ACCIDENT SERVICES – WHO PAYS?

The Impact of the Accident Insurance Act 1998 on District Health Boards

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Foreword

This guide has been developed by the Accident Compensation Corporation (ACC) and the Ministry of Health. The Accident Insurance Act 1998 and amendments have been interpreted as they may be applied in practice.

Written specifically for health and disability providers working in the public hospital and health services sector, it replaces *Accident Services – Who Pays?* (Ministry of Health, July 1999) and *Purchasing ACC Treatment Services,* Edition One and Edition Two, (1998, 1998).

The Government is expecting to make further changes to accident compensation legislation; in particular, the Injury Prevention and Rehabilitation Bill was introduced to Parliament late last year. Once the new legislation has been passed, this information will be updated.

The impact of the current accident insurance legislation on District Health Boards (DHBs) is outlined with regard to the provision of accident-related treatment services for people who have cover under the Accident Insurance Act 1998.

The major change is a return to the single-insurer environment from 1 July 2000, when ACC again became responsible for all accidents: work- and non-work-related. Registered private insurers will maintain responsibility for their claimants who had accidents during the period 1 July 1999 to 30 June 2000. The recent amendment to the Accident Insurance Act 1998 reintroduced the Accredited Employers Programme, which is also outlined here.

The implementation of the New Zealand Health Public Health and Disability Act 2000 (NZPH&DA 2000) is also relevant. While Hospital and Health Services (HHS) and the Health Funding Authority (HFA) no longer exist as separate named entities to date there are no new administrative practices or procedures associated with the provision and payment of accident-related services arising because of the new Act. In practice, this means that where in the past we used HHS, we are now using DHB and where we used the HFA we are using the Ministry of Health.

As various HFA functions transfer from the Ministry of Health to DHBs, this may affect these procedures. Circulars outlining the implications of these changes will be published on the ACC and Ministry of Health websites and provided to DHBs.

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.

Disclaimer
This information is intended to serve only as a general guide to purchasing arrangements under the Accident Insurance Act 1998 and regulations, and Accident Insurance (Transitional Provisions) Act 2000. For any legal or financial purposes, these two Acts, and contractual arrangements between funders and providers, take precedence over the contents of this guide.

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1 INTRODUCTION

1.1 PURPOSE

This guide helps determine whose responsibility it is to pay for services provided to injured persons who have cover under the Accident Insurance Act 1998 (AI Act).

It is addressed mainly to District Health Boards (DHBs) which arrange the provision of some services funded through arrangements with the Ministry of Health, and others that are purchased through arrangements with the Accident Compensation Corporation (ACC)[1].

Section 1 outlines the **key issues** arising from the AI Act, and **changes** that have resulted from the Transitional Provisions Act 2000 which returns the accident insurance environment to a single insurer, ACC.

Section 2 defines **services** that the Ministry of Health and ACC have a responsibility to purchase on behalf of 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 on behalf of ACC.

Section 5 outlines the **disputes resolution process.**

New Zealand Public Health and Disability Act 2000

The Health and Disability Services Act 1993 was replaced by the New Zealand Public Health and Disability Act 2000 on 14 December 2000. Implementation of the Act is expected to require some changes to the administrative practices and procedures outlined in this guide.

The Ministry of Health has fully absorbed the functions of the HFA, which means that payment issues or information concerns should be directed to the Ministry of Health. However, the addresses, processes and systems have not changed.

The term 'public hospital' will be used in selected circumstances to refer to the scope of activities previously undertaken by the HHS, to distinguish from the broader level of potential activities of the DHB.

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[1] There may also be some arrangements with residual insurers or accredited employers

1.2 DEFINITIONS

Throughout this document the following terminology is used:
ACC – the Accident Compensation Corporation. ACC is referred to throughout the document as the organisation responsible for payment of all accident cases not covered by the 'public health acute services' levy. However, for claims resulting from workplace injury between 1 July 1999 and 30 June 2000, and for which there is ongoing cover, the responsibility for accident patients may be with a registered 'residual insurer'. Further, 'accredited employers', as agents of ACC, may be parties who pay for the treatment of non-public health acute services. In some circumstances there may be another agency acting on the behalf of ACC, residual insurers or accredited employers (eg, third party administrator).

Accredited employer – an employer who has signed a contract with ACC, under the ACC Partnership Programme, whereby the employer accepts responsibility for managing and directly funding most of the statutory entitlements of their employees who suffer a work-related injury. *ACC remains liable for meeting the costs associated with the public health acute services provided by DHBs.*

Injured person or Patient – a person who has cover under the AI Act.

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

DHB Funding Arrangement – the term used in this document to refer to the arrangement whereby DHBs are required to provide public health acute services to accident patients within their allocated funding for different hospital services (Accident and Emergency, orthopaedics etc) by the Minister of Health.

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

Public health acute services – acute and emergency treatment services provided by DHBs, defined in s.14(2) of the AI Act (see Appendix A). The hospital treatment services covered by this definition are outlined in section 2.

Residual insurer – a registered insurer that covers an injured person, mainly for work accidents, in terms of work accident insurance under the AI Act during the period 1 July 1999 to 30 June 2000 (when the competitive insurance market ended).

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

Treatment providers – a range of health providers recognised in the AI Act as able to provide acute treatment for personal injuries (see section 2.7)

1.3 LEGISLATIVE PROVISIONS

The Accident Insurance Act 1998 came into force on 1 July 1999, and was amended by the Accident Insurance (Transitional Provisions) Act 2000 on 1 April 2000 and the Accident Insurance Amendment Act 2000 on 1 July 2000. However, the Accident Insurance Act 1998 (AI Act) remains the principal act governing accident compensation. The Government is currently reviewing the provisions for accident compensation, with the intention of introducing further legislation in 2002 to replace the current AI Act.

The main features of the current accident compensation legislation are listed below.

- The competitive market for the provision of workplace accident insurance, introduced by the AI Act on 1 July 1999, ended with the passing of the Accident Insurance (Transitional Provisions) Act 2000.
- ACC resumes overall responsibility for providing cover and entitlements for all injuries arising from accidents occurring from 1 July 2000 covering work-related personal injuries and other personal injuries covered by the Act, for example, motor vehicle injuries, work-related injuries, sexual abuse, gradual process injuries, and medical misadventure.
- Residual registered insurers will continue to be responsible for managing all work-related injuries that occurred between 1 July 1999 and 30 June 2000, for whom the insurer provided cover[2].

The legislation enables a registered insurer to arrange for another insurer or ACC to take over their residual or ongoing claims. ACC has assumed responsibility for managing the claims of all @Work claimants, and DHBs will be kept advised of any other transfers of claim management.

- Re-establishment of the 'Accredited Employers' Scheme administered by ACC under the 'ACC Partnership Programme' from 1 April 2000 provides employees of accredited employers with coverage for work injuries.

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[2] Claims may be lodged with insurers some time after 1 July 2000, however, registered insurers still retain responsibility for these delayed claims, so long as the injury occurred during the period they provided cover.

- An injured person has similar entitlements as prescribed in former accident compensation Acts, but their choice of treatment provider is broadened in some areas.
- 'Public health acute services' provided by DHBs are publicly funded through Vote: Health. The Crown recovers these costs from ACC through an annual levy. The AI Act prohibits ACC from purchasing these services directly from DHBs.
- ACC is responsible for directly purchasing any services outside the public health acute services definition, and this can be from the provider of their choice, including DHBs.

