If the service is transport or accommodation ACC pays the amount specified in the Ancillary services regulations (which may be an amount agreed in a contract with a provider).	
	<u>Ambulance services</u> : ACC purchases emergency and non-emergency ambulance services under contract, and user part-charges cannot be applied by the provider.	

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Type of Service	Type of Provider	
	DHB hospital	Non-DHB hospital
	<p><u>Escort costs:</u> the Ancillary services regulations prescribe the amount ACC must pay towards escorts costs, when a claimant requires an escort. The contracted price ACC pays for an ambulance service includes the cost of crewing and medical/nursing escorts required, and user part-charges cannot be applied by the provider.</p>	
	<p><u>Pharmaceuticals:</u> ACC makes bulk payments for pharmaceuticals under an agreement with the Minister of Health. ACC reimburses claimants for user part-charges on pharmaceuticals related to non-public health acute treatment.</p>	
Elective surgery (see section 2.3)	<p>No user part-charge may be made as the hospital is either the provider nominated by ACC, or, if not the nominated provider, the DHB is able to charge ACC the cost of surgery.</p>	<p>If the provider is nominated by ACC, then no user part-charge may be made. If the private hospital is not the 'nominated' provider, user part-charges are payable. The part-charge is the difference between the cost of the treatment and 60% of the price ACC would have paid a nominated provider.</p>

Where a contract for a service exists, any contractual conditions on user part-charges take precedence over the above chart. A refundable deposit may be charged for services, such as supply or loan of equipment. Such deposits are not considered to be a user charge.

1.5 COVERAGE

1.5.1 Who is covered?

New Zealanders

All New Zealanders who are 'ordinarily resident' in New Zealand are covered by the Act, even if they are injured while temporarily overseas. The meaning of 'ordinarily resident' is defined in s.17 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see Appendix A)³

³ The 'ordinarily resident' test under the IPRC Act 2001 differs from the 'ordinarily resident' test under the 2000 Direction of the Minister of Health Relating to Eligibility for Publicly Funded Personal Health and Disability Services

Overseas visitors and foreign diplomats

Overseas visitors are covered for personal injury that they suffer once in New Zealand. They are considered to be in New Zealand once they disembark from the aircraft or boat bringing them to New Zealand.

The Minister of Health's funding arrangements for public health acute services extends to overseas visitors and foreign diplomats who have ACC personal injury cover. All overseas visitors and foreign diplomats who sustain any type of personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001 have the same entitlement to public health acute services as New Zealand residents. They cannot be directly charged for any public health acute service although they must meet the same part-charges as any New Zealander for other services.

ACC is responsible for purchasing all other accident-related non-public health acute services provided by DHBs to overseas visitors and foreign diplomats, such as elective surgery, allied services and district/community nursing services.

The only situations where a DHB can directly invoice an overseas visitor for acute hospital services and the patient is not otherwise eligible for treatment are when:

- the overseas visitor declines to lodge a claim with ACC; or
- ACC does not accept the injury as covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, for example, because:
 - the injury occurred while on board (including embarking or disembarking) a ship, aircraft or other means of conveyance when travelling to, around, and from New Zealand (s.23 of the Act)
 - the injury did not occur in New Zealand (as defined in s.16 of the Act).

1.5.2 What is covered?

People who sustain a personal injury by way of accident – whether in the home, at recreation, on the sports field, on the road or at work – or in certain other circumstances, may be eligible for treatment, other forms of rehabilitation, and compensation entitlements.

There are several key terms used in defining coverage under the Injury Prevention, Rehabilitation, and Compensation Act 2001, namely 'accident', 'personal injury' and 'work-related personal injury'. Personal injury cover now includes damage (other than wear and tear) to dentures or prostheses that replace a part of the human body (other than hearing aids, spectacles, or contact lenses).

The Injury Prevention, Rehabilitation, and Compensation Act 2001 also contains details of the cover provided for particular types of personal injury and circumstances, for

example, New Zealanders injured overseas (s.22), exclusions for visitors while on an aircraft or ship (s.23), specific instances of mental injury covered by ACC (s.21) and medical misadventure (s.32). (For specific sections of the Injury Prevention, Rehabilitation, and Compensation Act 2001 covering these definitions and circumstances see Appendix A.)

DHBs should contact ACC directly if there is any doubt regarding coverage of a particular type of injury, or person, under the Act.

1.5.3 Who manages injury claims?

- (a) ACC manages the claims for all personal injuries from 1 July 2000, including work-related personal injuries, for all employers except those who have been accepted into the Partnership Programme.
- (b) Accredited employers are responsible for managing all work-related personal injuries of their employees which occur from the date of the employer's accreditation (earliest date is 1 July 2000) for a specific time period.

A current list of Accredited Employers is available in the Providers' Resource area of the ACC website: www.acc.co.nz/for-providers/resources/search-for-accredited-employers/

2 GENERAL CATEGORIES OF SERVICE

This section lists the general categories of service provided to injured people and describes the services and payment responsibility. Table 2 gives an introductory overview.

Table 2: Hospital service categories

Service Category	Service Type	Funded by Ministry of Health	Purchased by ACC
DHB hospital admissions (including day cases)	Acute admissions through to discharge from the acute event (home or non-acute services)	✓	
	Elective admissions through to discharge		✓
	Non-acute inpatient or residential rehabilitation services		✓
DHB emergency department attendances (see 2.4)	Initial presentation	✓	
	Subsequent attendance within seven days from initial presentation	✓	
	Subsequent attendance after seven days from initial presentation		✓
DHB hospital outpatient services (see 2.5)	Services provided by registered medical practitioner up to six weeks following discharge from an acute admission or emergency department attendance	✓	
	Services provided by registered medical practitioner post six weeks from discharge from acute admission or emergency department attendance		✓
	Services provided by a registered medical practitioner less than seven days from a referral by another medical practitioner ⁴	✓	
	Services provided by a registered medical practitioner seven days or more from a referral by another medical practitioner		✓
	Elective surgery pre-assessment or post-operation services provided by registered medical practitioner		✓
	Services provided by other health professionals, eg physiotherapy, occupational therapy		✓
	Non-acute outpatient rehabilitation services		✓

Continued over...

⁴ Referrals to radiologists by registered medical practitioners are not included in public health acute services, if the referral is made as part of providing non-public health acute treatment.

Service Category	Service Type	Funded by Ministry of Health	Purchased by ACC
DHB community health services (see 2.6)	District/community nursing services provided after discharge from an acute admission, or emergency department attendance or on referral from a GP		✓
	All other services (eg, physiotherapy, occupational therapy)		✓
DHB Non-hospital treatment services (see 2.7)	Acute services provided by 'treatment providers' (eg, GPs, nurses, physiotherapists, osteopaths, dentists, counsellors, etc), and other rehabilitation services		✓

2.1 PUBLIC HEALTH ACUTE SERVICES

The Injury Prevention, Rehabilitation, and Compensation Act 2001 defines 'public health acute services' to mean services (as defined in regulations made under s.322(2)) that are purchased through the Minister of Health and provided by publicly funded providers.

New regulations specifying the services to be included in public health acute services came into effect on 1 July 2002 (see Appendix B for details).

The following interpretations of ACC legislation (by a working group of ACC and Ministry of Health representatives) are designed to serve as a guide to DHBs and relevant agencies, in determining who pays for particular treatment services provided in public hospitals.

For financial and legal purposes, the Injury Prevention, Rehabilitation, and Compensation Act 2001 and the Service Agreement between the Minister of Health and the Minister for ACC take precedence.

2.2 DHB ACUTE ADMISSIONS

All acute admissions (including day patients) are purchased through the Minister of Health's funding arrangements for public health acute services, and provided by the DHB or other publicly funded provider. An acute admission may be from the emergency department, outpatient department, or a GP/private specialist referral.

Services include all hospital-based treatment required **during the period from admission to discharge**. This treatment covers all associated and related treatment services, including but not limited to:

- trauma management services, including emergency department care and intensive care
- diagnostic support services, eg, diagnostic imaging, laboratory services, audiology, electro-diagnostic imaging, optometry, spirometry and urodynamics

- therapeutic support services, including nursing, allied health, pharmacy, blood transfusion, counselling and interpreter services
- procedures required during the admission, such as skin grafting, internal fixations, tissue repairs, urgent dental treatment
- medical supplies, such as plasters, dressings, incontinence products (for medical consumables required by patients immediately upon discharge see section 3.7)
- aids and appliances required during the admission, such as orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (aids and appliances required upon discharge are discussed in section 3.11).
- hotel services, such as accommodation, food, cleaning
- ancillary services including transport and accommodation (see Table 3 in section 3.17.5)
- administrative support services, such as information systems, clerical support, medical records.

Date of discharge

The date of discharge is the date the patient is discharged from the hospital. A patient returning home 'on leave' from the hospital does not constitute a permanent discharge (eg, weekend leave for a seriously injured patient).

The date of discharge can also be the date of discharge to non-acute services within the hospital setting, for example, from the medical/surgical ward to rehabilitation or residential care (see section 3.10).

For a staged discharge, agreement on funding responsibility may need to be negotiated between ACC (or the accredited employer) and the DHB (see section 4.4).

2.3 ELECTIVE ADMISSIONS

Except for specific purchases outlined in section 3 of this document, ACC is responsible for all elective admissions where the admission date is seven or more days after the date the decision was made by the specialist that the admission was necessary.

ACC is responsible for payment of **elective procedures identified during**

- acute admissions
- outpatient attendance or emergency department 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 Treatment costs regulations (clause 13 of the Regulations). An accident patient has no access to funding through the Ministry of Health for an elective accident-related procedure.

ACC may enter into contractual agreements with providers (including DHBs) nominated by them for elective surgery. No user part-charges are to be paid by patients using this 'nominated' provider.

However, a patient can choose to have their surgery with a provider who has not been 'nominated' by ACC. In these cases, ACC must pay the patient's chosen provider 60% of the price they would pay the nominated provider, and the chosen provider may charge the patient a co-payment. Where the patient chooses to have the elective surgery performed at a DHB hospital, ACC pays the full cost of the treatment to the DHB, and the patient is not liable for any co-payment or part-charge.

The patients of ACC are defined as 'private patients' for services provided outside the public health acute services definition. However, DHBs are exempt from the 'Private Involvement Protocols' when they treat patients who are *'fully or partly funded by ACC in accordance with the Injury Prevention, Rehabilitation, and Compensation Act 2001, for treatment for personal injury by accident covered by that Act'*.

If ACC requests an elective procedure within seven days of the injury, this should not be coded as a public health acute admission. Electives within seven days should be coded as WN, with ACC as the purchasing agent.

2.4 DHB EMERGENCY DEPARTMENT ATTENDANCES

All emergency department attendances and arranged returns within seven days from the date of the first visit are purchased through the Minister of Health's funding arrangements for public health acute services. Treatment provided under these purchasing arrangements includes related services **directly associated with the visit**, including:

- trauma management services
- diagnostic support services **ordered during the attendance**, eg, diagnostic imaging, laboratory services, audiology, electro-diagnostic imaging, optometry, spirometry and urodynamics
- therapeutic support services **provided in the emergency department**, including nursing, allied health, pharmacy, blood transfusion, counselling and interpreter services
- procedures required **during the attendance**, such as suturing, plastering, fracture manipulation, urgent dental treatment

- medical supplies used **during the attendance**, such as plasters, dressings
- aids and appliances assessed by emergency department staff as required by the patient **during the attendance or immediately on discharge**, such as orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (see section 3.11.1)
- administrative support services, such as information systems, clerical support, medical records.

Further outpatient follow-up associated with the emergency department attendance, such as fracture clinic, is covered in section 2.5.

There is no definition within the Injury Prevention, Rehabilitation, and Compensation Act 2001 or associated regulations of what constitutes the 'emergency department'. It is interpreted in this context to mean any area in the DHB or other publicly funded provider that provides treatment services that would generally be considered as part of a normal emergency department operation of a public hospital.

