PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

Nursing Services

Operational Guidelines for Providers

March 2018

This document is updated as required.

ACC contact details

Provider Contact Centre	If you have a general query or need assistance regarding a specific invoice, please contact the provider helpline: Phone: 0800 222 070 Email: providerhelp@acc.co.nz	
Client Helpline	Phone: 0800 101 996	
Provider Registration	Phone: 04 560 5211	Email: registrations@acc.co.nz
	Fax: 04 560 5213	
eBusiness	Phone: 0800 222 994, option 1	Email: ebusinessinfo@acc.co.nz
Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team: Phone: 0800 400 503 Email: health.procurement@acc.co.nz	
Engagement and Performance Managers	Engagement and Performance Managers (EPMs) can help you to provide the services outlined in your contract. Contact the Provider Contact Centre for details of the EPM in your region.	
Website	For more information about ACC, please visit: www.acc.co.nz	

Contents

Introduction

The Operational Guidelines for Nursing Services ("the Guidelines") are designed to assist with your service delivery.

The Guidelines should be read in conjunction with:

- the *Accident Compensation Act 2001 (AC Act)*
- the ACC *Standard Terms and Conditions*
- the *Nursing Services Service Schedule*

Further information to support your delivery of services for ACC clients is available on our webpage (www.acc.co.nz) and in the *ACC Treatment Provider Handbook*.

Services must be provided in accordance with the Guidelines unless there is a conflict between the Guidelines and the contract, in which case the provision within the contract takes precedence.

Updates to the guidelines will be made available as the need arises.

Purpose of the Service

The purpose of the Nursing Services is to provide community-based nursing treatment – usually in the client's home – for the injury-related needs of clients whose treatment cannot be delivered by their General Practice Team (GPT). This may be because:

- the nursing needs are too complex to be managed by the GPT,
- the client is physically unable, or unsafe to travel to their GPT, or
- the client requires nursing treatment outside of usual GPT opening hours.

Injuries, that can be managed by the GPT, will vary between different GPTs and this depends on the experience of the practice nurses and doctors.

Table One – Examples to determine eligibility

Meets Eligibility Criteria…		Does Not Meet Eligibility Criteria…	
✓	The client has reduced mobility.	✗	The client, or a client's parents, would prefer a home-based service for their convenience.
✓	The client has little or no natural support making it unsafe or impractical for them to attend their General Practice Team (GPT).	✗	General skin integrity management for an ACC-covered spinal cord injury.
✓	The client requires nursing treatment for Serious Injury.	✗	The nursing treatment is to assist a medical specialist
✓	The client needs care outside of normal practice hours.	✗	The client receives nursing treatment at an outpatient clinic that could be managed by a GPT, e.g. suture removal or nurse-led fracture clinics.
✓	Complex injuries, e.g. ulcers, wounds with heavy exudates, large bacterial burden, pressure wounds or skin grafts	✗	The referral is considered to allow the client to access a fully funded service rather than incur a co-payment at their GPT.
✓	Specialised treatment needs, e.g. stoma care, compression therapy, Negative Pressure Wound Treatment (NPWT).	✗	The client lives in residential care and requires treatment for a minor injury that would usually be self-managed or managed through natural supports. Residential care facilities are expected to manage these injuries (without lodging a claim) in lieu of self-management or family support. Residence can access Nursing Services for more significant injuries.
✓	Where the client has a history of leg ulcers, slow healing wounds, heart disease, diabetes, or is immunocompromised, which may adversely impact on their injury related rehabilitation.		

Service location

Nursing Services can be provided at the client's home, school or workplace, as well as the suppliers outpatient clinic, or another suitable community location. The location is determined by

the client's ability to travel and the complexity of the treatment they require.

Client choice should be considered when determining where services are delivered. The exception would be where the client is physically able to travel, has transport available and lives within reasonable travelling distance from a supplier outpatient clinic. In these cases the supplier can require the client to attend the clinic.