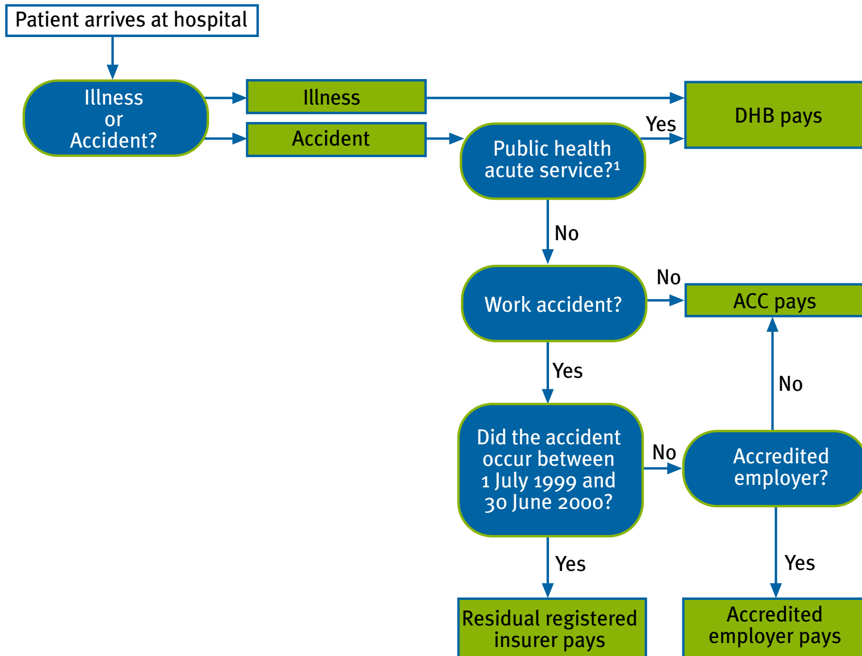
DHBs need to be able to:

- identify and track service provision for people who are being treated under multiple purchasing arrangements
- complete the appropriate claim forms – that is, an ACC 45 for all ACC or accredited employer patients
- bill ACC (or appropriate insurer or accredited employer) for treatment that is not part of the defined 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 elective.

Figure 1: Payment arrangements for services provided by DHBs



Note: [1]'Public health acute service' are acute and emergency services provided by DHBs, defined in the AI Act (see section 2).

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[1] There may also be some arrangements with residual insurers or accredited employers

1.4.1 DHB PURCHASING ARRANGEMENTS

ACC pays a levy to the Crown to cover funding of 'public health acute services'. The amount and conditions relating to this levy are specified in the Accident Insurance (Insurers' Payments for Public Health Acute Services) Regulations 2000.

The Minister of Health enters into 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. The DHB's funding mechanism will vary according to DHB/provider relationship.

1.4.2 PURCHASING ARRANGEMENTS FOR NON-PUBLIC HEALTH ACUTE SERVICES

When a DHB provides treatment services that fall outside the definition of 'public health acute services', the DHB must bill ACC or the accredited employer. (For injuries that occurred between 1 July 1999 and 30 June 2000, bill the relevant insurer.)

The cost of treatment payable by ACC for these non-public health acute services is an amount:

either

(a) specified in treatment cost regulations

Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999 ('treatment cost regulations'), covering the costs of treatment for counsellors, dentists, hyperbaric oxygen treatment, radiologists, registered medical practitioners (including specialists), specified treatment providers (see section 2.7), practice nurses, elective surgery, transport and accommodation, and escorts;

or

(b) cost of treatment or as contracted between ACC and hospitals

For those services where the cost of treatment is not regulated, ACC is liable to pay the cost of treatment when the acute services have been provided by a 'treatment provider' (see section 2.7).

Services that could be provided by a 'treatment provider', including a hospital, here include acute treatment by district nurses, occupational

health nurses, rural health nurses and optometrists (that is, non-public health acute treatment). The cost of treatment is determined by hospitals/providers and the various ACC contractual arrangements or negotiations. ACC is not liable to pay for any services provided by other types of health care providers (eg, dieticians, 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 AI Act specifies a clear rehabilitation objective for treatment: to enable a patient to lead as normal a life as possible given the nature of the injury.

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

- treatment is necessary and appropriate
- treatment is of appropriate quality for the purpose
- treatment is provided only as often as necessary
- treatment is provided at an appropriate time for the purpose
- treatment is the type of treatment normally provided by a treatment provider
- treatment is provided by a treatment provider who would normally provide that treatment.

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

Contracts

ACC may enter into direct contractual arrangements with DHBs for specified elective services. However, ACC are prohibited by the AI Act (s.360) from entering into contracts with DHBs for public health acute services.

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, accredited employers or residual insurers. 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 non-public health acute services may be made on the basis of one of the following:

- a contract between ACC and the provider, covering a specified service
- a claim against payment schedules specified in the treatment cost regulations
- negotiated agreements between ACC and the provider, covering individual cases
- the cost of service if not covered by any of the above arrangements.

1.4.3 USER PART-CHARGE

In certain circumstances, DHBs may charge the injured person an amount over and above the amount that ACC pays. The AI Act, the Health and Disability Services Act 1993 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 defined in s.14(2) of the AI Act – see section 2.1 and Appendix A)	The user part charge conditions specified in the 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 cost regulations and the treatment providers' total cost for providing the services. But, if the amounts are *not* specified in the treatment cost regulations, ACC must pay the provider the full cost of treatment, and therefore no user part-charges needs to be made	
Non-public health acute services provided as ancillary services(eg, pharmaceuticals and ambulance services)	ACC remain liable for the full cost of this treatment service, and providers of ancillary services may charge either ACC or injured person, for all (or part) of the cost of treatment. But, injured people may claim reimbursement from ACC for any amounts they are required to pay in the way of part-charges.	
Elective surgery (see section 2.3)	No user part-charge may be made as the hospital is either the provider nominated by the ACC, *or* if not the nominated provider, the DHB is able to charge ACC the cost of surgery.	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.

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.24 of the AI Act (see Appendix A).

Overseas visitors and foreign diplomats

All overseas visitors who sustain any type of personal injury covered by the AI Act have the same entitlement to DHB public health acute services as New Zealand residents. They cannot be directly charged for any acute accident treatment service. The Ministry of Health purchases public health acute services for all overseas visitors and foreign diplomats who have accidents who:

- are covered by the Australian reciprocal arrangements
- are covered by the United Kingdom reciprocal arrangements
- have a motor vehicle accident
- have an accident at work
- have an accident outside usual work hours for a person in paid employment
- have a recreational or sporting accident

If an overseas visitor does not fit one of the circumstances listed, the DHB should bill the Ministry of Health (for invoicing arrangements see section 4.2). These arrangements are likely to change as funding is devolved to DHBs. DHBs will also need to code any overseas accident patients at variance with the above to the new purchaser code 18 on the NMDS (see section 4.6.2).

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, district nursing services, etc.

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

- ACC does not accept the injury as covered by the AI Act
- 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.42 of the AI Act)
- the injury did not occur in New Zealand.

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 – are covered for treatment, compensation and rehabilitation.

There are several key terms used in defining coverage under the AI Act, namely 'accident', 'personal injury' and 'work-related personal injury'. (For specific sections of the AI Act covering these definitions see Appendix A.)

The AI Act also contains details of the cover provided for particular types of personal injury, for example, New Zealanders injured overseas (s.41), exclusions for visitors while on an aircraft or ship (s.42), specific instances of mental injury covered by ACC (s.40). 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 COVERS INJURED PERSONS?

(a) ACC is responsible for covering:

- all personal injuries incurred as a result of accidents which occurred prior to 1 July 1999
- all work-related personal injuries for new employers and new self-employed from 1 April 2000 to 30 June 2000
- all non-work related personal injuries which occur as a result of accidents from 1 July 2000
- all work-related personal injuries from 1 July 2000, for all employers except those who have been accepted into the Accredited Employers Programme.

(b) Accredited employers are responsible for covering:

- all work-related personal injuries of their employees which occur from the date of accreditation (earliest date is 1 July 2000) for a specific time period.