2.5 DHB OUTPATIENT SERVICES

2.5.1 Medical follow-up from public health acute services

The Minister of Health's funding arrangements for public health acute services covers attendances to a DHB facility-based registered 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 emergency department services. The outpatient services provided include those **directly associated with the visit**, including:

- diagnostic support services ordered by DHB registered medical practitioners and related to the attendance, eg, diagnostic imaging, laboratory services, audiology, electro-diagnostic imaging, optometry, spirometry and urodynamics
- therapeutic support services **provided during the clinic**, including nursing, allied health (where multi-disciplinary clinics are involved), pharmacy, counselling and, interpreter services
- procedures required during the attendance, such as wound dressing, plastering, fracture manipulation, urgent dental treatment
- medical supplies used **during the attendance**, such as plasters, dressings
- aids and appliances assessed **by clinic staff** as required by the patient **during the attendance or for the six weeks following discharge**, such as orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints
- ancillary services including transport and accommodation (see Table 3 in section 3.17.5)

- administrative support services such as information systems, clerical support, medical records.

These outpatient services *do not* include allied health services, district/community nursing, non-acute outpatient rehabilitation services, or nurse-led outpatient services.

Any follow-up outpatient services or associated services provided by the DHB from six weeks after the date of discharge are purchased directly by ACC.

2.5.2 Medical referrals

The Minister of Health's funding arrangements for public health acute services covers urgent attendances to a DHB facility-based registered medical practitioner, other than admissions or emergency department attendances, provided less than seven days after the date the patient was referred for those services by a registered medical practitioner. Services covered include services **directly associated with the visit** (see section 2.5.1).

Medical referrals *do not* include referrals to a radiologist by a registered medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 of the Act or under clause 1 of Schedule 1 of the Act (that is, radiology referrals related to non-public health acute treatment). ACC is responsible for purchasing these services for eligible claimants.

DHBs should note that the seven-day rule applies to the date of referral - the date of the patient's injury only providing an indication of the urgency of the need for referral.

2.5.3 Other

All other outpatient services are purchased directly by ACC, including services such as allied health attendances, non-urgent referrals from registered medical practitioners, referrals from other treatment providers and medical follow-up beyond the six-week and seven-day periods outlined above. Prior approval conditions may apply (see section 4.3).

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

- the ACC45 claim for cover form has been completed and sent to ACC; and
- a written referral is made to the private sector treatment provider that includes all 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).

ACC will require an ACC45 claim form completed by the referring treatment provider, or the private provider, before the private provider is paid and the claimant receives further entitlements.

Self-referrals

Patients who self-refer to a DHB outpatient service, other than an emergency department service (see section 2.2), may be treated by any of the treatment providers listed in section 2.7. ACC is liable to pay for any such acute treatment, by paying either the:

- amount specified in the DHB's contractual arrangements with ACC; or
- amount specified in the Treatment costs regulations; or
- the cost of the treatment, if no contract/agreement or regulations apply.

Prior approval is required for most non-acute treatment, as well as any treatment provided by health professionals who are not 'treatment providers'.

Follow-up from private treatment

Patients who are referred to outpatient services following treatment by a non-DHB owned provider should be treated as new referrals. The outpatient treatment of such patients is included in public health acute services only when they are referred on an urgent basis to a registered medical practitioner by another registered medical practitioner and clinically require to be seen within seven days of referral (see section 2.5.2). Otherwise ACC is responsible for payment.

2.6 DHB COMMUNITY SERVICES

All community health services, including district/community nursing, allied health domiciliary services, home help and personal care services, are purchased directly by ACC. This includes patients referred to DHB community health services by primary care service providers.

District/community nursing

All district/community nursing services required by ACC claimants immediately on discharge from hospital are purchased directly by ACC, including any related services provided (or identified as required and referred in accordance with appropriate practice) **during the nurse's visit**, such as diagnostic services, equipment and consumables.

Self-referrals

Patients who self-refer to a DHB community health service may be treated by any of the 'treatment providers' (see section 2.7). ACC is liable to pay for that treatment of a claimant for personal injury under the terms of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see section 1.4.2 for details about ACC's purchasing arrangements.) Prior approval is required for most non-acute treatment as well as any treatment provided by health professionals who are not 'treatment providers' (see 4.3).

2.7 COMMUNITY-BASED (OR NON-HOSPITAL) TREATMENT AND REHABILITATION SERVICES

A person who has sustained a personal injury is entitled to rehabilitation provided by ACC, to the extent provided by the Injury Prevention, Rehabilitation, and Compensation Act 2001, to assist in restoring the claimant's health, independence and participation to the maximum extent practicable. The injured person is also responsible for their own rehabilitation to the extent practicable having regard to the consequences of their personal injury.

ACC purchases rehabilitation services (including treatment) from a range of non-DHB hospital treatment and rehabilitation providers.

2.7.1 Acute treatment

The following treatment providers can provide **acute** treatment of a claimant for personal injuries for which he or she has cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001, without having to obtain the prior approval of ACC (see section 1.2 for a definition of acute treatment):

- acupuncturist
- audiologist
- chiropractor
- counsellor – defined in the Accident Insurance ('Counsellor') Regulations 1999
- dentist
- medical laboratory technologist
- nurse
- occupational therapist
- optometrist
- osteopath

- physiotherapist
- podiatrist
- registered medical practitioner (includes registered specialists)
- speech therapist.

The treatment conditions listed in section 1.4.2 apply.

Treatment providers can exercise their clinical judgement as to the urgency of need for treatment only if they are appropriately qualified to make a clinical judgement of that kind, otherwise they must refer the patient to a relevantly qualified treatment provider.

2.7.2 Other rehabilitation (including non-acute treatment)

A claimant may be entitled to any of the following types of rehabilitation assistance, in addition to acute treatment:

- non-acute treatment
- aids and appliances
- attendant care
- child care
- education support
- home help
- modifications to the injured person's home
- training for independence
- transport for independence
- vocational rehabilitation assistance.

ACC is required to develop an individual rehabilitation plan in consultation with the claimant within 13 weeks of the acceptance of the claim for cover, if the claimant 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 Injury Prevention, Rehabilitation, and Compensation Act 2001 (Schedule 1, Part 1).

The individual rehabilitation plan must identify the injured person's need for rehabilitation, the assessments to be done, the services appropriate to those needs, and which of the services ACC will provide, pay for or contribute to.

An opportunity to participate in developing the rehabilitation plan must be provided to the claimant (and their representative), any registered medical practitioner providing treatment to the claimant, and the employer. When the rehabilitation plan is agreed or finalised, ACC must implement the plan. Agreeing to the rehabilitation plan does not affect the claimant's rights to make a review application with respect to the plan.

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

3 SPECIFIC SERVICES

This section lists specific services provided to injured people, describes when these services are included in public health acute services, and outlines payment responsibility. Responsibility for payment for some of these services remains the subject of discussion and resolution between ACC and the Ministry of Health. Where responsibility is unclear, interim arrangements are in place to resolve the issue.

3.1 FRACTURE TREATMENT AND REMOVAL OF METAL (ROM)

Agency responsibility for treatment involving fracture manipulation, removal of plaster or removal of metal is as follows:

- (a) Acute – acute treatment at a DHB (inpatient or emergency department) involving the removal of plaster or metal (for example, for reasons of infection) is covered by the Minister of Health's funding arrangements for public health acute services.
- (b) Elective – elective treatment provided for injured people by a DHB is the responsibility of ACC. However, the DHB is responsible for elective treatment when it is part of an outpatient service provided by a doctor **within six weeks** after discharge from an acute admission or emergency department attendance.

Decisions for elective removal of metal are made by ACC, taking into account medical advice from the patient's doctor and ACC's medical staff. Patients who are declined removal of metal by ACC cannot seek to have this treatment provided by the public health waiting lists. The claimant can, however, apply in writing to ACC for a review of the decision to decline the treatment, as described in the Injury Prevention, Rehabilitation, and Compensation Act 2001 (Part 5 Dispute Resolution).

3.2 HYPERBARIC OXYGEN TREATMENT

Hyperbaric oxygen treatment provided by:

- a DHB as part of an acute admission, or emergency department attendance, is purchased through the Minister of Health's funding arrangements for public health acute services.
- the naval hospital at Devonport Naval Base as part of a claimant's acute treatment, is purchased by ACC under contract arrangements.
- a DHB or other provider as part of a claimant's non-acute treatment is purchased by ACC under contract arrangements, or if a contract does not apply, then ACC pays the amount specified in the Treatment costs regulations.

3.3 DENTAL TREATMENT

Agency responsibility for dental treatment required to treat a dental injury for which a person has cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001 is as follows:

- (a) Public health acute services
 - i Acute admission/emergency treatment** – all dental treatment provided by a DHB or other publicly funded provider as part of an acute admission or emergency department attendance is purchased through the Minister of Health's funding arrangements for public health acute services.
 - ii Outpatient treatment** – all outpatient services provided by a dentist are the responsibility of ACC. The Minister of Health's funding arrangements for public health acute services covers dental outpatient services only when oral or maxillo-facial surgeons provide them within six weeks after discharge from an acute admission or emergency department attendance, or when the patient has been referred by a GP within seven days. Outside this time period, dental outpatient services by oral or maxillo-facial surgeons are payable by ACC.
- (b) Elective treatment** – ACC is responsible for considering requests for elective treatment, including restorative dental treatment and specialist dental procedures. Such treatment usually requires ACC's prior approval.
- (c) Community – based or private dental services**

All accident-related dental treatment provided outside of a DHB or other publicly funded provider's facility is the responsibility of ACC. The Ministry of Health's general dental benefits, which provide free dental care for children, do not extend to accident-related dental services. Consequently, children (or their parents) may be required to pay a part-charge for acute accident-related dental treatment when a private or community-based dentist provides this treatment.

3.4 TREATMENT FOR CONCURRENT MEDICAL CONDITIONS

Where patients with an underlying medical condition require an accident-related intervention, ACC is responsible for the costs of elective treatment and related services for eligible claimants, taking into account the patient's condition. ACC is not responsible for treating the underlying medical condition.

Where the patient, on discharge, has both ongoing health and accident-related problems, there is a dual responsibility for ongoing care. Services arising outside of the public health acute period that are related to the accident are the responsibility of ACC; those relating to non-accident-related health conditions are the responsibility of the Ministry of Health (see sections 3.8–3.10).

3.5 TREATMENT COMPLICATIONS REQUIRING ACUTE ADMISSION TO A PUBLIC HOSPITAL

If, during elective treatment for which ACC is responsible, a patient requires a service that is part of public health acute services, those services are purchased through the Minister of Health's funding arrangements for public health acute services. This applies from the time the need for the public health acute service was determined. Public hospital to public hospital transfers relating to the acute event are the responsibility of the DHB, but private hospital to public hospital transfers are the responsibility of the referring hospital or ACC. Examples of such cases are an unplanned transfer to intensive care, a patient having a heart attack or a stroke.

Note: The patient should be discharged as an elective admission and readmitted as an acute admission and the purchaser code changed for the acute event.

3.6 BLOOD AND BLOOD PRODUCTS

Provision of blood transfusion services (cross-matching, collection, accreditation, storage and administration of blood) is purchased as a part of the treatment. The DHBs and ACC each purchase blood transfusion services provided as part of their responsibilities as described in sections 2.2–2.6. (The blood is donated and cannot be charged for by the blood transfusion service provider.)

Provision of any blood products required during the course of treatment (eg, Factor VIII for people with haemophilia) is regarded as treatment of an underlying medical condition and is purchased by the DHBs. This includes blood products required to support elective treatment or other services that are the responsibility of ACC.

3.7 MEDICAL CONSUMABLES

A medical consumable is a non-returnable item that is supplied for a claimant's personal use to assist in restoring his or her independence in everyday activities to the maximum extent practicable.