Prior approval from ACC is not required for the choice of service location. The supplier should ensure the service location is clinically safe for their patient, provides client privacy and doesn't pose a health and safety risk for the nurse.

Designated Providers

A Designated Provider (DP) is a Registered Nurse or Nurse Practitioner, with applicable postgraduate qualifications and work experience, who has been **approved by ACC as a DP**.

DPs have an important role within the Nursing Services contract. They ensure service quality by:

- providing clinical oversight for the supplier's nursing staff treating ACC clients,
- conducting Oversight Consultations and Comprehensive Nursing Assessments, and
- approving the use of high cost consumables.

Designated Provider criteria

The criteria required for a nurse to be approved as a Designated Provider is described in Section 6.8.3 of the Service Schedule. They are:

- has a current Annual Practising Certificate with no known conditions/restrictions on their practice and is not undergoing any formal or informal competency review/investigation; and
- has demonstrated post graduate experience of not less than three years full time work in the assessment and treatment of injury related conditions; and
- has demonstrated post graduate experience working with people in their own homes for no less than three years full time work; and
- provides clinical assessment and treatment services to clients as a regular component of their role; and
- Is readily accessible to the nursing staff who are treating clients under the Nursing Services contract. In this regard, accessibility may be in the form of clinical governance, assessment, treatment or supervision.
- has or is undertaking post graduate education at NZQF Level 8 (minimum post graduate certificate) in relevant nursing specialties, and
- participates in annual professional development directly related to their sphere of practice (e.g. wound care / aged care / nutrition / infection control); and
- maintains membership with a relevant professional organisation.

All applications will be assessed by ACC. There may be occasions where discretion will be applied for applicants, who don't meet all criteria listed above, but where equivalent experience or qualifications are detailed in support of their DP application.

Minimum Designated Provider availability requirements

Suppliers are required to have enough DPs on staff to ensure all their treating nurses have access to DP support during all hours of operation.

If at any time you don't have sufficient DP cover (outside of short term planned or unplanned leave) to provide support to all your treating nurses and complete Comprehensive Nursing Assessments, please inform your local Engagement and Performance Manager (EPM) or our Health Procurement team (health.procurement@acc.co.nz) immediately.

You are not required to have DPs located in every Territorial Authority (TA) you provide services in. However we will not pay for travel from outside the TA for a DP to conduct Oversight Consultations or Comprehensive Nursing Assessments.

Adding and removing Designated Providers from your contract

You may need to add or remove DPs from your contract as staff change in your organisation.

You need to advise our Health Procurement team immediately (health.procurement@acc.co.nz When a DP leaves your organisation.

If you wish to add a DP to your contract you and the candidate submit an application to ACC for approval.

The application includes information about the candidate's postgraduate qualifications and work experience as well as other relevant information required to assess whether they meet all requirements for DPs as outlined above.

You may have a DP candidate, who doesn't meet all criteria, but has additional experience or qualifications that you think could be deemed equivalent. Where this situation occurs the application should be submitted with detailed information about the candidate's additional experience or qualifications, allowing us to make an informed case by case decision.

If your application includes all required information, we will make a decision within 10 working days of receipt of the application. We may ask you for more information as required.

Service item code overview

The Nursing Services contract is invoiced via service item codes for treatment, assessment services, consumables and travel as outlined in Table Two below.