Note: ACC will regularly send updated lists of all accredited employers and their date of accreditation, together with details of any third party administrators via the monthly ACC News, as well as

maintaining a current list on the ACC health provider website:
www.healthwise.co.nz

(c) Residual registered insurers are responsible for covering:

- all employees' work-related injuries which occurred between 1 July 1999 and 30 June 2000
- both the non-work and work injuries of self-employed people during the period 1 July 1999 and 30 June 2000 who had accident insurance cover with registered insurers.[3]

[3] Self-employed people were able to choose to insure with either ACC or a registered insurer for both their work and non-work injury insurance.

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 and arranged 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 less than 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 or nurse **up to six weeks** following discharge from an acute or arranged admission or emergency department attendance	●	
	Services provided by registered medical practitioner or nurse **post six weeks** from discharge from acute/arranged admission or emergency department attendance		●
	Services provided by a registered medical practitioner **less than seven days** from a referral by another medical practitioner	●	
	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 or nurse		●
	Services provided by other health professionals, eg physiotherapy, occupational therapy		●
	Non-acute outpatient rehabilitation services		●
DHB community health services (see 2.6)	District nursing services provided after discharge from an acute/arranged 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, physio-therapists, osteopaths, dentists, counsellors, etc) and rehabilitation services.		●

2.1 PUBLIC HEALTH ACUTE SERVICES

The AI Act defines 'public health acute services' in s.14 (2) of the AI Act (see Appendix A). This definition covers the following services when provided by a DHB:

a) unplanned admissions ('acute admissions' within the NZHIS definition – see Appendix C)

b) planned admissions where the admission date is less than seven days [4] after the date on which the decision to admit was made (for 'arranged admissions' within the NZHIS definition see Appendix C)

c) emergency department attendances and follow-up at the emergency department less than seven days [4] from the initial presentation

d) outpatient services, provided by registered medical practitioners or nurses, associated with services provided under paragraphs (a) to (c) above, up to six weeks following discharge or treatment

e) services provided by a registered medical practitioner less than seven days [4] after the date an insured person is referred[5] for those services by another registered medical practitioner.

The following interpretations of the accident insurance 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 DHB hospitals. For financial and legal purposes, the AI Act and the contractual arrangements between ACC and the DHBs take precedence.

2.2 DHB ACUTE AND ARRANGED ADMISSIONS

All acute and arranged admissions (including day patients) are funded (through the Ministry of Health) by the DHB. An admission may be from the emergency department, outpatient department, or a GP/private specialist referral. The NZHIS definitions of acute and arranged admissions apply (see Appendix C).

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[4] Less than seven days is defined as follows: Date of presentation is Day 0. Day 1 therefore starts from midnight on the date of presentation. Therefore, if a patient presents at 11 pm on 1 October (Day 0), the count starts at mid night on 1 October (beginning of Day 1, technically the morning of October 2), with Day 6 ending at midnight on October 7. Any visits after midnight of 7 October (that is, on 8 October) will be on Day 7, and therefore not within the definition of public health acute services.

[5] The date of referral is the date on the doctor's referral letter or day of the telephone referral, NOT the date the DHB receives the referral letter or the date of the patient's injury.

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
- 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).

A staged discharge, agreement on funding responsibility may need to be negotiated between ACC (or their agent) and the DHB (see section 4.4).

2.3 ELECTIVE ADMISSIONS

Except for specific purchases outlined in section 3 of this booklet, ACC is responsible for all planned 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/arranged 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 cost 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 patient 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 percent 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 must pay 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 'Protocols for Treatment of Private Patients' when they treat patients who are *'fully or partly funded by ACC or any insurer registered in accordance with the Accident Insurance Act 1998, for treatment for personal injury by accident covered by that Act'.*

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

2.4 DHB EMERGENCY DEPARTMENT ATTENDANCES

All unplanned emergency department attendances and arranged returns less than seven days from the date of the first visit are funded by the DHBs from Ministry of Health contracts. Treatment covered by the levy includes related services directly associated with the visit, including:

- trauma management services
- diagnostic support services **ordered during the attendance**, for example, 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
- 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 agreed definition within the AI Act of what constitutes the 'emergency department', but it is interpreted in this context to mean any area in the DHB which provides treatment services that would generally be considered as part of a normal emergency department operation of a DHB hospital.

2.5 DHB OUTPATIENT SERVICES

2.5.1 MEDICAL AND NURSING FOLLOW-UP FROM ACUTE SERVICES

The DHB funding arrangement covers arranged attendances to a DHB facility-based registered medical practitioner or nurse, not involving an admission to a DHB, for up to six weeks from the date of discharge from acute and arranged 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 or nurses and related to the attendance, for example, 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

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

These outpatient services do *not* include allied health services, district/ community nursing or non-acute outpatient rehabilitation 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 DHB funding arrangement 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 medical practitioner. Services covered include treatment services directly associated with the visit (see section 2.5.1).

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 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. ACC will require a claim form completed by the referring treatment provider, or the private provider, before the private provider is paid.

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 are liable to pay for any such acute treatment, by paying either the:

- amount specified in the treatment cost regulations, or
- full cost, when the treatment is not specified in regulations, or
- amount specified in the DHB's contractual arrangements with ACC.

Prior approval may be required for some 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. Such patients fall under the definition of public health acute services only when they are referred on an urgent basis to a medical practitioner by another medical practitioner and clinically require to be seen within seven days of referral (see section 2.5.2). Otherwise ACC are responsible for payment.

2.6 DHB COMMUNITY SERVICES

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

District or community nursing

From 1 July 2000 all district or community nursing services required immediately on discharge from hospital are purchased directly by ACC, including any related services provided (or identified as required) 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 are liable to pay for that treatment under the terms of the AI Act (see section 1.4.2 for details about ACC's purchasing arrangements.) Prior approval may be required for 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 SERVICES

ACC purchase treatment services from a range of non-DHB-hospital treatment and rehabilitation providers.

2.7.1 ACUTE TREATMENT

The following treatment providers can provide acute treatment for personal injuries by accident without having to obtain the prior

approval of ACC:

- acupuncturist
- audiologist
- chiropractor
- counsellor – defined in the Accident Insurance ('Counsellor') Regulations 1999
- dentist
- laboratory technologist
- nurse
- occupational therapist
- optometrist
- osteopath
- physiotherapist
- podiatrist
- registered medical practitioner (includes specialists)
- speech therapist.

The treatment conditions listed in section 1.4.2 apply.

Acute treatment is defined in s.14(1) of the AI Act (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).

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 REHABILITATION

A person who has sustained a personal injury is entitled to rehabilitation that will enable them to lead as normal a life as possible, depending on the injury.

ACC are required to develop a rehabilitation plan within 13 weeks of the acceptance of the claim. Prior to that plan being developed, ACC is

liable for the provision of rehabilitation services in accordance with the minimum statutory entitlements in the AI Act (schedule 1, part 3).

The aim of the rehabilitation plan is to assist the person to undertake the activities of daily life to the greatest extent possible, given the injury. The plan must identify the injured person's needs and the appropriate services to meet these needs. The rehabilitation plan may cover:

- aids and appliances
- attendant care
- child care
- home help
- modifications to the injured person's home
- training for independent living
- transport for independence
- vocational rehabilitation needs.

An opportunity to participate in developing the plan must be provided to the insured person (or their representative), the treatment provider and the employer. The injured person has to agree to and sign the rehabilitation plan before it can be implemented. Agreeing to the plan does not affect the person's rights to request a review or to appeal the entitlements provided.

People already covered by the regulations relating to complex personal injuries continue to be covered by these regulations after 1 July 1999.

3 SPECIFIC SERVICES

This section lists specific examples of the services referred to in the previous section. Responsibility for payment for some of these services remains the subject of discussion and resolution between ACC and the health sector. 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 DHB funding arrangement through the Ministry of Health

(b) Elective – elective treatment at a DHB is ACC's responsibility. However, the DHB is responsible for elective treatment when it is part of an outpatient service provided by a doctor or nurse **within six weeks** of discharge of 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 patient and/or their doctor can, however, appeal this decision through the dispute mechanisms available in the AI Act.