Examples of medical consumables include items such as:

- incontinence sheets and pads
- urine bags, tubing, connectors and tapes
- syringes and needles
- dressing and catheter packs
- feeding tube sets
- sterile and non-sterile gloves
- ostomy bags

- gastrostomy and nasogastric tubing
- tracheostomy brushes
- ventilator disposables – humidifiers, oxygen
- tracheostomy tubes and holders
- tubing, swivel connectors, filters
- burn garments
- oxygen – cylinders, concentrators, repairs
- catheters (urinary and suction), irrigation solutions for bladder irrigations
- wound care/prevention products.

The Minister of Health's funding arrangements for public health acute services includes funding for medical consumables provided as part of those services (see sections 2.2–2.6). The hospital is responsible for assessing the immediate need for medical consumables prior to discharge. In cases where discharge planning with ACC or the Accredited Employer is not possible, hospitals should arrange a reasonable supply for the patient, sufficient to cover the period until ACC can organise medical consumables (up to a week).

ACC purchases medical consumables as part of the services ACC is responsible for as described in sections 2.2–2.6, ie, all non-public health acute services. These consumables are purchased by ACC via contract arrangements (eg, via community nursing or elective services contracts).

Treatments specified in the Treatment costs regulations include medical supplies associated with each item. For example, plaster cast costs are part of the payment for fracture treatments.

3.8 REHABILITATION AND DISABILITY SUPPORT SERVICES

Disability Support Services (DSS) are not part of public health acute services and cannot be automatically accessed by people who have cover for personal injury under the Injury Prevention, Rehabilitation, and Compensation Act 2001. The acute component of specialised services, such as traumatic brain injury and spinal injury services are provided by DHBs as part of public health acute services (medical/surgical services).

An injured person can only access Ministry of Health-funded DSS services if the service is not included in public health acute services and either:

- they do not have ACC personal injury cover; **or**

- they have ACC cover for personal injury, but they have been disentitled to the service in terms of ss.118-122 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (eg, if disentitled to rehabilitation other than treatment, because the injury was wilfully self-inflicted – see section 3.22 for more detail about self-injury).

Injured people who are eligible for DSS services, as specified above, must meet the same Ministry of Health access criteria as non-injured people for the relevant service.

The Ministry of Health and ACC have jointly developed clinical criteria to clarify the point at which it is clinically appropriate to transfer patients from acute to non-acute inpatient rehabilitation services, and later, from non-acute inpatient rehabilitation to a community setting. The bases of these clinical criteria are outlined in section 3.10, with details in Appendix D.

Any matters of doubt or difficulty should be referred through a boundary issues resolution procedure (see section 5).

3.9 ELDERLY VICTIMS OF CRIME

An amendment to the Health Funding arrangement effective from 1 November 1998 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 further details regarding the joint responsibilities of ACC and the Ministry of Health please refer to the *Protocols between the Accident Rehabilitation and Compensation Insurance Corporation and the Health Funding Authority: To Implement the Amendment to the 1998/99 Health Funding arrangement on Residential Care for Elderly Victims of Crime*, November 1998.

In this protocol ‘elderly people’ are defined as ‘people 65 years and older’ or who are ‘close in age and interest’ (a clinical decision made by a geriatrician/psycho-geriatrician following a comprehensive assessment that determines that a person aged between 50 and 65 years has similar care needs to a person who is actually over the age of 65 and is resident in an aged care environment).

3.10 NON-ACUTE INPATIENT REHABILITATION

The Minister of Health’s funding arrangements for public health acute services cover all patient care required from admission to discharge or transfer to a non-acute inpatient rehabilitation service. Non-acute inpatient rehabilitation is the responsibility of ACC.

There are four conditions that must be met before a patient can transfer from public health acute services purchased through the Minister of Health’s funding arrangements, to non-acute inpatient rehabilitation purchased by ACC:

1. The patient requires inpatient rehabilitation under a multidisciplinary team headed by a specialist in rehabilitation or geriatrics;
2. The person is clinically stable and likely to improve, as well as there being no life-threatening condition(s) that would require emergency surgery or intensive monitoring;
3. The clinical team responsible for discharge from acute services and the rehabilitation team agree to the transfer;
4. The person has been accepted, or is likely to be accepted as an ACC claimant.

Providers must have a contract arrangement with ACC to be able to provide non-acute inpatient rehabilitation for ACC claimants.

Appendix D outlines in more detail the process for transfer from acute services to non-acute inpatient rehabilitation of patients who meet the specific clinical criteria. DHBs will also need to re-code NMDS information for those patients who are transferred within a DHB, from acute to non-acute inpatient rehabilitation, to reflect the change in principal health service purchaser code from the Ministry of Health to ACC.

3.11 EQUIPMENT (AIDS AND APPLIANCES)

Equipment (aids and appliances) are items that are supplied to assist in restoring a claimant's independence in everyday activities to the maximum extent practicable. Examples of equipment/aids and appliances include mobility aids and orthoses.

A distinction is normally made between items supplied on a short-term basis in order to address short-term functional loss, and the supply of the items on a long-term basis to meet a more permanent need.

3.11.1 Short-term loan equipment

The Minister of Health's funding arrangements for public health acute services includes short-term loan equipment required to assist recovery from a personal injury that was treated under public health acute service arrangements, as outlined in sections 2.2–2.6. This covers items:

- required by patients during acute admissions, emergency department attendances and following discharge as part of medical outpatient services for up to six weeks
- required or identified during treatment provided by medical practitioners less than seven days from referral by another registered medical practitioner.

It is the responsibility of the hospital to assess the immediate need for equipment prior to the patient's discharge, and to supply or loan equipment until reassessment, or up to six weeks, whichever is the shorter period. Where a patient's need cannot be assessed

prior to discharge (eg, because the person is in a hospital distant from their home), it is the hospital's responsibility (as part of public health acute treatment) to make arrangements with the person's nearest DHB to assess and supply equipment. Where a reassessment within six weeks of discharge occurs as part of a medical outpatient service, the hospital remains responsible for providing the equipment until the expiry of the six-week period.

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

In accordance with Ministry of Health and relevant DHB policies, the patient may be required to pay a deposit for short-term use of equipment. The deposit is to be no more than the cost of the item or \$37 (whichever is the lesser), and the deposit is fully refundable on return of the item in acceptable condition. A patient may not be required to pay the deposit if they can demonstrate resultant financial hardship.

3.11.2 Long-term or permanent equipment (eg, wheelchairs)

ACC is responsible for the assessment and provision of long-term or permanent equipment from the point of discharge from a public health acute service if the need for the equipment results from personal injury and the need is predicted to last more than six months. Short-term loan equipment is used until the permanent equipment is available (as described in section 3.11.1). Wherever possible, DHBs should give ACC one month's notice of the need for the long-term or permanent equipment.

3.11.3 Orthotics

The Minister of Health's funding arrangements for public health acute services includes short-term loan orthoses required to assist recovery from a personal injury that was treated under public health acute service arrangements (see section 3.11.1). There is no deposit required for short-term use of orthoses.

ACC is responsible for the assessment and provision of long-term or permanent orthoses from the point of discharge from a public health acute service, if the need for the orthotic device results from personal injury and the need is predicted to last more than six months.

ACC only pays for an orthotic if an appropriate registered medical specialist or physician (such as an orthopaedic surgeon, rheumatologist, or sports medicine physician) has prescribed the device for a covered personal injury.

Under the terms and conditions of ACC's elective surgery contracts, DHBs are required to supply orthoses for up to 13 weeks post-discharge, as these are part of the ACC contract price for such elective services. A DHB without an elective surgery contract will need to discuss payment arrangements with ACC.

3.12 ARTIFICIAL LIMBS AND EYES

Artificial eyes and limbs are normally provided more than six weeks after discharge from an acute inpatient admission, and are therefore the responsibility of ACC. However, any artificial eyes or limbs supplied during an inpatient admission or during the six-week medical outpatient services are part of public health acute services and are purchased through the Minister of Health's funding arrangements for public health acute services.

Note: Amputees who have lost limbs as a result of war action remain the responsibility of the Department of Work and Income.

3.13 OTHER PROSTHESES

3.13.1 Implants

Surgical implants (eg, hip prostheses, cochlear implants, spinal stimulators) are paid for as part of the related surgical procedure. Implants provided as part of public health acute services are the responsibility of the DHBs. Replacement or maintenance of implants is the responsibility of ACC once the acute public health episode is complete. ACC is responsible for implants provided as part of an elective service.

3.13.2 External prostheses

External prostheses (eg, breast prostheses, wigs, artificial aids) are normally provided after discharge and are therefore the responsibility of ACC. However, any external prostheses supplied during an inpatient admission or during the six-week medical outpatient services are part of public health acute services and are covered by the Minister of Health's funding arrangements for public health acute services.

3.14 HEARING AIDS

Hearing aids are a type of equipment (aid or appliance) that are supplied to assist in restoring a claimant's independence in everyday activities to the maximum extent practicable. ACC is responsible for assisting with hearing aid costs if the claimant is assessed as needing this assistance as a result of hearing loss that is covered as a personal injury under the Injury Prevention, Rehabilitation, and Compensation Act 2001.

If the hearing loss is not the result of a personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, then the patient is responsible for paying for the cost of a hearing aid in terms of the current arrangements for non-accident

patients. The hearing aid subsidy of \$89.10 or the Ministry of Health funding for hearing aid provision is available if set criteria are met. Ministry of Health funding is not available for patients who are entitled to assistance with hearing aid costs from ACC.

3.15 FERTILITY SERVICES

ACC is responsible for the payment of any treatment for infertility where such a treatment need has arisen as a consequence of a claimant's personal injury, for which they have cover under the Injury Prevention, Rehabilitation, and Compensation Act 2001. Prior approval from ACC for the treatment is required.

3.16 RESPITE SERVICES (CARER SUPPORT)

ACC is responsible for the assessment and provision of respite care services required for injured persons. ACC can make a payment for personal care services for another carer to enable the regular carer to take a break.

Prior to the provision of the service, ACC must agree to the level of respite care services.

3.17 TRANSPORT AND ACCOMMODATION

As a general rule, the DHBs are responsible for decisions on transport and accommodation associated with treatment provided as part of public health acute services. The nature of transport and accommodation assistance, and eligibility to the assistance, is contained in the Ministry of Health and DHB policies on emergency transport and travel and accommodation assistance. Accident patients have the same access to the Ministry of Health and DHB's travel and accommodation assistance as illness patients.

ACC is responsible for decisions on the provision of transport and accommodation required by accident patients outside the public health acute services period, as well as any emergency transport required within 24 hours⁵. The type and amount of transport and accommodation assistance that ACC can provide for claimants, their escorts and support persons is specified in the Injury Prevention, Rehabilitation, and Compensation (Ancillary Services) Regulations 2002.

Details of emergency transport, travel and accommodation assistance provided by ACC and the DHBs are outlined below, and responsibility for transport is summarised in Table 3.

3.17.1 EMERGENCY TRANSPORT

ACC is responsible for emergency transport (air, road and water-based) within 24 hours of the patient being injured or being found after being injured. This includes emergency inter-hospital transfers (that is, within 24 hours) where the patient's condition deteriorated

⁵ The 24-hour period starts when a claimant is injured, or is found after being injured (whichever is later).

or the hospital was not able to provide the level of specialist care required. All emergency transport must be dispatched by an ambulance control centre.

However, ACC is not responsible for transport of patients who die before the ambulance arrives or situations where it is assessed that there is no need for ambulance transport after arrival of the ambulance. In such circumstances the cost of the callout is an overhead to be borne by the ambulance provider.

The DHB is responsible for funding inter-hospital transfers more than 24 hours after the patient is injured or is found after being injured. The DHB only funds inter-hospital transport within 24 hours if a patient requires transferring because the hospital's normal services are not available (eg. if the ICU is full, or the specialist is on leave). Inter-hospital transfers funded by ACC are part of emergency transport so must be dispatched by an ambulance control centre.