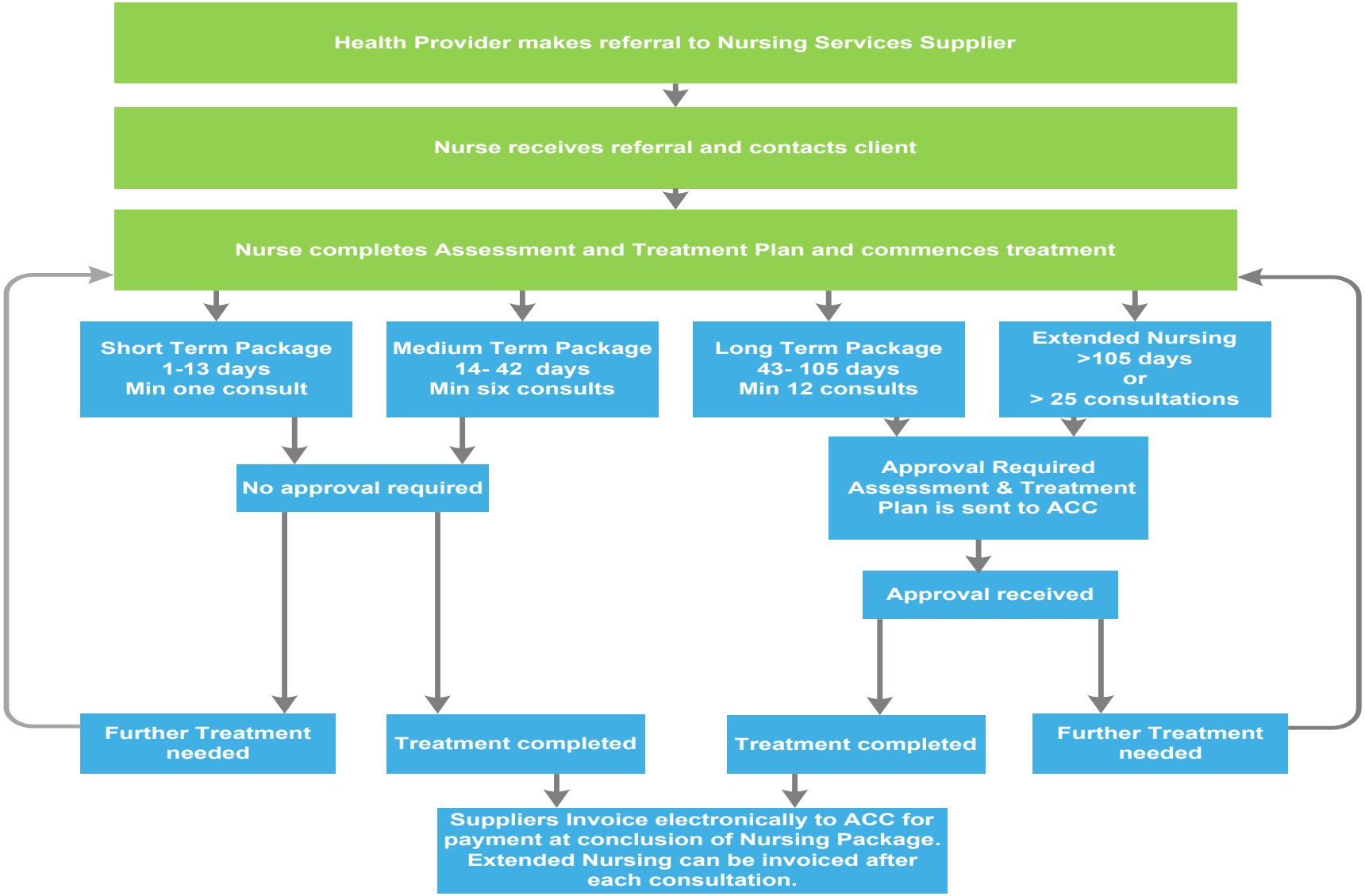
Table Two – Service item codes

Type of service	Service code and description	Used for…	See section…
Treatment	NS01 – Short Term Nursing Package	Non permanent nursing needs	Treatment for non-permanent nursing needs
	NS02 – Medium Term Nursing Package		
	NS03 – Long Term Nursing Package		
	NS04 – Extended Nursing		
	NS05 – Ongoing Nursing	Permanent nursing needs – usually accessed by Serious Injury clients	Treatment for permanent nursing needs / Ongoing Nursing
	NS06 – Treatment of Subsequent Injury	Treatment for injuries on a new claim	Treatment for subsequent injuries
Assessment	NS07 – Oversight Consultation by a Designated Provider	Assessment by the treating nurse's Designated Provider to review the injury and the treatment plan.	Oversight Consultations
	NS20 – Comprehensive Nursing Assessment	In-depth assessment conducted by the Designated Provider of a secondary supplier	Comprehensive Nursing Assessment
High Cost Consumables	NS10 – Medical Consumables per consultation	Reimbursement for high cost consumables outside of Ongoing Nursing	Consumables
Travel	Various codes NST and NSAC codes	Travel and accommodation reimbursement for provider travel	Travel

Treatment for non-permanent nursing needs

These services are for clients, who have sustained an injury that requires Nursing Services for an acute episode. It is predominantly used for wound management and most clients accessing this service are elderly. Diagram One outlines the process for non-permanent nursing treatment (excluding treatment for subsequent injuries) and this will be explained in detail in the sections below.

Diagram One – Overview non-permanent nursing needs



Referral into Nursing Services for non-permanent treatment

Non-permanent treatment under Nursing Services can only be accessed from a referral from a Medical Practitioner, Nurse Practitioner or a Registered Nurse under supervision of a doctor or Nurse Practitioner.

Suppliers are only able to refer clients into their own service when:

- they are a DHB supplier
- the referral follows discharge from inpatient care

However they still need to give clients the choice between their own community nursing service and other Nursing Services suppliers in the region. ACC may request confirmation that the client was given a choice of supplier.

Clients referring themselves

Generally clients cannot refer themselves for Nursing Services. The only exception is where the Nursing Services base is 50km or 30 minutes away from the nearest hospital or general practice with a doctor in regular attendance.

Declining referrals

You can decline a referral under the following circumstances:

