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ACC – Frequently Asked Questions for NZSA

for NZSA members

Introduction from the New Zealand Society of Anaesthetists

The NZSA meets with ACC regularly to advocate on behalf of our members and to be kept informed of ACC policies that affect the specialty and our patients. We discussed with ACC the need to provide our members with clear, accessible information across a range of issues and submitted questions to ACC to develop this member resource. We trust you find this an informative document and welcome your comments, including suggestions for additional questions you would like us to include.

What procedures do I need to follow to claim for ACC cases?

- **What is an ACC Provider Number and what do I need it for?**

  An ACC Provider Number is required before you can claim reimbursement for an ACC case funded under the Elective Surgical Contract. You can register with ACC if you are a treatment provider or a registered health professional under the Accident Compensation Act 2001. ACC's website provides information on who can register as a health provider and how to register – see Register with us as a health provider (acc.co.nz)

- **What is an ACC Vendor number and what do I need that for?**

  If you hold a Clinical Services Contract and are the supplier for that contract, you'll also need an ACC Vendor number to enable ACC to pay you for the service you provide. Application forms to register for ACC provider numbers or vendor numbers can be found here Register with us as a health provider (acc.co.nz)

What is the Clinical Services Contract (CSC)?

The purposes of the Service are:

- To provide specialist assessment and treatment services for clients who have an accepted claim for cover. The assessment must be related to the injury for whichthe client has cover and require a specialist opinion; and
- To restore clients' health to the maximum extent practicable; and
- To allow suppliers to carry out a procedure as part of the assessment (inaccordance with clause 10); or
- To provide specialist assessment for clients who have an accepted claim for cover or have been referred by ACC for an assessment which may help determine cover and

- Determine the cause of a client's on-going symptoms or condition; and/or
- Make recommendations for onward investigations, treatment, and rehabilitation.

- **Who can hold a Clinical Services Contract?**

  Appropriately qualified medical practitioners who are registered under the Medical Council of New Zealand who hold a vocational scope of practice in at least one of 24 specialties, which includes anaesthesia. See clause 3.1.(a) in the Contract Service Schedule

- **What is the process to set up a Clinical Services Contract?**

  To apply to set up a CSC, request an application form by emailing acchealthtenders@acc.co.nz and email the completed forms back to that email address. If you do not have success with this process, email electiveservices@acc.co.nz.

What is the Elective Surgical Contract (ESC)?

Under the Elective Surgical Contract ACC purchases a package of care including client liaison, preparation for surgery, delivery of surgical procedures, recovery, discharge, and follow-up care for a period of six weeks from the date of discharge from the treatment facility.

- **Who can hold this contract?**

  Contract holders for this contract are Hospitals (DHB's and / or Private Surgical Hospitals)

- **What does it cover?**

  Provision of surgical treatment for ACC clients with a covered injury. The Service commences upon receipt by the supplier of a draft surgical Assessment Report and Treatment Plan (ARTP) from a referring specialist and concludes either at the point an ARTP submitted as a request for approval is declined by ACC or the Client terminates treatment, or (if the ARTP is approved) six weeks from the date of discharge from the treatment facility. This period from commencement of services to conclusion of the services is the care period.

What are the different ways anaesthetists can be financially recognised for their care of patients funded by ACC?

Pre-operatively – Clinical Services Contract (CSC)

Anaesthetic pre-assessments may be funded via the CSC under the following circumstances:

- a surgical ARTP (Assessment Report and Treatment Plan) for the patient has been

submitted by the referring specialist and approved by ACC.
- it occurs pre-operatively.

The Clinical Services Operational Guidelines also state that these assessments will typically be undertaken for clients:

- whose co-morbidities are likely to pose anaesthetic risk.
- require non-core complex/unpredictable procedures if the client isexpected to need high dependency unit/intensive care unit care post-surgery.
- who have been identified with significant anxiety about anaesthesia.
- with a known prior history of complex anaesthetic needs.
- with a personal injury of unusual complexity requiring more complex level of investigation.

The relevant ACC codes relating to pre-assessments are: CS250, CS260 and CS70 (see more below).