The contracted price for emergency transport includes paramedic and/or medical crewing. Any additional crewing or medical/nursing escorts required as part of the emergency transport service (including inter-hospital transfers within 24 hours) are the responsibility of the DHB.

3.17.2 Non-emergency travel and accommodation assistance

The DHB is responsible for funding travel and accommodation assistance for injured patients who are receiving public health acute services. The Ministry of Health and DHB travel and accommodation assistance policies apply to accident patients on the same eligibility grounds as illness patients. Assistance by the DHB is not automatic and is dependent upon criteria such as distance to travel, income levels, age and relationship to the patient and so forth. Overseas visitors are generally not eligible for travel assistance, as they will not meet the criteria of 'home' defined in the Ministry of Health's policy⁶.

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

ACC is responsible for providing non-emergency transport for accident patients to travel to treatment (excluding the majority of public health acute services – see Table 3 in section 3.17.5) and to travel to the specified types of social or vocational rehabilitation listed in the Ancillary services regulations. Criteria to receive payment by ACC for transport and accommodation costs related to treatment and rehabilitation are specified

⁶ 'Home' is currently defined in the Ministry of Health Travel and Accommodation Assistance Policy as the person's normal place of residence, where the person has been living continuously for more than three months.

in the Ancillary services regulations. ACC's prior approval will be required in some cases (eg, for non-emergency transport by air).

ACC can also pay the cost of non-emergency ambulance transport to rehabilitation (excluding the majority of public health acute services – see Table 3 in section 3.17.5), which is available to claimants where the claimant's injury is such that no other form of public or private transport is appropriate. To access the service, the claimant must have obtained a certificate from their doctor that validates the need for an ambulance. The service can be arranged by contacting the ambulance control centre.

ACC contracts for the provision of this service with their emergency ambulance providers. Payment is made per kilometre. It should be noted that non-emergency transport by ambulance is not subject to the same access criteria as applies under the Ancillary services regulations to most other forms of non-emergency transport to rehabilitation.

3.17.3 Escort costs

ACC is responsible for decisions on payment for travel and accommodation assistance for an escort, but only when an escort is accompanying the patient in non-emergency transport to treatment or rehabilitation that is not part of public health acute services (see Table 3 in Section 3.17.5 for more detail).

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

- the injured person is under 18 years of age; or
- the medical condition of the injured person is such that he or she needs an escort; or
- 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 claimant. Prior approval should be sought from ACC to check if escort costs can be paid in a particular case.

3.17.4 Support person costs

ACC is responsible for decisions on payment for travel and accommodation assistance for support persons, but only when a support person is visiting a claimant who is receiving ACC-approved inpatient or residential rehabilitation that is not a public health acute service. If the claimant 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 claimant. If the claimant is under the age of 18 years, the claimant travel rules apply to support person travel.

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

Prior approval should be sought from ACC to check if support person costs can be paid in a particular case.

3.17.5 Table 3: Summary of agency responsibility for determining travel/transport assistance

Type of Hospital-Related Attendance	Type of transport	Agency	
		DHB	ACC
DHB emergency department attendance	Emergency transport of injured person and escort within 24 hours ⁷		✓
	Non-emergency transport (non-ambulance) ⁸		✓
DHB acute admission	Emergency transport of injured person and escort within 24 hours ⁹		✓
	Inter-hospital transfers within 24 hours		✓
	Inter-hospital transfers after 24 hours	✓	
	Non-emergency transport prior to admission		✓
	Non-emergency transport of a claimant travelling home after discharge from an acute admission	✓	
	Non-emergency transport of a claimant transferring to a non-acute inpatient rehabilitation facility after discharge from an acute admission	✓	
	Non-emergency transport for family/support person to travel between their home and the DHB	✓	
DHB medical outpatient services:			
• provided by doctor within 6 weeks of an emergency department attendance discharge or 6 weeks following an acute admission	Non-emergency transport for the injured person (and family/support person) to travel to and from the DHB for treatment at medical outpatients	✓	
• provided by a doctor within 7 days of a referral by a doctor			
DHB other outpatient services:			
• all non-medical outpatient services (eg. physiotherapy, occupational therapy)	Non-emergency transport for the injured person (and escort) to travel to and from the DHB for treatment at outpatients		✓
• medical outpatient services outside the public health acute period			
DHB elective admissions	Non-emergency transport and other travel assistance for injured person (and support person/escort) for hospital visits associated with elective admissions		✓
Services provided by non-DHB hospital treatment providers ¹⁰	All non-emergency transport and travel assistance		✓

⁷ The 24-hour period starts when a claimant is injured, or is found after being injured (whichever is later).

⁸ ACC does not consider it necessary, or appropriate, to pay for non-emergency transportation in an ambulance to an emergency department.

⁹ The 24-hour period starts when a claimant is injured, or is found after being injured (whichever is later).

¹⁰ Treatment must be from a treatment provider specified in the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see section 2.7.1).

3.18 PHARMACEUTICALS

ACC is liable to pay or contribute to the cost of pharmaceuticals that are prescribed by a treatment provider who has statutory authority to prescribe pharmaceuticals, but only when the pharmaceuticals are reasonably required to facilitate a claimant's treatment for personal injury (see section 1.2 for the s.6 definition of pharmaceutical). ACC pays or contributes to pharmaceutical costs for ACC claimants in three ways:

- through bulk payments to the Crown for public health acute services
- through bulk payments to the Crown for primary-referred pharmaceuticals
- through reimbursements to claimants for co-payments on primary-referred pharmaceuticals, and in some cases, reimbursement of the cost of pharmaceuticals not on the Pharmaceutical Schedule.

The Minister of Health's funding arrangements for public health acute services includes pharmacy services and pharmaceuticals that are provided as part of the services the DHB and other publicly funded providers are responsible for (as described in sections 2.2–2.6). Public health acute services include pharmaceuticals:

- required by patients during acute admissions or emergency department attendances
- administered by a registered medical practitioner as part of the treatment associated with an outpatient visit for up to six weeks from discharge or treatment
- required during treatment provided by medical practitioners less than seven days from referral by another registered medical practitioner.

ACC is responsible for the cost of pharmaceuticals that are reasonably required to facilitate non-public health acute treatment for which ACC is responsible (as described in sections 2.2–2.6). This covers pharmaceuticals appropriately prescribed to facilitate any of the following treatment services: community-based acute treatment, post-six-week medical outpatient services, services provided as part of elective assessments/admissions and other treatment outside of the public health acute period.

Community-referred pharmaceuticals prescribed for ACC claimants are purchased through the Minister of Health from the Pharmaceutical Schedule, under the Service Agreement between the Minister of Health and the Minister for ACC. Claimants can seek reimbursement of co-payments on community-referred pharmaceuticals from ACC or their accredited employer. If pharmaceuticals prescribed for non-public health acute treatment are not on the Pharmaceutical Schedule (that is, they are not subsidised), accident patients can apply to ACC or their accredited employer for approval of these non-subsidised pharmaceutical costs.

DHBs are required to record the accident claim form (ACC 45) number against each item when prescribing medicines. A Ministry of Health identifier must be recorded for all medical illness scripts to distinguish between accident and medical cases.

3.19 LABORATORY SERVICES

The Minister of Health's funding arrangements for public health acute services include laboratory services provided as part of the services DHBs are responsible for as outlined in sections 2.2–2.6. This covers laboratory tests required by patients or ordered during acute admissions or emergency department attendances and medical outpatient services for up to six weeks from discharge or treatment. It also covers tests required or ordered during treatment provided by medical practitioners less than seven days from referral by another registered medical practitioner. Laboratory tests supporting the above services are covered by the DHB even when private laboratories provide them.

ACC is liable for the cost of laboratory services provided as part of the services they are responsible for as outlined in sections 2.2–2.6. This covers self-referrals, primary referrals, post-six-week follow-up medical outpatient services, community nursing services, all allied health outpatient services and services provided as part of elective assessments or admissions.

Community-referred laboratory services for ACC and accredited employers are purchased by the Ministry of Health, under arrangements made under a Service Agreement between the Minister of Health and the Minister for ACC.

DHBs are required to record the accident claim form number (from the ACC 45) on any forms requesting laboratory tests.

3.20 RADIOLOGY SERVICES

The Minister of Health's funding arrangements for public health acute services include radiology services provided as part of the services DHBs are responsible for as outlined in sections 2.2–2.6. This covers diagnostic imaging required by patients or ordered during acute admissions or emergency department attendances and as part of medical outpatient services for up to six weeks from discharge or treatment.

ACC purchases radiology services provided as part of the services they are responsible for as outlined in sections 2.2–2.6. This covers self-referrals, primary referrals, post-six-week follow-up services, and services provided as part of elective assessments or admissions.

ACC purchases community-referred radiology services directly - whether patients are referred to private or DHB radiology clinics.

DHBs are required to record the accident claim form number (from the ACC 45) on any forms requesting diagnostic imaging.

3.21 TREATMENT PROVIDED BY COMMUNITY TRUST HOSPITALS

Community Trust Hospitals as publicly funded providers

The Injury Prevention, Rehabilitation, and Compensation Act 2001 includes Community Trust Hospitals as providers of public health acute services, when they are funded by the Minister of Health or a DHB to provide those services (see the definitions of public health acute services and publicly funded provider in section 1.2).

ACC is prohibited by s.303 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 from purchasing public health acute services directly from a DHB or other provider. ACC ceased direct purchasing of these services from Community Trust Hospitals from 1 July 2002.

Purchasing arrangements for non-public health acute services

ACC is only responsible to pay for treatment provided by a Community Trust Hospital when the treatment is not part of public health acute services, the claimant qualifies for the treatment for personal injury, and the treatment is provided by an appropriate treatment provider. Refer to section 1.4.2 for more information about purchasing arrangements for non-public health acute services including treatment conditions, what ACC pays, and prior approval requirements.

ACC commenced the purchasing of non-acute inpatient rehabilitation from Community Trust Hospitals from 1 March 2001 as per the clinical criteria for hospitals (Appendix D) via the process described in section 3.10.

3.22 MENTAL HEALTH SERVICES

Specialist publicly funded mental health services are targeted at the 3% of the population estimated to have the most severe mental health problems. People who do not fall within this level of severity are expected to access less specialised mental health services, which are usually provided on a fee-for-service basis.

ACC provides cover and entitlements for people who have a diagnosed, clinically significant mental health condition that is:

- caused by a sensitive claims event (as defined in section 1.2); or
- caused as a consequence of a physical injury for which a person has ACC personal injury cover.

People who have a mental health condition covered by ACC are entitled to the same mental health services as any other person, under public health acute service arrangements.

Emergency department attendances

Treatment for personal injury at a hospital emergency department is purchased through the Minister of Health's funding arrangements for public health acute services. This includes any consultations by mental health staff during the attendance.

Consultation/liason services

People who experience a sensitive claims event or sustain a physical injury may be seen by mental health staff as part of their provision of consultation/liason services to non-psychiatric areas of the hospital. If these people are eligible for specialist mental health services, they will be transferred into mental health inpatient or community health services when clinically appropriate.

Acute admissions

Treatment for people requiring acute admission to a mental health inpatient unit is funded by DHBs. Inpatient services provide care for people in the acute stage of a psychiatric 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 or less acute inpatient service. Inpatient services - including consultations by psychiatrists, psychologists, counsellors, nurses, and social workers - are fully funded by the DHBs for the period of admission.

Non-acute residential rehabilitation for mental health patients

A claimant who has a mental injury arising from a sensitive claims event (as defined in section 1.2) may be eligible for non-acute residential rehabilitation purchased by ACC under contract arrangements.

If a DHB identifies a need for a claimant to receive non-acute residential rehabilitation because of a mental injury caused by a sensitive claims event, contact the Sensitive Claims Unit on 0800 735 566 to discuss the patient's needs. ACC will explain the process for determining if non-acute residential rehabilitation is needed due to mental injury covered by ACC, and if it is the most appropriate intervention for the claimant at this time.