3.2 HYPERBARIC OXYGEN TREATMENT

Hyperbaric oxygen treatment provided by:
- a DHB as part of an acute/arranged admission, or emergency department attendance, is covered by the DHB funding arrangement
- a DHB as part of an elective service is covered by ACC purchasing arrangements
- by the naval hospital at Devonport Naval Base, or any other non-DHB hospital provider, is purchased by ACC under the treatment cost regulations.

3.3 DENTAL TREATMENT

Dental treatment provided by a DHB is the funding responsibility of the DHB or ACC on the following basis:

(a) i Acute admission/emergency treatment – all dental treatment provided by a DHB as part of an acute or arranged admission or emergency department attendance is covered by the DHB funding arrangement.

ii Outpatient treatment – all outpatient services provided by a dentist are the responsibility of ACC. The DHB funding arrangement covers dental outpatient services only when they are provided by oral or maxillo-facial surgeons within six weeks of discharge of 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 max illo-facial surgeons are payable by ACC.

(b) Elective treatment – ACC is responsible for all elective treatment, including restorative dental treatment and specialist dental procedures. Such treatment may require ACC's prior approval.

Community-based or private dental services

All accident dental treatment provided outside a DHB facility is the responsibility of ACC. The Ministry of Health general dental benefits, which provides free dental care for children, does 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 this treatment is provided by a private or community-based dentist.

3.4 TREATMENT FOR CONCURRENT MEDICAL CONDITIONS

Where patients with an underlying medical condition require an accident-related intervention, ACC is responsible for funding the elective episode of care, taking into account the patient's condition. ACC are 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 from the accident are the responsibility of ACC as funders; 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 DHB HOSPITAL

If, during elective treatment for which ACC is responsible, a patient requires a service that is part of public health acute services, funding responsibility is covered by the DHB funding arrangement from the

time the need for the acute service was determined. DHB hospital to DHB hospital transfers relating to the acute event are the responsibility of the DHB, but private hospital to DHB 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, or a patient having a severe asthma attack leading to a pneumothorax.

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 Ministry of Health 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 Ministry of Health. This includes blood products required to support elective treatment or other services which are the responsibility of ACC.

3.7 MEDICAL CONSUMABLES

A medical consumable is an item supplied to assist an injured person to undertake the activities of daily living to the extent possible with the limitation caused by their personal injury, where the item is non-returnable (for example, incontinence equipment).

Examples of medical consumables include items such as:

- incontinence sheets
- 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 substances
- 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 Ministry of Health funds DHBs for medical consumables provided as part of the services they are responsible for as part of the provision of public health acute services (see sections 2.2–2.6). The hospital is responsible for assessing the immediate need for medical consumables prior to discharge, in conjunction with an accident case manager. In cases where discharge planning with ACC is not possible, hospitals should arrange a reasonable supply for the patient, sufficient to cover the period until ACC can organise medical supplies (up to a week).

ACC purchases medical consumables as part of the services they are responsible for as described in sections 2.2–2.6, that is, all non-public health acute services. These consumables are purchased by ACC via a national contract, and mechanisms for DHBs to supply consumables to patients in the following circumstances should be discussed with ACC:

- following discharge from the hospital
- who self-refer or are referred by GPs for consumables only
- as part of medical/nursing outpatient services more than six weeks post-discharge
- by allied health outpatient services
- by district or community nursing and other community services
- as part of elective assessments or admissions.

However, the price paid by ACC for these services usually includes routine medical supplies, such as the dressing packs used as part of a district nursing visit. The items covered in the contract price will be specified in ACC's contracts for purchasing community health and elective services. Treatments covered by treatment cost 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 ring-fenced financially and cannot be automatically accessed by accident-related injured persons, and are generally not part of public health acute services. The acute component of specialised services, such as head injury and spinal

injury services are generally provided by DHBs as part of public health acute services (medical/surgical services).

For services not included under the public health acute definition, an injured person can only access Ministry of Health-funded DSS services where they have cover and entitlement under the AI Act, but have been disentitled to some services in terms of ss.117–123 of the AI Act (for example, because of wilfully self-inflicted 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.

During 1999/2000 the Ministry of Health and ACC worked together to develop clinical criteria to clarify the point at which it is clinically appropriate to transfer patients from services focussing on the provision of acute treatment to services primarily focussed on rehabilitation. The basis for these clinical criteria are outlined in section 3.10, with details in Appendix B. These clinical criteria will be applied progressively during 2001 and beyond, in accordance with an implementation plan jointly developed by ACC and Ministry of Health.

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 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 REHABILITATION

The duration of the acute event is from admission to discharge or transfer to a non-acute inpatient rehabilitation service. Non-acute rehabilitation is the responsibility of ACC.

There are four conditions that must be met before a patient can transfer from acute to non-acute ACC funded services:

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.

Specific clinical criteria for the acute/non-acute boundaries will be applied progressively during 2001 in accordance with an implementation plan jointly developed by ACC and Ministry of Health. From 1 March 2001 ACC will be responsible for paying for non-acute care for the following groups of patients who are assessed as meeting the criteria:

- Moderate or severe traumatic brain injury, that is, an initial or worst Glasgow Coma Score (GCS):
  - less than or equal to 8; or
  - between 9 and 15, and post-traumatic amnesia (PTA) lasting more than 24 hours
- spinal cord injury
- severe multiple injuries, burns, or other comparable injuries
- limb amputations
- people with severe injury as a result of medical misadventure.

Patients with age-related disabilities in addition to a personal injury, or those with mental health conditions and/or dual diagnosis will transfer to ACC from 1 July 2001.

In order to provide non-acute inpatient rehabilitation providers must have a contract with ACC.

Appendix B covers the process for transfer from acute to non-acute services of patients who meet the 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 Ministry of Health to ACC.

3.11 EQUIPMENT, AIDS AND APPLIANCES

Equipment, aids and appliances are items supplied to assist injured people undertake the activities of daily living to the extent possible for a person with the limitation caused by their personal injury, (eg, mobility aids, orthoses).

A distinction is normally made between items supplied on a short-term basis where return of the item is expected, and in order to aid recovery, and supply on a long-term basis to meet a more permanent support need.

3.11.1 SHORT-TERM LOAN EQUIPMENT

The DHB funding arrangement includes short-term loan equipment as part of public health acute services, as outlined in sections 2.2–2.6. This covers items:

- required by patients during acute/arranged admissions, emergency department attendances and following discharge as part of medical/nursing 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 or nursing 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-acute services including elective assessments or admissions.

In accordance with Ministry of Health policy, 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 the acute event if incapacity as the result of personal injury is predicted to last more than six months. Short-term loan equipment is used until the permanent equipment is available. Wherever possible, DHBs should give ACC one month's notice of the need for the service.

3.11.3 ORTHOTICS

Short-term loan orthoses provided to assist recovery from an acute event are the responsibility of the DHB (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 the acute event, if incapacity as the result of personal injury is predicted to last more than six months.

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/arranged 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/nursing outpatient services are part of public health acute services and covered by the DHB funding arrangement.

Note: Amputees who have lost limbs as a result of war action remain the responsibility of the Department of Social Welfare.

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 are responsible for implants provided as 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/nursing outpatient services are part of public health acute services and covered by the DHB funding arrangement.

3.14 HEARING AIDS

ACC is responsible for meeting the reasonable cost of hearing aids when cover and entitlement for a hearing loss has been determined under the AI Act (Schedule 1, Part 3, clause 43).

If the hearing loss is not the result of a personal injury covered by the AI Act, then the patient is responsible for paying for the cost of a hearing aid in terms of the current arrangements for non-accident patients, and the hearing aid subsidy of $89.10 is available. This Ministry of Health subsidy is not available for patients who have cover under the AI Act.