- The client doesn't meet the eligibility criteria.
- Another supplier is already providing Nursing Services.
- There is a conflict of interest.
- The referral originated within your own organisation (or within their community nursing service for DHBs).
- You don't have the capacity to provide the required services in a timely manner.

Initial assessment and treatment plan

Once you have received a referral for non permanent treatment needs, you should arrange for a Registered Nurse to meet with the client within two business days to complete an initial assessment and treatment plan.

A whole person assessment, including wound assessment (where applicable), is required for every client. You need to use an ACC approved initial assessment and treatment plan template to document the information in table below.

Initial assessment section	Treatment plan section
• client's personal details • ACC claim number • NHI number • reason for referral into the services • accident and diagnosis details • relevant past health history	• treatment to date • treatment goal(s) • approximate timeframe and number of consultations required to reach the goal • required package of care and/or Extended Nursing

• medications • co-morbidities • relevant non-injury details which may impact on the management of the covered injury • wound/injury status and health status • pressure injury stage using classification tool (when present)	• consumables required, and • location of service delivery.

Determining the appropriate service for the client

There are three packages of care for non-permanent treatment:

Service item	Duration of treatment	Minimum number of consultations	ACC approval required?
Short Term Package (NS01)	One to 13 days	n/a	No
Medium Term Package (NS02)	14 to 42 days	six	No
Long Term Package (NS03)	43 to 105 days	12	Yes

All packages of care cover a maximum of 25 consultations. Extended Nursing (NS04) requires approval from ACC and is available for Nursing Services beyond 105 days or from the 26th consultation onward. The duration of treatment is the time between the initial face to face assessment (Day 1 of package of care) and the last face to face consultation with the client.

You need to estimate the required service level for the client as part of your initial assessment and treatment plan. The appropriate service level is primarily determined by how long the client will require Nursing Services.

The number of consultations required is only relevant if:

a) the minimum number of consultations for a package is not needed

b) more than 25 consultations are required, in which case Extended Nursing is used from the 26th consultation onward.