Community mental health services, including follow-up outpatient services

Once the person is discharged from a mental health inpatient unit or attendance at an emergency department, they may need services in the community to help them in their recovery from their mental illness. These services are also aimed at the 3% of the

population with the most severe mental health problems, and are provided as long as clinically required.

Treatment for personal injury by a community mental health service is purchased through the Minister of Health's funding arrangements for public health acute services only if a registered medical practitioner provides the outpatient service:

- as part of the outpatient follow-up to an acute admission or emergency department attendance, for up to six weeks after the discharge or treatment date; or
- there is a doctor-to-doctor referral, and the person is seen within seven days of referral.

Any follow-up medical outpatient treatment (including treatment at a multi-disciplinary clinic) is included in public health acute services for up to six weeks, including all services directly associated with the consultation (see section 2.5.1). The services do not include referred services to allied health services, such as counselling. After six weeks ACC is responsible for paying for any further outpatient treatment required to treat the claimant's personal injury.

ACC is responsible for considering a claimant's eligibility for assistance with the costs of any medical treatment for which non-doctors refer them and for any outpatient or community-based treatment that is not included in public health acute services.

ACC considers requests to pay for follow-up treatment by any other type of treatment provider in terms of the eligibility criteria for treatment outlined in Schedule 1, Part 1 of the Injury Prevention, Rehabilitation, and Compensation Act 2001 (see the treatment conditions in section 1.4.2). ACC must be satisfied that any counselling has been provided by a recognised counsellor before contributing to the costs of these services for a claimant. Recognition as a counsellor is in terms of the Accident Insurance ('Counsellor') Regulations 1999. ACC is responsible for paying for counselling services provided to eligible claimants by counsellors who meet the criteria in the regulations. Hospital or community mental health counselling services should contact ACC to arrange recognition of counsellors employed by their service.

Self-injury

Where an injury is deliberately self-inflicted the Injury Prevention, Rehabilitation, and Compensation Act 2001 provides entitlement to treatment only, but not to other forms of rehabilitation or to compensation entitlements. People whose deliberately self-inflicted injuries are the result of an underlying clinically significant mental condition are eligible for ACC rehabilitation and compensation entitlements on the same basis as any other claimant.

Treatment for people with self-inflicted injuries covered by ACC is purchased through the Minister of Health's funding arrangements for public health acute services, if the service is of a type that is included in public health acute services. ACC is responsible for the purchase of any treatment that the claimant qualifies for that is not included in public health acute services.

The treatment included in public health acute services or direct purchased by ACC is treatment of the personal injury only, and not any underlying mental health condition such as depression (unless the underlying mental health condition is covered by ACC as a mental injury).

3.23 SEXUAL ASSAULT SERVICES

The Minister of Health's funding arrangements for public health acute services cover sexual assault treatment and counselling services provided to a patient as part of an acute inpatient admission or emergency department presentation. Medical outpatient follow-up visits and GP referrals to registered medical practitioners within seven days are also covered by the DHB.

If counselling is required to treat a person with a mental injury caused by a sensitive claims event (as defined in section 1.2) then counselling services provided at hospital outpatient clinics are paid for directly by ACC. However, ACC must be satisfied that the counselling has been provided by a recognised counsellor. Recognition as a counsellor is in terms of the Accident Insurance ('Counsellor') Regulations 1999. ACC is responsible for paying for counselling services provided to eligible claimants by counsellors who meet the criteria in the regulations. Hospital counselling services should contact ACC to arrange recognition of counsellors employed by their service.

See section 3.22 for more information about mental health services for claimants who have a diagnosed mental injury caused by a sensitive claims event.

Any physical injuries sustained by a claimant in circumstances related to a sensitive claims event should be recorded on the ACC45 claim form, and treated appropriately (see section 2 General Categories of Service for information about who pays for treatment services).

4 ADMINISTRATIVE PROCESSES

4.1 NOTIFICATION

ACC should be notified as early as possible (through the ACC 45 form) of injured people who are admitted as an acute admission. ACC should be provided with reasonable access to injured persons covered by them while they are in hospital so that post-discharge treatment or rehabilitation services can be arranged as required. This includes access to the health professionals who are treating the patient.

4.2 FORMS AND INVOICING

ACC – all accidents

All patients must have an ACC 45 form completed for the first attendance or admission including:

- patients treated under public health acute services
- patients whose personal injury cover is the responsibility of an accredited employer.

Where a patient is delivered to hospital by an ambulance provider who has started an ACC 45, that form should be completed for ACC. The DHB can complete the form and advise the ambulance provider of its number for invoicing ACC. Where the ambulance provider has completed and submitted an ACC45 to ACC and the DHB's injury diagnosis is different from the diagnosis made by the ambulance officer, the DHB should advise ACC, quoting the original ACC45 number.

Invoicing for non-acute services is via the DHB bulk-billing form or on a case-by-case basis. Other ACC forms should be used (eg, ACC 18 for work incapacity) where appropriate.

Accredited employers

DHBs must complete an ACC 45 form for any patients who suffer a work-related personal injury. This includes patients whose injury is covered by an accredited employer. Accredited employers under the ACC Partnership Programme accept the responsibilities that ACC would accept in relation to the work-related injuries of their employees.

In respect of public health acute services, accredited employers pay ACC a fee to cover the free provision of these services to employees, and the DHB cannot invoice an accredited employer for these services. However, DHBs will need to invoice an accredited employer for non-public health acute services provided to employees for work-related injuries (eg, allied health outpatient services, rehabilitation, post-six-weeks medical outpatient services and elective surgery).

The ACC 45 form asks for the name of the employer. If the DHB or patient knows they are an accredited employer, the DHB should send both a copy of the ACC 45 form and, if relevant, any invoices for non-public health acute treatment, directly to that employer. If you are not sure whether your patient's employer is an accredited employer, send the form directly to ACC. The 'accredited employer' status can be checked by a DHB directly by accessing the ACC website: <http://staff/for-providers/resources/search-for-accredited-employers/>

If any invoices for payment by an accredited employer are sent in error to ACC, then ACC will send the invoice back to the DHB, together with a letter advising of the accredited employer details.

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

Further information

For information about accredited employers, telephone the ACC provider helpline – 0800 222 070. This helpline and the ACC website provide up-to-date advice on an employer's accreditation status, and give name and contact details of the account manager for each accredited employer.

4.3 PRIOR APPROVALS

ACC is prohibited by the Injury Prevention, Rehabilitation, and Compensation Act 2001 from requiring prior approval for acute treatment or public health acute services.

ACC does not require prior approval when a person transfers from acute care to non-acute inpatient rehabilitation under the approved clinical criteria (ie, patients with moderate or severe traumatic brain injury, severe multiple injury or spinal cord injury, as outlined in section 3.10). Notification of the transfer is required within two days and prior approval after six weeks post injury if the person remains in non-acute inpatient rehabilitation.

Most other non-acute treatment and rehabilitation services will require the prior approval of ACC. If prior approval conditions are not met payment will not be made by ACC.

4.4 ACC PAYMENT ARRANGEMENTS AND PRIOR APPROVAL REQUIREMENTS

The following table shows ACC's payment arrangements and prior approval requirements for specific services.

Table 4: ACC’s payment arrangements and prior approval requirements

Service category	Provider	Payment arrangement	Prior approval
Emergency department visits after seven days	Doctor Nurse	Claim through Treatment costs regulations	Not required
Elective surgery	Package of services	Elective surgery contracts or claim through Treatment costs regulations	Required
Non-acute inpatient/residential rehabilitation services		Inpatient/residential rehabilitation service contracts	Required for all cases except those patients covered by the clinical criteria ¹¹ unless the claimant is to stay longer than 6 weeks post-injury
Elective outpatient assessments (new referrals)	Specialist	Clinical services contracts or claim through Treatment costs regulations	Not required
All other outpatient clinic attendances (excluding rehabilitation assessments and pain management services)	Physiotherapist	Claim through Treatment costs regulations	Not required
	Occupational therapist		
	Counsellor		
	Audiologist		
	Dentist		
	Speech therapist		
	Podiatrist		
	Optometrist	Optometry contract	Not required
Rehabilitation assessments		Rehabilitation assessment contracts	Required
Pain management services		Pain management contracts	Required
Community health services	Community nurse	Community nursing contracts	Required only after 6 weeks or 12 visits (whichever comes first)
	Home support/personal care	Home-based rehabilitation contracts	Required with one working day’s notice to ACC, but services can be put in place without prior approval in certain instances ¹²

Continued over...

¹¹ Notification to ACC is required within 2 days for accident patients transferred to non acute inpatient rehabilitation under the clinical criteria outlined in section 3.10 of this document (ie, patients who have moderate or severe traumatic brain injury, spinal cord injury or severe multiple injuries or burns).

¹² Home support services can be put in place by the DHB without prior approval of an ACC case manager if the patient’s safety would be at risk, where timing factors make prior approval very difficult (eg, discharge during weekends). DHBs must then follow up with case managers within one working day (eg, first thing Monday morning). Generally, ACC requires one working day’s notice of a need for home support/personal care. If this is not possible, DHBs should seek verbal approval from ACC, with follow-up written approval as soon as possible.

	Physiotherapist	Claim through relevant contracts	Required
	Occupational therapist	Claim through Treatment costs regulations	Not required
	Counsellor/psychologist		
	Audiologist		
	Podiatrist		
	Speech therapist		
Radiology		Claim through High Tech Imaging contracts, if applicable	Required
		Claim through Treatment costs regulations	Not required
Laboratory and Pharmacy	Primary-referred Services	Purchased under the Service Agreement (see section 1.2)	Not required
Equipment		Managed Rehabilitation Equipment Services Contracts	Required
Consumables	Baxter Healthcare Limited	Contracts	Required

In cases where prior approval is not required ACC monitors service provision and investigates any apparent excessive service provision.

4.5 DISCHARGE PLANNING

The Funding Agreement between the Minister of Health and the DHB requires that DHBs must grant such access to ACC, as is reasonable in the circumstances, to any patient receiving treatment in that hospital for a personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, and to those health professionals necessary for arranging post-discharge treatment, care, rehabilitation or other services.

The intent of the discharge planning requirement is to ensure the injured person has continuity of appropriate care. ACC is entitled to access relevant medical information on individual patients who are covered by them. Patient consent for this is included on the ACC 45 form.

Service specifications contained within the Minister of Health's funding arrangements for public health acute services include requirements for discharge planning. Discharge planning requirements include provision of a discharge summary sent on the day of

discharge to general practitioner and referring consultant (if different from operating surgeon/attending physician); and letter sent within 72 hours. The discharge summary should include, as appropriate, the diagnosis, treatment provided, prognosis and recommended treatment plan. See below for discharge planning requirements for the seriously injured.

ACC (or the accredited employer) may request a copy of the discharge summary or letter following receipt of the ACC 45 form, but does not require a copy routinely. Depending on individual arrangements, accredited employers may request discharge summaries.

ACC may arrange for assessment of post-discharge care requirements prior to discharge. Such assessments will be carried out by an assessor (which may be a DHB) contracted by ACC.

Seriously injured

For patients with serious or complex long-term disability who require long-term residential care or residential rehabilitation, DHBs should provide ACC with the earliest possible notice of future discharge (preferably at least one month).

Where ACC cannot find suitable residential care by the designated discharge date, ongoing funding of inpatient care will be the responsibility of ACC.

The discharge report for the seriously injured should be an integrated 'snapshot' of support currently being provided. This should include the daily routine of nursing care, occupational therapy, physiotherapy, speech language therapy and any other relevant information to ensure continuity of care upon discharge.

Payments for special reports/assessments requested by ACC from the DHB need to be negotiated with the requesting office. Such payments will be made to the relevant DHB, and ACC will only make payments directly to a designated treatment provider within the DHB if the DHB has given express written agreement for such an arrangement.