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 an accident covered under the AI Act. Prior approval from ACC would be 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. Payment for personal care services can be continued while a patient is in a DHB facility or a rest home receiving respite care.

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

3.16 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 policy on emergency transport and travel and accommodation assistance. Accident patients have the same access to the Ministry of Health 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 hours[6]. ACC's level of assistance for transport and accommodation provided by ACC is specified in the treatment cost regulations.

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

3.16.1 EMERGENCY TRANSPORT

ACC is responsible for emergency transport (including air ambulance) within 24 hours of the initial accident or patient being found. This includes emergency inter-hospital transfers (that is, within 24 hours) where the patient's condition deteriorated or the hospital was not able to provide the level of specialist care required.
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 initial retrieval. The DHB only funds inter-hospital transport within 24 hours if a patient requires transferring because

[6] The 24 hour period begins when an injured patient is located and picked up by emergency transport.

the hospital's normal services are not available (for example, if the ICU is full, or the specialist is on leave).

3.16.2 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 travel and accommodation assistance policy applies 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 policy[7].

If the Ministry of Health policy does not provide for assistance to an injured person, 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, following discharge home or transfer to rehabilitation, or after six weeks of medical/nursing outpatient services.

ACC is responsible for providing assistance for accident patients to travel to treatment (excluding public health acute services treatment). Criteria to receive payment by ACC for transport to treatment, and associated accommodation and costs payable, are determined by regulation. The transport must be for transport to treatment payable by ACC either directly through contract or regulation, or indirectly through the DHB. If the ACC policy does not provide for assistance to an injured person, the DHB is not responsible for providing any assistance.

3.16.3 ESCORTS

ACC is responsible for decisions on payment for travel and accommodation assistance for an escort, but only when an escort is accompanying the patient for non-emergency transport. ACC pays accommodation costs for escorts for as long as the availability of transport services prevents the escort returning home.

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

- the injured person is under 15 years of age
- the medical condition of the injured person is such that he or she needs an escort

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[7] '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.

- a person providing public transport requires the injured person to be escorted.

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[8]		●
	Non-emergency transport (non-ambulance)[9]		●
DHB acute/arranged admission	Emergency transport of injured person and escort within 24 hours		●
	Inter-hospital transfers within 24 hours		●
	Inter-hospital transfers after 24 hours	●	
	Non-emergency transport prior to admission		●
	Non-emergency transport following discharge home or to non-acute inpatient facility	●	
	Non-emergency transport for family/support person to travel between their home and the DHB	●	
DHB outpatient services: a) provided by doctor/nurse within 6 weeks of an emergency department attendance discharge or 6 weeks following an acute/arranged admission; **or** b) provided by a doctor within 7 days of a referral by a doctor.	Non-emergency transport for the injured person (and family/support person) to travel to and from the DHB for treatment at medical outpatients	●	
c) all other outpatient services other than (a) or (b) above (eg physiotherapy, occupational therapy, post 6 weeks medical outpatients)	Non-emergency transport for the injured person (and escort) to travel to and from the DHB for treatment at outpatients		●
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		●

[8] The 24 hour period begins when an injured patient is located and picked up by emergency transport.

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

[10] Treatment must be from a provider specified in the Accident Insurance Act 1998 (see section 2.7.1).

3.17 PHARMACY SERVICES

The DHB funding agreement covers pharmacy services and pharmaceuticals provided as part of the services they are responsible for as described in sections 2.2–2.6. This covers pharmaceuticals:

- required by patients during acute or arranged admissions or emergency department attendances
- administered by a nurse or 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.

The DHB funding arrangement **does not** cover pharmaceuticals prescribed by a doctor as part of an outpatient visit.

ACC is liable for the cost of pharmacy services and pharmaceuticals as described in sections 2.2–2.6. This covers outpatient prescriptions, self-referrals, primary referrals, post-six-week follow-up services, and services provided as part of elective assessments or admissions.

Community-referred pharmacy services for ACC and accredited employers are purchased by the Ministry of Health from the Pharmac schedule, through a payment arrangement between ACC and the Crown. If pharmaceuticals are not covered on the Pharmac Schedule, accident patients can seek reimbursement for the costs directly from ACC or their accredited employer. Residual insurers purchase such services directly.

DHBs are required to record the insurer identification code and 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.

3.18 LABORATORY SERVICES

The DHB funding arrangement covers laboratory services provided as part of the services they are responsible for as outlined in sections 2.2–2.6. This covers laboratory tests required by patients or ordered during acute/arranged admissions or emergency department attendances and medical/nursing 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 they are provided by private laboratories.

ACC are 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/nursing outpatient services, district 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, through a payment arrangement between ACC and the Crown. Residual insurers purchase such services directly.

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

3.19 RADIOLOGY SERVICES

The DHB funding arrangement covers radiology services provided as part of the services they are responsible for as outlined in sections 2.2–2.6. This covers diagnostic imaging required by patients or ordered during acute/arranged admissions or emergency department attendances and as part of medical/nursing outpatient services for up to six weeks from discharge or treatment.

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

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

3.20 TREATMENT PROVIDED BY COMMUNITY TRUSTS/COMPANIES

A number of DHBs have transferred ongoing responsibility for the provision of certain services in the area to community-based trusts. A

trust may have contracts with the Ministry of Health for the provision of healthcare services but because it is not legally part of a DHB, the trust is not funded by the DHB funding arrangement to provide public health acute services to accident patients.

Payment for inpatient acute treatment

Services provided by a community-based trust are therefore viewed by ACC as for a private provider, similar to a private accident and medical (A&M) centre. Accordingly, ACC is responsible for the payment of costs associated with acute treatment at a community-based trust.

ACC is responsible only for payment of inpatient '**planned**' admissions for acute treatment at community trusts when it is not 'practicable' to refer the patient to a DHB for acute treatment. ACC considers the **only** situation where it would not be 'practicable' to refer to an DHB hospital would be if the clinical condition of the patient/claimant is such that they must receive treatment immediately and it would not be feasible to transfer the patient to a DHB hospital.

Payment for outpatient acute treatment

For all other acute treatment, ACC is responsible for the payment for community-based services provided to non-inpatient accident patients (eg, emergency department presentation, radiology, treatment by registered medical practitioners, nurses or other treatment providers, transfers to a DHB for emergency treatment, and other non-inpatient acute treatment). Any patient who stays three hours or more is an inpatient.

Payment arrangements

Payments for acute treatment will be made by ACC in terms of the treatment cost regulations. For treatment that is covered by these regulations, the community trust can charge the patient a co-payment (which cannot be recouped from ACC).

If the treatment is not covered by these regulations, then ACC is liable for the 'cost of treatment' and the patient cannot be required, by either ACC or the hospital, to pay any portion of this cost.

Non-acute inpatient rehabilitation

ACC will also purchase non-acute inpatient rehabilitation from community trusts from 1 March 2001 as per the clinical criteria for hospitals (Appendix B) via the process described in section 3.10.

3.21 MENTAL HEALTH SERVICES

Acute admissions

All people requiring acute admission to a DHB, for whatever reason, are funded through the DHB funding arrangement. Admission for mental health treatment may be due to a person's physical injuries (eg, physical abuse or rape) or to a sudden mental health crisis linked to historic abuse. Planned admissions within seven days of the decision to admit are also covered in this way under the public health acute services levy. The service funded by the Ministry of Health covers the period from admission to discharge or transfer to another facility regardless of length of stay. It covers all treatment given during the admission including consultations by psychiatrists, psychologists, counsellors, nurses, social workers, etc.

Once the person is discharged from hospital, follow-up outpatient treatment by doctors or nurses is covered by the DHB funding arrangement for up to six weeks. This includes multi-disciplinary clinics where a doctor is present. The service includes all treatment provided as part of the clinic, but does not include referred services such as counselling. From six weeks after the discharge date, ACC is responsible for paying for further treatment.