- **What is the difference between a CS250 (Simple Pre-operative Anaesthetic Assessment-initial) and a CS260 (Complex Pre-operative Anaesthetic Assessment-initial)?**

  A Pre-operative Anaesthetic Assessment can be Simple or Complex, based on clinical best practice and the complexity of the client's injury. The two options are outlined below:

  - a Simple Pre-operative Anaesthetic Assessment is expected to take up to 45 minutes
  - a Complex Pre-operative Anaesthetic Assessment is expected to take over 45 minutes.

- **What is a CS70 used for?**

  Pre-operative anaesthetic phone consultation - CS70

  This consultation is a phone call to a client to serve as an initial or informational form of consultation to:

  - clarify answers on the anaesthetic pre-assessment form
  - discuss the perioperative plan
  - relieve anxiety.

  This is not a consultation in the sense applying above to the CS250 or CS260 codes. Following the initial discussion, it may be necessary to arrange a further assessment using the CS250 or CS260 codes, including by telehealth. The purpose of CS70 is to improve the service to clients as it is time- and cost-efficient to screen those clients who might require more in-depth assessments.

- **Who decides on the remuneration anaesthetists receive under this contract?**

  Prices for consultations under the Clinical Services Contract are set by ACC and adjusted annually.

Day of surgery - Elective Surgery Contract (ESC)

Under the Elective Surgery Contract ACC purchases a package of care including client liaison, preparation for surgery, delivery of surgical procedures, recovery, discharge, and follow-up care for a six-week period from the date of discharge. An approved ARTP determines the price that ACC will pay for the care provided. The exception is where a client requires an anaesthetic modifier (see more below).

- **What is a core (coded) vs non-core (non-coded) procedure?**

Core codes are a set of commonly performed procedures named in the ACC Elective Surgery Contract, for which a fixed price has been set.

A non-core procedure is one that is not able to be identified on the Elective Surgery Core procedures list and cannot be fairly and reasonably matched to a Procedure on ACC's Core Procedure List. Non-core surgery is priced by use of 18 different components (ESR codes) to create a final price.

- **Where do we find these codes?**

Service items codes and prices are in the Elective Surgery Contract Service Schedule.

Core codes:

  - Elective Surgery Contract Service Schedule (page 1)
  - Service Items and Prices (Part B; Clause 32) Table 1: Core Service Items and Prices

Non-core Items:

  - Elective surgery contract service schedule (page 36)
    Table 2: Non-core Service Items and Prices.

- **What is an ESR03?**

ESR03 is the code for recording the number of Relative Value Units (RVUs) for the Anaesthetist's Base Set in a noncore procedure.

Values are based on the NZSA Relative Value Guide 2021 table of Base Units (pp.7-11).

- **Who decides on the remuneration anaesthetists receive for a coded procedure?**

Remuneration is subject to the agreement between the anaesthetist and the contract holder.

- **How do we find out how much we will get paid per non-coded procedure?**

Anaesthetists are paid by the Elective Surgery Contract Holder not ACC. Any payments to anaesthetists are subject to arrangements between the contract holder and the anaesthetist.

  - ACC pays a rate per anaesthetic Relative Value Unit (RVU). This can befound under the code ESR03 in the Elective Surgery Contract (page 36)
  - Table 2: Non-core Service Items and Prices.

ACC allows the Elective Surgery Contract holder to claim for anaesthetic modifiers given that some circumstances cannot be predicted at the time the contract holder submits the ARTP for the client's surgery. Claims for these modifiers should be made through the Elective Surgery contract holder (see more below).

Post-operatively – Elective Surgery Contract

Under the Elective Surgery Contract, ACC purchases a package of care including client liaison, preparation for surgery, delivery of surgical procedures, recovery, discharge and follow-up care for a period of six weeksfrom the date of discharge from the treatment facility. Usually, all post-operative care is covered under the single payment for that particular procedure, but under certain circumstances the patient may qualify for the addition of modifying units (see more below).

What about the financial recognition of more complex patients having ACC funded procedures?

- Under certain circumstances patients may qualify for modifying units in addition to their coded reimbursement fee.
- The modifiers are based on the NZSA Relative Value Guide 2021.
- A summary of those situations where a patient may qualify for ACC related Modifiers can be found in Appendix One of the Elective Surgery Operational Guidelines.