To estimate the appropriate service level, please follow the steps below:

1. On Day 1, assess how long the client is likely to require nursing services

Treatment duration	Service level
under 14 days	Short Term Package
between 14 and 42 days	Medium Term Package
between 43 and 105 days	Long Term Package
over 105 days	Extended Nursing for the consultations from Day 106 onward plus package of care

2. Estimate the number of face to face consultations the client will require and check that:
   a) the minimum number of consultations for the package of care identified in Step 1 is met.
   If the client will not require the minimum number of consultations for a package of care, the appropriate package defaults to a smaller package of care, i.e. Short Term Package for fewer than six consultations, and Medium Term Package for under 12 consultations.
   b) the consultations required don't exceed 25.
   Extended Nursing can be used in addition to the identified package of care where over 25 consultations are required.

3. If you identify that the client requires a Long Term Package or Extended Nursing, please submit an ACC179 Nursing Services Notification form to ACC to request approval for these services.
   You don't have to wait for ACC approval before commencing services as the first 42 days or 25 consultations are covered by the Short or Medium Term Package, which don't require approval from ACC.

If at any point during the client's treatment it becomes apparent that the client will require treatment for longer than initially estimated, you should update your assessment and treatment plan accordingly. If the treatment is now estimated to fall into the Long Term Package and/or require Extended Nursing please advise ACC and request (additional) prior approval for these services.

You can only invoice for packages of care once the service has been completed. This is because your initial estimate may not have been accurate, and the applicable package of care can only be determined once you provided either services for 105 days or 25 consultations.

Extended Nursing can be invoiced after each individual consultation. In some cases all of the pre-approved consultations may not be required, in which case the supplier will only invoice for the number of consultations delivered.

Examples of how the appropriate package and amount of extended nursing is determined

1. A client needs 24 nursing consultations over 12 days. The treatment timeframe falls within the ***Short Term Package*** (up to 13 days) and doesn't exceed the maximum number of consultations of that package.
2. A client requires 20 nursing consultations over 44 days. The treatment timeframe falls within the ***Long Term Package*** (between 43 and 105 days) and more than the minimum number of treatments for that package is required.
3. A client needs 10 nursing consultations over 50 days. Even though this falls within the timeframe for a Long Term Package, the minimum number of consultations for the Long Term Package is not met (12 consultations). Therefore the ***Medium Term Package*** is the appropriate service level in this case.
4. A client requires weekly visits for a period of 20 weeks. The ***Long Term Package*** will cover the first 15 weeks (105 days) of this service. In addition, ***five Extended Nursing consultations*** are required to cover the remaining weeks.
5. A client requires daily visits for a period of 35 days. The ***Medium Term Package*** will be used for the first 25 days/visits. In addition, ***10 Extended Nursing consultations*** are required for the remaining days.

Use of Extended Nursing outside of packages of care

Extended Nursing can also be used to provide Nursing Services that do not fit well within the parameters of packages of care. This is either the case where:

a) two nurses are required at the same visit. In this case Extended Nursing can be approved in addition to the appropriate package of care to fund the second nurse

or

b) the client requires one or less consultations per month. In these cases Extended Nursing may be approved instead of a package of care.

Interruption of services

If a client is admitted into hospital during their treatment, and requires ongoing treatment after discharge, you will determine the appropriate service level based on the entire timeframe from initial assessment (Day 1) to the last face to face consultation after discharge from hospital. Bear in mind you must also meet the minimum number of consultations for the package. If you do not meet the minimum threshold for visits, please charge a lesser package.

Examples for interruption of services:

1) On Day 10 of Nursing Services, after two face to face consultations, your client is admitted to hospital. The client is discharged on Day 16 and you provide two further visits over the following week, which completes the treatment on Day 23. Even thought the service duration falls within the Medium Term Package, you would only be able to invoice for the Short Term Package as the minimum of six face to face consultations for a Medium Term Package were not reached.

2) You are planning to deliver a Medium Term Package for a client for 12 treatments over a course of six weeks. On Day 20, after six treatments have been delivered, the client is admitted to hospital for an unrelated condition and is discharged on Day 27.