Follow-up by any other type of professional is funded by ACC under the terms of the AI Act.

Emergency department attendances

People who attend a hospital emergency department are funded through the DHB funding arrangement. This includes any consultations by mental health staff during the attendance.

Any follow-up outpatient treatment (including treatment at a multi-disciplinary clinic) by doctors or nurses is covered by the DHB funding arrangement for up to six weeks, including all treatment services directly associated with the visit (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 all outpatient services.

Follow-up by any other type of professional is funded by ACC under the terms of the AI Act.

Outpatient department attendance

People who are referred or self-refer direct to a hospital outpatient department are funded through the DHB funding arrangement only if there is a doctor-to-doctor referral, and the person is seen within seven

days of referral. The service covers only the initial appointment and any further follow-up is funded through ACC.

ACC is responsible for funding referrals to doctors by non-doctors or referrals to any other category of staff.

Community health services

People receiving community mental health services are funded by the DHB funding arrangement only if the service is provided by a doctor or nurse as part of the follow-up to an acute admission or emergency department attendance, for up to six weeks after the discharge date.

Self-injury

Where an injury is deliberately self-inflicted the AI Act provides entitlement to treatment only, but not to rehabilitation or compensation entitlements. The treatment covered is treatment of the physical injury only, and not any underlying mental health condition such as depression. ACC therefore pays for the physical treatment costs of self-injury outside the public health acute period.

The Mental Health Service and Disability Support Services, funded by the Ministry of Health, are responsible for the physical rehabilitation and ongoing mental health treatments of patients who are disentitled under the AI Act because they wilfully self-inflicted their injuries.

3.22 SEXUAL ASSAULT SERVICES

The DHB funding arrangement covers sexual assault treatment and counselling services provided to a patient as part of acute inpatient admission or emergency department presentation. Outpatient follow-up visits to doctors or nurses and GP referrals to doctors within seven days are also covered by the DHB. 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 approving counsellors, and hospital counselling services should contact ACC to arrange recognition of counsellors employed by their service.

4 ADMINISTRATIVE PROCESSES

4.1 NOTIFICATION

ACC should be notified as early as possible (through the ACC 45 form) of patients who are admitted as an acute or arranged 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

Ministry of Health – overseas visitors' variation

For a specific class of overseas visitors, DHBs must invoice the Ministry of Health separately for public health acute services. The specific class of overseas visitors covered by this invoicing arrangement are those visitors who have not had a motor vehicle accident, a work accident, a non-work accident (but a worker), and are not visitors from Australia or the UK.

All DHB invoices for overseas visitors must be accompanied by a Ministry of Health claim form (distributed by HFA in August 2000), outlining the details of the treatment provided by the DHB.

ACC – all accidents

Hospitals should complete the revised ACC 45 form for all accidents which occur after 30 June 2000, including when a patient's accident cover is the responsibility of the accredited employer.

The date of injury is critical for hospitals' identification just following the 1 July 2000 date, as residual insurers still remain responsible for work-related injuries that occurred in the 1 July 1999 to 30 June 2000 period.

All patients must have an ACC 45 form completed for the first attendance or admission, including patients treated under public health acute services. 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.

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.

Residual insurers

All patients with a work-related injury that occurred between 1 July 1999 and 30 June 2000 remain the responsibility of the registered insurers, who must be notified of treatment by any DHB.

A DHB cannot charge these insurers for any service provided as part of public health acute services, but should continue to bill them for all non-acute and elective services.

From 1 October 2000, DHBs use the new ACC 45 form to advise, or invoice, residual insurers for any treatment of work-related accidents that occurred during the year before 30 June 2000.

Residual insurers can arrange for another accident insurance company to assume responsibility for their ongoing claims. All providers will be advised of any instances when this occurs. To date only one registered insurer has transferred responsibility for managing its work-related claims – all @Work Insurance's ongoing claims are the responsibility of ACC from 1 July 2000.

Accredited employers

From 1 July 2000, DHBs will complete an ACC 45 form for any patients who suffer personal injury through a work-related accident. This includes patients whose injury is covered by an accredited employer.[11] Accredited employers, as agents of ACC (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 nursing/medical outpatient services and elective surgery).

The ACC 45 form now 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-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

[11] If the patient first presents for treatment from 1 July 2000 onwards, but the accident occurred between 1 July 1999 and 30 June 2000, then the responsibility for the claim rests with the residual insurer.

by a DHB directly by accessing the ACC Healthwise website: **www.healthwise.co.nz**[12]

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. ACC is not able to forward the DHB's account on to the accredited employer as the invoice will be made out to ACC, nor is ACC able to pay an invoice on behalf of an employer and 'back-charge' the costs.

If a DHB has consistent difficulty with an accredited employer, for example, 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 (see Appendix D).

Further Information

Appendix D provides contact details of residual registered insurers for your queries on invoicing for non-acute or elective services, discharge planning, etc.

For information about accredited employers, telephone the ACC provider help line – 0800 222 070. This help line and the Healthwise 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 AI Act from requiring prior approval for acute treatment.

ACC do not require prior approval when a person transfers from acute care to inpatient rehabilitation under the approved clinical criteria (that is, 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 inpatient rehabilitation.

If prior approval conditions are not met payment will not be made by ACC.

4.4 ACC PAYMENT ARRANGEMENTS

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

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[12] Procedures for checking accredited employer status at ACC Healthwise: go to home page at www.healthwise.co.nz, click on the link to accredited employers on this page

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 Cost Regulations	Not required
Elective surgery	Package of services	Elective surgery contracts or claim through Treatment Cost Regulations	Required
Inpatient/residential rehabilitation services	DHB	Inpatient/residential rehabilitation service contracts	Required for all cases except those patients covered by the clinical criteria[13] and the claimant is to stay longer than 6 weeks post injury
Elective outpatient assessments (new referrals)	Specialist	Clinical services contracts or claim through Treatment Cost Regulations	Not required
All other outpatient clinic attendances (excluding rehabilitation assessments and pain management services)	Physiotherapist Occupational therapist Counsellor Audiologist Dentist Speech therapist Podiatrist	Claim through Treatment Cost Regulations	Not required
	Optometrist	Optometry contract or claim through regulations	Not required
Rehabilitation assessments		Rehabilitation assessment contracts	Required
Pain management services		Pain management contracts	Required
Community health services	District or community nurse	Community nursing contracts or claim through regulations	Required only after 6 weeks or 12 visits (whichever comes first)
	Home support/ personal care	Home support contracts	Required with one working day's notice to ACC, but services can be put in place without prior approval in certain instances[14]
	Physiotherapist Occupational therapist Counsellor/psychologist Audiologist Podiatrist Speech therapist	Claim through Treatment Cost Regulations	Not required
Radiology		Claim through Treatment Cost Regulations	Not required
Laboratory and Pharmacy	Primary-referred Services	Purchased by Ministry of Health through Crown-ACC agreement	Not Required
Equipment	Enable NZ Invacare	Contracts	Required
Consumables	Baxter Healthcare Ltd	Contracts	Required

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

[13] 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 booklet (that is patients who have moderate or severe traumatic brain injury, spinal cord injury or severe multiple injuries or burns).

[14] 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 dis charge during weekends). DHBs must then follow-up with case managers within one working day (eg first thing Monday morning). Generally, ACC require one working days 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.

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 AI Act, and to those health professionals necessary for arranging post discharge treatment, care, support rehabilitation or other services.

The intent of the discharge planning requirement is to ensure the injured person has continuity of appropriate care. ACC are 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.

The Ministry of Health service specifications include requirements for discharge planning, including: 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.

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. Residual insurers should be sent a copy of the discharge summary for work-related injuries at the time of discharge, or as soon as practicable thereafter. 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.