- **How do we claim for these modifiers?**

  Claims should be made via the Elective Surgery contract holder.

How do you claim for a patient having surgery under an ACC treatment injury claim? What is the process?

- ACC does not differentiate between the types of covered injury for Elective Surgery Services.
- The process for a patient having surgery under an ACC treatment injury claim is no different to that of surgery for any other type of covered injury.

- **What is the remuneration based on?**

  Remuneration is subject to the agreement between the anaesthetist and contract holder.

- **How long does this process take?**

  Once ACC receives the contract holder's invoice, they will usually receive payment after eight working days for electronic billing, or 10 working days for manual billing or invoices sent by email.

What is a treatment injury?

A treatment injury is a personal injury caused by treatment by, or at the direction of, a registered health professional. Three core requirements need to be met for a treatment injury claim to be accepted:

- An injury has occurred that has resulted in physical harm or damage to the patient.
- The injury has been caused by treatment.
- The injury is not a necessary part or an ordinary consequence of treatment, having regard to the clinical knowledge at the time of treatment, and the underlying health condition of the patient.

What is a treatment injury mental injury?

A mental injury is a clinically significant behavioural, cognitive, or psychological dysfunction. ACC cover for treatment injury can include mental injuries caused by physical injuries that are part of treatment, whether or not the physical injury is covered by ACC (physical injury won't be covered if it is a necessary part or ordinary consequence of treatment). This provision was determined by the Court of Appeal in 2012 and applies to new claims or previously declined claims where the mental injury occurred after 1 July 2005.

For ACC to cover a Treatment Injury Mental Injury, it must meet the definition of a "personal injury" (as outlined in section 20(2)(b) of the Accident Compensation Act) and is a treatment injury (as outlined in section 32 of the Accident Compensation Act).

Therefore, ACC will cover a Treatment Injury Mental Injury if:

- there is a clinically significant mental injury
- the mental injury has been caused by a physical injury, even though the physical injury is not covered
- the mental injury also meets the following treatment injury criteria:
  — it was caused by treatment
  — it was not a necessary part of treatment
  — it was not an ordinary consequence of treatment.

Does ACC consider claims for anaesthesia awareness?

ACC considers claims for cover of cases involving anaesthesia awareness on a case-by-case basis. Cover is determined based on the test above and this involves consideration of the facts in each case. More detailed information about this has been provided by ACC and can be accessed from the NZSA members only section of the website.

What is the process for lodging a treatment injury claim?

As a registered provider, you can lodge claims on behalf of your patient if you think they have an injury that ACC covers, including a treatment injury. The claim must be lodged with the consent of the patient.

Clinical information is needed for a claim decision to show that the injury happened, and that it was caused by the treatment. Where available and relevant, clinical information should include: case notes, laboratory reports, referral letter(s), x-ray reports, MRI reports, operative notes, consent forms, discharge summaries, and a copy of the clinical incident review if completed for the injury and event. A letter explaining the reason for the claim, or a report about the treatment event, should be included especially if the situation is particularly complex.

Providing the required information to ACC as quickly as possible helps to ensure the quickest possible treatment injury claim cover decision. Legislation allows up to nine months for a decision to be made. ACC will write to the patient to let them know the outcome once a decision has been made.

Treatment injury claims can be lodged by completing an ACC2152 Treatment Injury Claim form. See https://www.acc.co.nz/assets/provider/3e3bd2aded/acc2152-treatment-injury-claim.doc

More guidance can be found in the Treatment Injury Claim Lodgement Guide https://www.acc.co.nz/assets/provider/405074f420/treatment-injury-claim-lodgement-guide.pdf

References

The following documents are accessible on the ACC website www.acc.co.nz:

- ACC (2020) *Clinical Services Operational Guidelines. Effective 1 July 2020*
- ACC (2020) *Elective Services: Operational Guidelines. Effective 30 July 2020*
- ACC (2016) *Service Schedule for Clinical Services – Includes In-Rooms Procedures.*
- ACC (2021) *Service Schedule for Clinical Services – Excludes In-Rooms Procedures.*
- ACC (2020) *Service Schedule for Elective Surgery Services.*
- ACC (2019) Treatment Injury: Claim Lodgement Guide.