Home-based rehabilitation – packages of care

Where it is identified that a claimant requires home support services after discharge, a home-based rehabilitation referral form must be completed and faxed to the nearest ACC Contact Centre. This should be completed as soon as possible to allow appropriate support services to be in place on discharge. The ACC Contact Centre will make the decision and notify the hospital as to:

- whether a package of care can be implemented without a prior assessment; or
- whether an assessment is required.

Note: the provision of short-term loan equipment remains the responsibility of the DHB for six weeks after discharge from an acute admission (see section 3.11).

Transfer to non-acute inpatient rehabilitation service

All patients transferring from acute to non-acute inpatient rehabilitation must meet the clinical criteria outlined in Appendix D.

Table 5: Protocol for management of patients with dual diagnosis

In addition to the clinical criteria a management protocol has been developed between ACC and the Ministry of Health for patients with dual diagnoses. The scenarios for ACC and DHB responsibilities are outlined in the following table:

Note: The underlying principle is that but for the accident, admission to a non-acute inpatient rehabilitation facility would not occur.

If the person has an accident	Then	Then
In the community and is admitted to an acute facility	Health pays until the person meets the clinical criteria; and A rehabilitation specialist accepts the person into a rehabilitation facility/service.	ACC will pay as long as rehabilitation relates to the injury.
In the community and is admitted to an acute facility	Health pays until the person meets the clinical criteria; and A rehabilitation specialist accepts the person into a rehabilitation facility; and It is identified that the person has significant medical/ mental health issues.	ACC pays the rehabilitation bed day price; and Under public health acute services, Health continues to pay the costs relating to medical/surgical /mental health services.
In the community and they are not admitted acutely for their accident but do require admission for a medical condition	They are transferred to an inpatient rehabilitation facility to manage their underlying medical condition.	Health pays
While in hospital and their injury is minor	The person remains in the same ward/unit because the injury is not expected to increase the length of stay and	Health continues to pay
While in hospital and their injury is major	Health pays until the person meets the clinical criteria; and The injury condition is expected to increase the length of stay.	ACC will pay as long as rehabilitation relates to the injury.

4.6 INFORMATION SUPPLY AND CODING

4.6.1 Public health acute services

The Ministry of Health incorporates information supply provisions in their funding agreement with DHBs including the:

- completion of ACC forms and medical certificates for individuals
- submission of data to the New Zealand Health Information Service (NZHIS) for all inpatients and day patients receiving public health acute services
- reporting on the volume of, and expenditure on, public health acute services provided by DHBs in outpatients and emergency departments:
 - by the purchase unit
 - whether the injuries were work related or non-work related
- supply of copies of relevant audit or monitoring reports related to the purchase of public health acute services.

4.6.2 National Minimum Data Set (NMDS)

NMDS coding plays a major part in identifying accident cases treated by hospitals and is used in calculating the amount ACC pays for public health acute treatment. Accident cases will normally be found among patients with ICD-10-AM 2nd Edition codes (used for hospital discharges) in the ranges S00-T98 (Injury, poisoning and certain other consequences of external causes) and V01-Y98 (External causes of morbidity and mortality). Not all such diagnoses will be covered by ACC legislation and some covered cases may have other diagnoses.

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

- Accident flag
- ACC claim number.

(For further information see *A Guide to Data Requirements 2001/2002*, NZHIS, May 2001.)

There are a few DHBs whose information systems do not enable use of these two fields, and for those hospitals the 'admission type' code should be used to identify ACC-covered cases.

The 'principal health service purchaser' code is used to identify the purchaser of treatment. In most cases, accident acute admissions will be coded '13', as they are funded through the Minister of Health's funding arrangements for public health acute services (the exception is the 18 coding for Ministry of Health purchasing of services for injured

overseas visitors). Codes for ACC and other accident payers should be used only for treatment directly purchased by ACC or accident payers (eg, elective admissions for elective surgery or non-acute/rehabilitative care).

Table 7: Coding of accident cases by DHBs on the NMDS

NMDS Field	Acute admissions	Elective admissions or non-acute transfers
Accident flag	Y	Y
ACC form number	ACC 45	ACC 45
Admission type (use only where above two fields cannot be supplied)	ZC or ZA	ZW
Principal health service purchaser	13 = all accident cases (except specific class of overseas visitors) 18 = overseas visitors who have not had a motor vehicle, work or workers' recreational accident, and are not Australian or UK residents	A0 = ACC A1-A7 = Private residual accident insurers 17 = Accredited employer

4.6.3 Codes used on ACC forms

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 ACC in meeting their obligations for treatment.

Read is the diagnosis coding system to be used by the primary sector, as it is the most commonly used system, and the ACC 45 form requires the primary sector to code injuries using this system.

The secondary sector, including DHBs, may choose to use either Read or **ICD-10-AM**.

Provider codes

ACC needs a number that identifies the DHB as the health provider. The aim for the future is that all health providers use the Distributed Provider Index (DPI), which is currently being developed by NZHIS.

In the meantime, ACC will continue to use its registration numbers.

Accredited employers

If it is a work-related injury, and the DHB is aware that the patient's employer is an accredited employer, the DHB should complete an ACC 45 form and forward it directly to the employer. Any further correspondence for payment or prior approvals should also be sent to the employer.

If the injury is a 'sensitive claim', the patient can request that the case be managed by ACC directly, in which case no ACC 45 form or claim details should be sent to the employer, but should go directly to the ACC Sensitive Claims Unit, which is responsible for managing all claims relating to sexual abuse or trauma (Telephone 0800 735 566).

4.7 Audit and monitoring

The Minister of Health's funding arrangements for public health acute services include provisions relating to quality of service provision and audit procedures that apply to the services purchased on behalf of ACC.

The Ministry of Health plans to audit the usage of NMDS accident-related fields and purchaser codes. Spot checks will be carried out by the Ministry of Health to identify probable accident cases via the use of ICD-10.

The Ministry of Health 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.

4.8 When other providers have initiated claims

Where another provider (eg, ambulance officer, accident and medical clinic) has completed an ACC 45 form before the person's treatment at a DHB, the DHB should use that form and claim number. Some DHBs have expressed reservations about using ACC 45 forms completed by other providers. For example, where a patient is delivered to hospital by an ambulance provider who has started an ACC 45, that form should be completed for ACC. The DHB can complete the form and advise the ambulance provider of its number for invoicing ACC.

Where the ambulance provider has completed and submitted an ACC45 to ACC and the DHB's injury diagnosis is different from the diagnosis made by the ambulance officer, the DHB should advise ACC, quoting the original ACC45 number.

If DHBs wish to complete a new ACC 45 form, rather than use the form completed by the ambulance service, this action will need to be agreed between the hospital and the ambulance service.

5 PROCESS FOR RESOLVING HEALTH/ACC BOUNDARY ISSUES

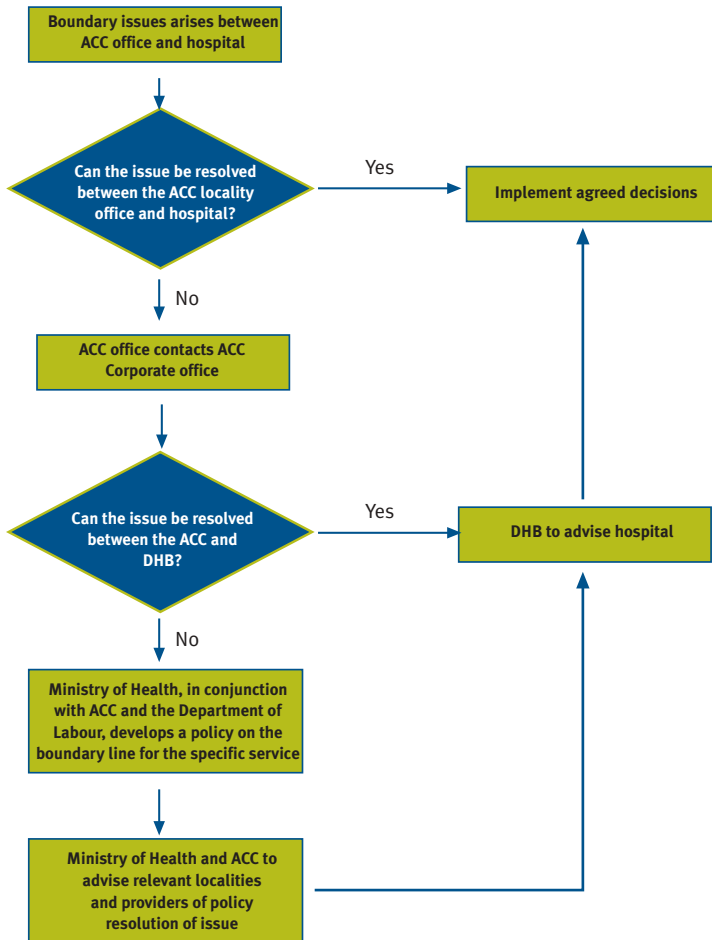
The following principles are to be used to reach agreement on boundary issues on services:

- Disputes should be resolved at the lowest possible level of management that is appropriate given the nature of the dispute concerned.
- Where responsibility for payment is disputed, services to individuals will be maintained by whichever agency is currently providing the treatment, until the issue is resolved.
- ACC is responsible for paying (either directly or through the Crown) for services for patients if these are required as a result of personal injury covered under the Injury Prevention, Rehabilitation, and Compensation Act 2001. Otherwise it is an illness or disability and the responsibility for determining the funding rests with the DHB and/or the Ministry of Health.

If ACC receives a request to pay for a service that ACC considers is part of the 'public health acute services' or is illness-related, the patient will be directed to his/her GP or the nearest hospital for the provision of the service. If the patient or provider disputes this decision, the first points of contact are the local ACC office and, in the case of a hospital, their local contact person in the DHB. If ACC declines to provide cover for the person's health condition, the patient can apply for a review of the decision using the disputes resolution procedure set out in the Injury Prevention, Rehabilitation, and Compensation Act 2001.

Where resolution cannot be reached at the local level by the DHB through negotiation with ACC/accredited employer on where responsibility lies, then they should contact the Ministry of Health. The Ministry of Health will work with ACC and the Department of Labour to determine whether a particular service is considered part of the public health acute services or not. ACC can seek a judicial review of any decision or determination by the Ministry with respect to whether ACC funds a particular service.

Figure 2: Process for resolving Health/ACC boundary issues Boundary issue arises between ACC office and hospital



APPENDIX A

Definitions of Terms in the Injury Prevention, Rehabilitation, and Compensation Act 2001

The following sections are from the Injury Prevention, Rehabilitation, and Compensation Act 2001. Only the officially printed version should be relied on.

6. Interpretation

6. **practicable**, in relation to rehabilitation, means practicable after considering and balancing the following:
 - (a) the nature and consequences of the injury;
 - (b) the achievement of rehabilitation outcomes;
 - (c) costs;
 - (d) cost effectiveness;
 - (e) the availability of other forms of rehabilitation;
 - (f) other relevant factors.
6. **public health acute services** means services (as defined in regulations made under section 322(2)) that are purchased through the Minister of Health and provided by a publicly funded provider.

Compare: 1998 No 114 s 13
6. **rehabilitation** –
 - (a) means a process of active change and support with the goal of restoring, to the extent provided under section 70, a claimant's health, independence, and participation; and
 - (b) comprises treatment, social rehabilitation, and vocational rehabilitation.
6. **treatment** includes –
 - (a) physical rehabilitation;
 - (b) cognitive rehabilitation;
 - (c) an examination for the purpose of providing a certificate including the provision of the certificate.

6. **treatment provider** –

- (a) means an acupuncturist, audiologist, chiropractor, counsellor, dentist, medical laboratory technologist, nurse, occupational therapist, optometrist, osteopath, physiotherapist, podiatrist, registered medical practitioner, or speech therapist; and
- (b) includes a member of any occupational group included in the definition of treatment provider by regulations made under section 322.