Serious injury

For patients with serious long-term disability who require long-term or residential care, DHBs should provide ACC 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 health professional within the DHB if the DHB has given express written agreement for such an arrangement.

Transfer to non-acute service

The following table shows the process for transferring a patient from an acute to a non-acute service (for details see section 3.10; for the clinical criteria for transfer see Appendix B). The transfer process applies to all claimants who require inpatient rehabilitation services.

There must be clinical agreement for a patient discharge to non-acute services and the ACC case manager must also be notified of the transfer.

Table 5: Process for the transfer from acute to non-acute rehabilitation patient setting

Stage	Responsibility	Description
1	DHB	Acute admission – treatment commences with DHB completing ACC 45 form and forwarding to ACC within 2 working days.
2	DHB	Assessment by hospital acute rehabilitation clinical team, using clinical criteria in Appendix B of this book, to determine patient's: • Transfer to non-acute inpatient rehabilitation; **or** • Discharge home, with any rehabilitation requirements advised to ACC as part of discharge planning session;**or** • Continuation of acute in-patient treatment.
Claimant progresses to non-acute inpatient rehabilitation		
3	DHB	Complete 'Transfer of Care Notification' for: – Technical transfer – Intra-hospital transfer – Inter-hospital transfer (No prior approval is required from ACC for transfer.) DHBs to send 'Transfer of Care Notification' to ACC branch within 2 working days of transfer.
4	DHB	TRANSFER • Technical transfer – no prior approval required for transfer when patient remains in same bed/ward, but responsibility for rehabilitation transfers from DHB to ACC; • **Intra-hospital transfer** – no prior approval required; • **Inter-hospital (public or private) transfer** – no prior approval required.
5	DHB	'Rehabilitation Goal and Progress Setting Report' sent to ACC when in-patient rehabilitation progresses beyond two weeks. (Reports sent to ACC at two weekly intervals.)
6	DHB	Six weeks post injury prior approval is required from ACC to continue inpatient rehabilitation.

Table 6: Protocol for management of patients with dual diagnosis (to be used from 1 July 2001)

In addition to the clinical criteria a management protocol has been developed between ACC and 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 accident.
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 the acute levy, 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 in patient rehabilitation facility to manage their underlying medical condition...	• Health pays
While in hospital and their accident is minor…	• The person remains in the same ward/unit because the accident is not expected to increase the length of stay and…	• Health continues to pay
While in hospital and their accident is major…	• Health pays until the person meets the clinical criteria; and • The accident condition is expected to increase the length of stay…	• ACC will pay as long as rehabilitation relates to the accident.

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 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 2000/2001, NZHIS, May 2000.)

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 and arranged admissions will be coded '13', as they are funded through the DHB funding arrangement (the exception is the 18 coding for Ministry of Health purchasing of overseas visitors' accidents). 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 or arranged admissions	Elective admissions or non-acute transfers
Accident flag	Y	Y
ACC form number	ACC 45 (or AITC)	ACC 45 (or AITC)
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 which identifies the DHB as the health provider. The aim for the future is that all health providers use the National Provider Index (NPI), which is currently being developed by NZHIS.

In the meantime, ACC will continue to use its registration numbers. Residual insurers have sent out information on provider identification for billing purposes, and should be contacted directly if DHBs have any queries.

Residual insurer codes

For residual claims, providers need to write the patient's insurer and code on the ACC 45 form. There are two codes that can be used to identify the insurer: either a three-letter acronym (for example, NZI, HIH) or an alpha-digit code (for example, A2).

Any claims for @Work Insurance should be recorded on the system as ACC from 1 July 2000 as ACC has assumed responsibility for @Work's ongoing claims.

The full list of insurer codes for referrals and diagnostic services, for use in the NMDS and when completing the insurer forms, can be found in Appendix D.

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 is 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 DHB funding arrangement provisions relating to quality of service provision and audit procedures will apply to the services contracted on behalf of ACC. The information requirements in the contract will reflect the requirements of the Regulator's office attached to the Department of Labour.

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.

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

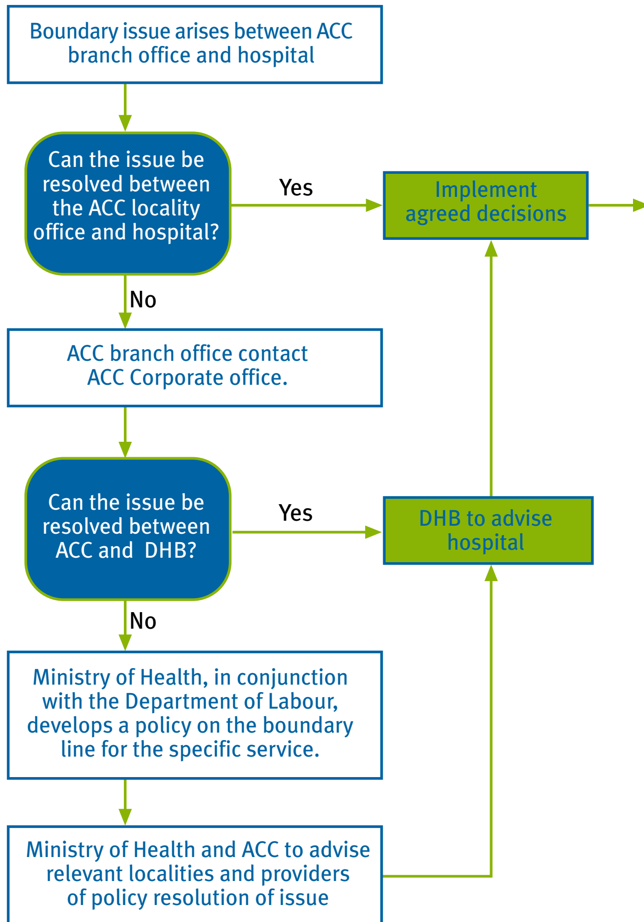
The following principles are to be used to reach agreement on boundary issues on services:

- Disputes should be resolved at the lowest possible level, for example, between local representatives of hospitals, the DHB and ACC/residual insurers.
- Where responsibility for payment is disputed, services to individuals will be maintained by whichever agency is currently funding 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 due to an accident. Otherwise it is an illness 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 the case is declined by ACC as being non-accident, the patient may use the disputes resolution procedure set out in the AI Act.

Where resolution cannot be reached at the local level by the DHB through negotiation with ACC/insurer on where responsibility lies, then they should contact the Ministry of Health. The Ministry of Health will work with the Department of Labour to determine whether a particular service is considered part of the public health acute services or not. ACC can request 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 branch office and hospital



APPENDIX A

Definitions of Terms in the Accident Insurance Act 1998
The following section is an extract from the Accident Insurance Act 1998. Only the officially printed version should be relied on

s.14 'Acute treatment' and 'public health acute service'

(1) 'Acute treatment', in relation to an insured, means —
(a) The first visit to a treatment provider for treatment for a personal injury for which the insured has cover; and
(b) The following treatments, if, in the treatment provider's reason able clinical judgement, the need for treatment is urgent (given the likely clinical effect on the insured 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).

(2) 'Public health acute service' means any of the following personal health services when those services are provided by a District Health Board:
(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.

s.24 '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 deemed to be 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).

s.28 'Accident'

(1) 'Accident', as defined in this section, is used in section 39 (2) (a).

(2) '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 or resistance external to the human body; and
(ii) Is not a gradual process:
(a) The inhalation or oral ingestion of any solid, liquid, gas, or foreign object on a specific occasion. This 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 insured:
(b) A burn, or exposure to radiation or rays of any kind, on a specific occasion. This kind of occurrence does not include a burn or exposure caused by exposure to the elements:
(c) The absorption of any chemical through the skin within a defined period of time not exceeding 1 month:
(d) Any exposure to the elements, or to extremes of temperature or environment, within a defined period of time not exceeding 1 month, that causes –
(i) Disability lasting for a continuous period exceeding 1 month; or
(ii) Death.

(3) However, 'accident' does not mean any of those kinds of occurrences, if the occurrence is treatment given, –
(a) In New Zealand, by or at the direction of a registered health professional; or
(b) Outside New Zealand, by or at the direction of a person who has qualifications equivalent to those of a registered health professional.

(4) The fact that an insured has suffered a personal injury is not of itself to be construed as an indication or presumption that it was caused by an accident.

s.29 'Personal injury'

(1) 'Personal injury' means –
(a) The death of an insured; or
(b) Physical injuries suffered by an insured, including, for example, a strain or a sprain; or
(c) Mental injury suffered by an insured because of physical injuries suffered by the insured; or
(d) Mental injury suffered by an insured in the circumstances described in section 40.

(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 39(2)(d),(e), (f), or (g).

(3) 'Personal injury' does not include a cardio-vascular or cerebro-vascular episode unless it is personal injury of a kind described in section 39 (2) (h) or (i).

(4) 'Personal injury' does not include –
(a) Personal injury caused wholly or substantially by the ageing process; or
(b) Personal injury to teeth caused by the natural use of those teeth.

s.32 'Work-related personal injury'

(1) A 'work-related personal injury' is a personal injury that the insured 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 insured 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
(a) 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 insurer is liable to provide under Part 1 of Schedule 1, whether or not the insurer provides any treatment in the particular case. 'Most direct practicable route' does not include those parts of a route that deviate from, or interrupt, a journey for purposes unrelated to the employment or the treatment.

(2) 'Work-related personal injury' includes a cardio-vascular or cerebro-vascular episode suffered by the insured, if the episode is caused by physical effort or physical strain –
(a) That occurs in any of the circumstances described in subsection (1); and (b) That is abnormal in application or excessive in intensity for the insured.

(3) 'Work-related personal injury' includes personal injury that is of a kind described in the first column of Schedule 2, and is suffered by an insured who is or has been employed in 1 of the corresponding trades, industries, or processes listed in the second column of the schedule, unless the insurer is able to decline, under section 68, a claim for cover lodged by the insured.

(4) An injury is a work-related personal injury, and is not a motor vehicle injury, if it –
(a) Falls within the definitions of both 'work-related personal injury' and 'motor vehicle injury'; but
(b) Is suffered in the circumstances described in subsection (1) (c) or (d).

(5) 'Work-related personal injury' includes personal injury caused by a work-related gradual process, disease, or infection.

(6) 'Work-related personal injury' includes personal injury suffered by an insured resulting from treatment for a work-related personal injury as defined in subsections (1) to (5), whether or not the injury is a personal injury caused by medical misadventure.

(7) 'Work-related personal injury' does not include personal injury suffered by an insured 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 40; and
(c) The insured elects to have the personal injury regarded as a

non-work injury. If the insured so elects, that personal injury is a non-work injury.

(8) It is irrelevant to the decision whether the insured suffered 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.

APPENDIX B

Clinical criteria for transfer from acute to non-acute 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-injury[15]

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 tracheosto my 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.

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[15] 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".

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 viscus disruption (anatomical or physiological) requiring intensive monitoring. Patients have 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.

Clinician agreement to transfer care

The clinician responsible for acute care (who may be a discipline-specific specialist) agrees to discharge with reference to this framework **and** the clinician who is to continue non-acute care agrees to accept (that is, take over responsibility)[16]. The two clinicians referred to may be the same person in situations where a physical transfer from one facility to another is inappropriate or not possible.

APPENDIX C

New Zealand Health Information Service (NZHIS) definitions

The following definitions are taken from *A Guide to Data Requirements 2000/2001, NZHIS, May 2000.*

Acute admission: An unplanned admission on the day of presenting at the admitting health care facility. Admission may have been from the Emergency or Outpatient Departments of the healthcare facility.

Arranged admission: A planned admission where:

- the admission date is less than seven days after the date the decision was made by the specialist that this admission was necessary, or
- the admission relates to normal obstetric cases, 37 to 42 weeks gestation, delivered during the event.

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

APPENDIX D

Code*	Company details	Contact details
ACC Contacts		
A0 or ACC	Accident Compensation Corporation (ACC) PO Box 242 Wellington	Provider Help Line Tel: 0800 222 070 www.healthwise.co.nz
A6 or @WK	@Work Insurance Limited As above	As above
Employers Name	ACC Partnership Programme (Accredited employers)	Partnership Programme Team Tel (04) 918 7700 www.acc.co.nz/employers
Residual Insurers *(For all work-related injuries between 1 July 1999 and 30 June 2000)*		
A1 or FIS	Fusion Insurance Services (Registered as Royal & Sun Alliance Accident Insurance Ltd) PO Box 90 351 Auckland	Rosealie Settle Tel 0800 800 807 fax 0800 807 877 info@fusioninsurance.co.nz
A2 or NZI	New Zealand Insurance (AI) Limited PO Box 196 Auckland	Justine Verrall Tel 0800 313 133 or (09) 359 7159 Justine_verrall@nzi.co.nz
A3 or HIH	HIH WorkAble Limited Private Bag 92147 Auckland	Joanne Pattison Tel 0800 496 752 jpattiso@hih.co.nz
A4 or MMI	Allianz NZ Ltd (formerly MMI General Insurance (NZ) Limited) PO Box 794 Auckland	Glenn Thomas Tel 0800 500 115 Glenn_Thomas@allianz.co.nz
A5 or FMG	Farmers' Mutual Accident Care Limited PO Box 1943 Palmerston North Justine Taylor	Tel 0800 366 466 or (06) 351 8903 justine.taylor@fmg.co.nz
A6 or @WK	@Work Insurance Limited	Claims managed by ACC - see above
A7 or ACE	ACE Insurance (Previously CIGNA Insurance) PO Box 734 Auckland	Ashok Lal or Roger Scholes Tel 0800 223 9675 or (09) 377 1459 ashok.lal@ace-ina.com roger.scholes@ace-ina.com

**Code for referrals, diagnostic services and NMDS*

FOOTNOTES

[1] There may also be some arrangements with residual insurers or accredited employers

[2] Claims may be lodged with insurers some time after 1 July 2000, however, registered insurers still retain responsibility for these delayed claims, so long as the injury occurred during the period they provided cover.

[3] Self-employed people were able to choose to insure with either ACC or a registered insurer for both their work and non-work injury insurance.

[4] Less than seven days is defined as follows: Date of presentation is Day 0. Day 1 therefore starts from midnight on the date of presentation. Therefore, if a patient presents at 11 pm on 1 October (Day 0), the count starts at midnight on 1 October (beginning of Day 1, technically the morning of October 2), with Day 6 ending at midnight on October 7. Any visits after midnight of 7 October (that is, on 8 October) will be on Day 7, and therefore not within the definition of public health acute services.

[5] The date of referral is the date on the doctor's referral letter or day of the telephone referral, NOT the date the DHB receives the referral letter or the date of the patient's injury.

[6] The 24 hour period begins when an injured patient is located and picked up by emergency transport.

[7] '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.

[8] The 24 hour period begins when an injured patient is located and picked up by emergency transport.

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

[10] Treatment must be from a provider specified in the Accident Insurance Act 1998 (see section 2.7.1).

[11] If the patient first presents for treatment from 1 July 2000 onwards, but the accident occurred between 1 July 1999 and 30 June 2000, then the responsibility for the claim rests with the residual insurer.

[12] Procedures for checking accredited employer status at ACC Healthwise: go to home page at www.healthwise.co.nz, click on the link to accredited employers on this page

[13] 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 booklet (that is patients who have moderate or severe traumatic brain injury, spinal cord injury or severe multiple injuries or burns).

[14] 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 require one working days 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.

[15] 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".

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