Compare: 1998 No 114 s 13

7. **Acute treatment**

Acute treatment, in relation to a claimant, means –

- (a) the first visit to a treatment provider for treatment for a personal injury for which the claimant has cover; and
- (b) the following treatments if, in the treatment provider's reasonable clinical judgment, the need for the treatment is urgent (given the likely clinical effect on the claimant of any delay in treatment):
 - (i) any subsequent visit to that treatment provider for the injury referred to in paragraph (a); and
 - (ii) any referral by that treatment provider to any other treatment provider for the injury referred to in paragraph (a).

Compare: 1998 No 114 s 14

17. **Ordinarily resident in New Zealand**

(1) A person is ordinarily resident in New Zealand if he or she –

- (a) has New Zealand as his or her permanent place of residence, whether or not he or she also has a place of residence outside New Zealand; and
- (b) is in 1 of the following categories:
 - (i) a New Zealand citizen;
 - (ii) a holder of a residence permit granted under the Immigration Act 1987;
 - (iii) a holder of a returning resident's visa or residence visa issued under the Immigration Act 1987 allowing the person to lawfully return to New Zealand or come to New Zealand for the purposes of residence:

- (iv) a person who is exempt from any requirement to hold a permit under the Immigration Act 1987:
 - (v) a person who is a spouse, child, or other dependant of any person referred to in any of subparagraphs (i) to (iv), and who generally accompanies the person referred to in the subparagraph.
- (2) A person does not have a permanent place of residence in New Zealand if he or she has been and remains absent from New Zealand for more than 6 months or intends to be absent from New Zealand for more than 6 months. This subsection overrides subsection (3) but is subject to subsection (4).
 - (3) A person has a permanent place of residence in New Zealand if he or she, although absent from New Zealand, has been personally present in New Zealand for a period or periods exceeding in the aggregate 183 days in the 12-month period immediately before last becoming absent from New Zealand. (A person personally present in New Zealand for part of a day is treated as being personally present in New Zealand for the whole of that day.)
 - (4) A person does not cease to have a permanent place of residence in New Zealand because he or she is absent from New Zealand primarily in connection with the duties of his or her employment, the remuneration for which is treated as income derived in New Zealand for New Zealand income tax purposes, or for 6 months following the completion of the period of employment outside New Zealand, so long as he or she intends to resume a place of residence in New Zealand.
 - (5) A person is not ordinarily resident in New Zealand if he or she is in New Zealand unlawfully within the meaning of the Immigration Act 1987. Any period during which a person is in New Zealand unlawfully is not counted as time spent in New Zealand for the purposes of subsection (3).

Compare: 1998 No 114 s 24

20. Cover for personal injury suffered in New Zealand (except mental injury caused by certain criminal acts)

- (1) A person has cover for a personal injury if –
 - (a) he or she suffers the personal injury in New Zealand on or after 1 April 2002; and
 - (b) the personal injury is any of the kinds of injuries described in section 26(1)(a) or (b) or (c) or (e); and
 - (c) the personal injury is described in any of the paragraphs in subsection (2).

- (2) Subsection (1)(c) applies to –
- (a) personal injury caused by an accident to the person:
 - (b) personal injury caused by medical misadventure suffered by the person:
 - (c) personal injury caused by medical misadventure in circumstances described in section 32(6):
 - (d) personal injury caused by treatment given to the person for personal injury for which the person has cover:
 - (e) personal injury caused by a work-related gradual process, disease, or infection suffered by the person:
 - (f) personal injury caused by a gradual process, disease, or infection that is personal injury caused by medical misadventure suffered by the person:
 - (g) personal injury caused by a gradual process, disease, or infection consequential on personal injury suffered by the person for which the person has cover:
 - (h) personal injury caused by a gradual process, disease, or infection consequential on treatment given to the person for personal injury for which the person has cover:
 - (i) personal injury that is a cardio-vascular or cerebro-vascular episode that is personal injury caused by medical misadventure suffered by the person:
 - (j) personal injury that is a cardio-vascular or cerebro-vascular episode that is personal injury suffered by the person to which section 28(3) applies.
- (3) Subsections (1) and (2) are subject to the following qualifications:
- (a) section 23 denies cover to some persons otherwise potentially within the scope of subsection (1):
 - (b) section 24 denies cover to some persons otherwise potentially within the scope of subsections (1) and (2)(d).
- (4) A person who suffers personal injury that is mental injury in circumstances described in section 21 has cover under section 21, but not under this section.

Compare: 1998 No 114 s 39

25. Accident

- (1) Accident means any of the following kinds of occurrences:
- (a) a specific event, or a series of events, that –

- (i) involves the application of a force (including gravity) or resistance external to the human body, or involves the sudden movement of the body to avoid such a force or resistance external to the human body; and
- (ii) is not a gradual process:
- (b) the inhalation or oral ingestion of any solid, liquid, gas, or foreign object on a specific occasion, which kind of occurrence does not include the inhalation or ingestion of a virus, bacterium, protozoa, or fungi, unless that inhalation or ingestion is the result of the criminal act of a person other than the injured person:
- (c) a burn, or exposure to radiation or rays of any kind, on a specific occasion, which kind of occurrence does not include a burn or exposure caused by exposure to the elements:
- (d) the absorption of any chemical through the skin within a defined period of time not exceeding 1 month:
- (e) any exposure to the elements, or to extremes of temperature or environment, within a defined period of time not exceeding 1 month, that, –
 - (i) for a continuous period exceeding 1 month, results in any restriction or lack of ability that prevents the person from performing an activity in the manner or within the range considered normal for the person; or
 - (ii) causes death.
- (2) However, accident does not include –
 - (a) any of those kinds of occurrences if the occurrence is treatment given, –
 - (i) in New Zealand, by or at the direction of a registered health professional; or
 - (ii) outside New Zealand, by or at the direction of a person who has qualifications that are the same as or equivalent to those of a registered health professional; or
 - (b) any ecto-parasitic infestation (such as scabies), unless it is work-related; or
 - (c) the contraction of any disease carried by an arthropod as an active vector (such as malaria that results from a mosquito bite), unless it is work-related.
- (3) The fact that a person has suffered a personal injury is not of itself to be construed as an indication or presumption that it was caused by an accident.

Compare: 1998 No 114 s 28

26. Personal injury

- (1) Personal injury means
 - (a) the death of a person; or
 - (b) physical injuries suffered by a person, including, for example, a strain or a sprain; or
 - (c) mental injury suffered by a person because of physical injuries suffered by the person; or
 - (d) mental injury suffered by a person in the circumstances described in section 21; or
 - (e) damage (other than wear and tear) to dentures or prostheses that replace a part of the human body.
- (2) Personal injury does not include personal injury caused wholly or substantially by a gradual process, disease, or infection unless it is personal injury of a kind described in section 20(2)(e) to (h).
- (3) Personal injury does not include a cardio-vascular or cerebro-vascular episode unless it is personal injury of a kind described in section 20(2)(i) or (j).
- (4) Personal injury does not include –
 - (a) personal injury caused wholly or substantially by the ageing process; or
 - (b) personal injury to teeth or dentures caused by the natural use of those teeth or dentures.
- (5) For the purposes of subsection (1)(e) and to avoid doubt, prostheses does not include hearing aids, spectacles, or contact lenses.

Compare: 1998 No 114 s 29

27. Mental injury

Mental injury means a clinically significant behavioural, cognitive, or psychological dysfunction.

Compare: 1998 No 114 s 30

28. Work-related personal injury

- (1) A work-related personal injury is a personal injury that a person suffers—
 - (a) while he or she is at any place for the purposes of his or her employment,

including, for example, a place that itself moves or a place to or through which the claimant moves; or

- (b) while he or she is having a break from work for a meal or rest or refreshment at his or her place of employment; or
 - (c) while he or she is travelling to or from his or her place of employment at the start or finish of his or her day's work, if he or she is an employee and if the transport –
 - (i) is provided by the employer; and
 - (ii) is provided for the purpose of transporting employees; and
 - (iii) is driven by the employer or, at the direction of the employer, by another employee of the employer or of a related or associated employer; or
 - (d) while he or she is travelling, by the most direct practicable route, between his or her place of employment and another place for the purposes of getting treatment for a work-related personal injury, if the treatment –
 - (i) is necessary for the injury; and
 - (ii) is treatment of a type that the claimant is entitled to under Part 1 of Schedule 1.
- (2) In subsection (1)(d), most direct practicable route does not include those parts of a route that deviate unreasonably from, or interrupt, a journey for purposes unrelated to the employment or the treatment.
- (3) Work-related personal injury includes a cardio-vascular or cerebro-vascular episode suffered by a person, if the episode is caused by physical effort or physical strain, in performing his or her employment, that is abnormal in application or excessive in intensity for the person.
- (4) Work-related personal injury includes personal injury caused by a work-related gradual process, disease, or infection.
- (5) Work-related personal injury includes personal injury suffered by a person resulting from treatment for a work-related personal injury as defined in subsections (1), (3), or (4), whether or not the injury is a personal injury caused by medical misadventure.
- (6) Work-related personal injury does not include personal injury suffered by a person when all the following conditions exist:
- (a) the personal injury is suffered in any of the circumstances described in subsection (1); and

- (b) the personal injury is suffered in the circumstances described in section 21; and
 - (c) the person elects to have the personal injury regarded as a non-work injury, in which case that personal injury is a non-work injury.
- (7) It is irrelevant to the decision whether the person suffered a work-related personal injury that, when the event causing the injury occurred, he or she –
- (a) may have been acting in contravention of any Act or regulations applicable to the employment, or in contravention of any instructions, or in the absence of instructions; or
 - (b) may have been working under an illegal contract; or
 - (c) may have been indulging in, or may have been the victim of, misconduct, skylarking, or negligence; or
 - (d) may have been the victim of a force of nature.
- (8) This section is subject to section 29 (personal injuries that are both work-related and motor vehicle injuries).

Compare: 1998 No 114 s 32

74. Limits on treatment providers in decisions on acute treatment

- (1) A treatment provider to whom a claimant presents for treatment may exercise the clinical judgment described in section 7(b) as to the urgency of the need for the treatment only if he or she is a treatment provider of a type appropriately qualified to make a clinical judgment of that kind.
- (2) A treatment provider qualified as required by subsection (1) who makes a clinical judgment that treatment requires an acute admission must ensure that the treatment is provided by –
- (a) a publicly funded provider; or
 - (b) if the Corporation gives its prior agreement, a provider that is not a publicly funded provider; or
 - (c) if, for reasons of clinical safety, treatment by a publicly funded provider is not practicable, a provider that is not a publicly funded provider.
- (3) A treatment provider who is not qualified as required by subsection (1) must refer the claimant to a treatment provider who is so qualified, and the visit to that treatment provider, on referral, is also regarded as acute treatment.

(4) For the purposes of subsection (2), –

acute admission means an admission within 7 days of the making of the decision to admit unless otherwise specified in regulations

publicly funded provider means a provider that, for the time being, is funded by a district health board or the Minister of Health to provide public health acute services.

Compare: 1998 No 114 s 81

Schedule 3 - Cover for mental injury caused by certain acts dealt with in Crimes Act 1961 s21(2)

Section

- 128 Sexual violation
- 129 Attempt to commit sexual violation
- 129A Inducing sexual connection by coercion
- 130 Incest
- 131 Sexual intercourse with girl under care or protection
- 132 Sexual intercourse with girl under 12
- 133 Indecency with girl under 12
- 134 Sexual intercourse or indecency with girl between 12 and 16
- 135 Indecent assault on woman or girl
- 138 Sexual intercourse with severely subnormal woman or girl
- 139 Indecent act between woman and girl
- 140 Indecency with boy under 12
- 140A Indecency with boy between 12 and 16
- 141 Indecent assault on man or boy
- 142 Anal intercourse
- 142A Compelling indecent act with animal
- 194 Assault on a child, or by a male on a female. For the purposes of this schedule, section 194 of the Crimes Act 1961 must be regarded as relating only to situations where a female sexually assaults a child under 14 years old.
- 201 Infecting with disease
- 204A Female genital mutilation
- 204B Further offences relating to female genital mutilation.

Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002

Silvia Cartwright, Governor-General

Order in Council

At Wellington this 18th day of March 2002

Present:

Her Excellency the Governor-General in Council

Pursuant to section 322(2) of the Injury Prevention, Rehabilitation, and Compensation Act 2001, Her Excellency the Governor-General, acting on the advice and with the consent of the Executive Council, makes the following regulations.

Contents

1	Title	4	Definition of public health acute services
2	Commencement		
3	Interpretation		

Regulations

1 Title

These regulations are the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002.

Price code: KS

2 Commencement

These regulations come into force on 1 July 2002.

3 Interpretation

- (1) In these regulations, unless the context otherwise requires,—
Act means the Injury Prevention, Rehabilitation, and Compensation Act 2001

acute admission has the same meaning as in section 74(4) of the Act

emergency transport has the same meaning as in regulation 3 of the Injury Prevention, Rehabilitation, and Compensation (Ancillary Services) Regulations 2002

outpatient has the meaning set out in subclause (2)

personal health services has the same meaning as in section 6(1) of the New Zealand Public Health and Disability Act 2000; and **services** has a corresponding meaning.

- (2) A person is an **outpatient** in relation to a healthcare facility if—
- (a) the person receives from a registered 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 registered medical practitioner intends that the person will leave the facility within 3 hours after the consultation begins.

4 Definition of public health acute services

- (1) For the purposes of the Act, **public health acute services**, in relation to treatment of a claimant for a personal injury for which he or she has cover, means any of the following personal health services:
- (a) services provided as part of an acute admission:
 - (b) services provided as part of an emergency department presentation, and any subsequent services provided by the emergency department within 7 days after that presentation:
 - (c) outpatient services that are provided by a registered medical practitioner and associated with services

- described in paragraph (a) if those outpatient services are provided within 6 weeks after the day of discharge:
- (d) outpatient services that are provided by a registered medical practitioner and associated with services described in paragraph (b) if those outpatient services are provided within 6 weeks after the day of treatment:
 - (e) services that are provided by a registered medical practitioner less than 7 days after the date on which the claimant is referred for those services by another registered medical practitioner, other than—
 - (i) services associated with services described in paragraph (a) or paragraph (b); and
 - (ii) referrals to a radiologist by a registered medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 of the Act or under clause 1 of Schedule 1 of the Act:
 - (f) services that are ancillary to any of the services described in paragraphs (a) to (e), including non-emergency travel and accommodation for the claimant and an escort or support person for the claimant, but excluding emergency transport:
 - (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.
- (2) To avoid doubt, subclause (1) applies only to services that are purchased through the Minister of Health and provided by a publicly funded provider.

Marie Shroff,
Clerk of the Executive Council.

Explanatory note

This note is not part of the regulations, but is intended to indicate their general effect.

These regulations, which come into force on 1 July 2002, define the term **public health acute services** for the purposes of the Injury Prevention, Rehabilitation, and Compensation Act 2001. These services cover acute personal health services provided on the Accident Compensation Corporation's behalf by a publicly funded provider. The term needs to be defined to enable the Corporation to make a bulk payment to the Minister of Health to cover the costs of that treatment.

Issued under the authority of the Acts and Regulations Publication Act 1989.

Date of notification in *Gazette*: 21 March 2002.

These regulations are administered in the Department of Labour.

APPENDIX C

PUBLIC HEALTH ACUTE SERVICES: 1 APRIL 2002 TO 30 JUNE 2002

The purchasing arrangements for public health acute services described in the Second Edition of *Accident Services – Who Pays* (March 2001) continued to apply between 1 April 2002 and 30 June 2002 (ie, a regulated levy payment from ACC to the Crown for the financial year to 30 June 2002).

Services included in 'public health acute services' were the services described in s.14(2) of the Accident Insurance Act 1998, that is:

s14(2) "public health acute service" –

- (2) "Public health acute service", in relation to treatment of an insured for a personal injury for which he or she has cover, means any of the following personal health services when those services are provided by a hospital and health service:
 - (a) Services provided as part of –
 - (i) An unplanned admission; or
 - (ii) A planned admission, if the admission date is less than 7 days after the date on which the decision to admit was made:
 - (b) Services provided as part of an unplanned emergency department presentation, and any subsequent services provided by the emergency department within 7 days of that presentation:
 - (c) Outpatient services (not including services not provided by registered medical practitioners or nurses, such as, for example, services provided by audiologists, physiotherapists, and occupational therapists) that are associated with services –
 - (i) Provided under paragraph (a) within 6 weeks of the day of discharge; or
 - (ii) Provided under paragraph (b) within 6 weeks of the day of treatment:
 - (d) Services not associated with services provided under paragraph (a) or paragraph (b) that are provided by a registered medical practitioner less than 7 days after the date an insured is referred for those services by another registered medical practitioner.
- (3) In subsection (2), "personal health services" and "services" have the same meaning as "personal health services" in section 2 of the Health and Disability Services Act 1993.

Section 14(2) applied from 1 April to 30 June 2002 despite the repeal of the Accident Insurance Act 1998, because of a savings provision in s.348 of the Injury Prevention, Rehabilitation, and Compensation Act 2001.

ACC continued to purchase acute services provided by Community Trust Hospitals from 1 April 2002 until 30 June 2002, as funding for these services was not included in the public health acute levy that ACC paid to the Crown for the financial year to 30 June 2002.

APPENDIX D

CLINICAL CRITERIA FOR TRANSFER FROM ACUTE TO NON-ACUTE INPATIENT REHABILITATION

1. Generic criteria

The person's condition is medically stable and likely to improve, and injured person is medically stable when the following conditions are met.

1. Absence of any life-threatening condition which would require emergency surgery, for example:
 - to depressurise an intra-cranial haemorrhage
 - to arrest potentially catastrophic haemorrhage from a ruptured aneurysm, ruptured spleen or liver.
2. Absence of any life-threatening condition requiring intensive monitoring, for example:
 - no significant infection
 - no raised intra-cranial pressure
 - no cerebro-spinal fluid leak
 - no naso-gastric drainage.
3. Airway is secure and patient can control respiration, or can only control respiration with routine assistance from machine/people where this assistance is subordinate to rehabilitation needs.
4. Airway is secure, excluding patients with acute, short-term tracheostomy who have just come off a ventilator; the tracheostomy must be removed or be stable before medical stability is achieved.
5. Fractures are firmly fixed either internally or externally.
6. There are no issues requiring daily clinical input from the (non-rehab) specialist clinical team or issues requiring daily medical input but which are subordinate to rehabilitation needs.

Where the above clinical conditions are met, transfer to non-acute care may be suitable for people with the following conditions:

- patients feeding by mouth, naso-gastric tube or percutaneous gastrostomy
- patients requiring IV antibiotics with or without central line
- patients requiring CAPD, or haemodialysis, and who are stable with this management.

2. Specific clinical criteria

In addition to the above criteria people in the following patient groups must also meet the following specific clinical criteria.

People with moderate or severe brain-injury¹³

There is no uncontrolled or significantly unstable epilepsy, level of consciousness, psychiatric conditions, etc. People with stabilised epilepsy, cognitive disturbance and/or psychiatric conditions may be suitable provided other criteria are met.

'Medically stable' for a severely brain-injured person occurs when the patient meets the following conditions:

- no issues requiring daily input from the specialist medical team
- intra-cranial pressure not raised
- no intra-cranial haematoma requiring intensive monitoring
- no cerebro-spinal fluid leak
- no significant chest infection
- airway secure, excluding patients with acute, short-term tracheostomy who have just come off a ventilator; the tracheostomy must be removed before medical stability is achieved, (those who have a longer-term tracheostomy, such as for a fractured larynx, are regarded as medically stable)
- fractures firmly fixed either internally or externally, although people with fractures can be non-weight bearing
- no significant infection
- feeding by mouth, naso-gastric tube or percutaneous gastrostomy but not on naso-gastric drainage.

People with spinal cord injury

There are no pressure areas or ulcers requiring surgical intervention. People with pressure areas that require significant time on bed rest may be suitable, provided other criteria are met.

People with severe multiple injuries/burns

There are no actual or suspected DIC, renal failure, internal haemorrhage or viscous disruption (anatomical or physiological) requiring intensive monitoring. Patients have

¹³ Moderate brain injury is defined as:

- Best Glasgow Coma Score within first 24 hours is between 8 or 15, PTA between 24 hours and 5 days, Rancho Los Amigos scale 5-7.

Severe brain injury is defined as:

- Severe cognitive and/or physical injury, best Glasgow Coma Score within 24 hours is 8 or less, PTA more than 5 days, Rancho Los Amigos scale 1-4, "Likely to remain in this category".

restored fluid balance with normal intake and output. Patients have no suspect compromised limb/extremity circulation.

People who are receiving specialised dressings and/or bandages or are awaiting further surgery may be suitable provided other criteria are met.

CLINICAL TEAM AGREEMENT TO TRANSFER CARE

The clinical team responsible for acute care (which may be a discipline-specific specialist) agrees to discharge with reference to this framework **and** the clinical team that will continue non-acute care agrees to accept (ie, take over responsibility)¹⁴. The two clinicians/teams referred to may be the same in situations where a physical transfer from one facility to another is inappropriate or not possible.

¹⁴ In the event of disagreement about clinical stability, a formal mechanism for reaching an outcome is in place (see section 5).

APPENDIX E

CLINICAL CRITERIA FOR TRANSFER FROM NON-ACUTE INPATIENT REHABILITATION TO A COMMUNITY SETTING

Background and Purpose

ACC, HFA/Ministry of Health have worked jointly to clarify the boundary between non-acute inpatient services and the Community. In consultation with health professionals from hospital as well as community settings and support groups a set of criteria has been developed to assist in determining the point at which any particular individual is ready for transfer from the “non-acute inpatient rehabilitation service”.

It is acknowledged that a path towards transfer is planned for from the beginning of an episode of non-acute inpatient rehabilitation care.

The criteria are intended to:

- provide a framework for assessing when a person’s needs are no longer considered in-patient non-acute and when the person is suitable for transfer to community-based services or home.
- clarify funding responsibility for funders and providers
- contribute to greater consistency of decision making.

General Considerations

Transfer to the community from an inpatient rehabilitation facility must be a planned process. There are many parties that are potentially involved in this process and it is important that all parties that need to be consulted are consulted and agreement reached and plans detailed before the transfer occurs.

The following matters must be considered and satisfied:

1. The person is medically stable and it is clinically appropriate to transfer to community-based services or home.
2. The clinician responsible for non-acute inpatient rehabilitation service agrees to discharge with reference to this framework **and** the clinician who is to continue to provide rehabilitation and/or care in the community or at home agrees to accept (ie, take over responsibility).
3. There has been consensus-based and timely consultation with the patient, family, and community provider on all aspects of discharge.

4. The multidisciplinary team agree on the clinical timing of discharge.
5. The exit criteria have been met.

Exit Criteria

1. Entry criteria for Non-Acute Inpatient Rehabilitation continue to be met.
2. A post-discharge plan has been finalised.
3. Agreed multidisciplinary rehabilitation goals for the inpatient care have been met or it is agreed that more benefit can be gained by rehabilitation in a community setting.
4. Issues of safety and risk for the patient that may arise with the transfer to home or community services have been evaluated and where necessary mitigated.
5. Where there are issues still requiring daily input from non-acute inpatient rehabilitation specialist clinical team, these are subordinate to the benefits to be gained by being at home or in another community setting.
6. The discharge destination or accommodation has been identified which will meet the assessed needs of the person.