When you resume treatment your nurse reassess the client's injury and estimates treatment will need to continue for a further three weeks and seven treatments. An ACC179 Nursing Services Notification is submitted to ACC to request approval for Long Term Package as the client will require a total of 13 treatments over 48 days.

Re-entry into the service

In some cases a client may require further Nursing Services for injuries on the same claim after treatment is completed and the client is discharged from your service.

This is dealt with as a new episode of care and you would go through the process for non-permanent treatment as if it were the first time the client received Nursing Services.

If you have used a Medium or Short Term Package for the previous episode of care and require the same package of care for the new episode, you have to contact the client's ACC case owner and ask them to raise a purchase order number for this. This is because our payments system only allows payment for one Medium or Short Term Package of care per claim without a purchase order number.

Example for service re-entry

A serious injury client developed a pressure injury and received a package of care to treat this. Six months after the injury had completely resolved, the client sustains a new pressure injury. This new pressure injury is treated as a new episode of care under a new package of care.

Transfer of service

Sometimes a client may change supplier during the course of their treatment. This could happen for the following reasons:

a) The client moves permanently or temporarily (e.g. vacation) into a TA that the first supplier doesn't cover.

b) The client chooses to change supplier.

The first supplier should give a copy of their clinical notes to the client and ask them to share the notes with their new supplier.

The first supplier can invoice ACC for the services provided as soon as they have finished seeing the client. They will determine the appropriate service level at that stage based on the treatment timeframe and number of consultations they have provided for the client.

A Registered Nurse of the second supplier will complete an initial assessment and treatment plan at the first visit with the client and estimate the required service level using this first visit as Day 1.

If the client's treatment is expected to be completed within a Short or Medium Term Package, the second supplier needs to submit an ACC179 Nursing Services Notification form to notify ACC of the transfer of services and to advise what package of care they are planning to provide.

ACC will raise a purchase order for the appropriate package of care and advise the supplier of the Purchase Order Number.

This process is necessary because ACC's payment system only allows one Medium or Short Term Package per claim without a Purchase Order Number, and this may have already be used by the first supplier.

If the client requires a Long Term Package and/or Extended Nursing, the second supplier needs to submit their initial assessment and treatment plan and any supporting clinical notes together with an ACC179 form requesting approval for the Long Term Package and/or Extended Nursing, just like you would do with any other request for approval.

Treatment for subsequent injuries

A subsequent injury is an injury that has cover under a separate claim to the original injury and requires Nursing Services.

Treatment for Subsequent Injury (NS06) doesn't require prior approval from ACC, but can only be accessed via referral from a Medical Practitioner, Nurse Practitioner or Registered Nurse under the supervision of a doctor or Nurse Practitioner.

Once you accept a referral for subsequent injury, your treating nurse should update the client's assessment and treatment plan to include the subsequent injury. The document should clearly identify the "original" and the "subsequent" injury or injuries, as well as the estimated treatment timeframes, and number of consultations required for all injuries.

Please submit the updated assessment and treatment plan together with an ACC179 Nursing Services Notification form to notify ACC of the subsequent injury.

You can invoice for treatment of subsequent injuries after each consultation using the claim number of the subsequent injury claim.

When the treatment for the "original" injury is completed, but treatment is still needed for subsequent injury(ies), the oldest subsequent injury becomes the new "original" or "primary" injury.

The treating nurse needs to reassess the client's treatment needs to estimate the required package of care for the new "original" injury. The date of this reassessment is the new 'Day 1' for the purpose of determining the appropriate service level for the new "original" injury.

Please note: If your client as a new injury that has been caused as a direct consequence of the original injury or as a consequence of treatment for the original injury, this injury is considered a **consequential injury**.

Consequential injuries are covered under the same claim number as the original injury. Treatment for a consequential injury should be integrated into the package of care or Extended Nursing, that you are already providing for the client, or under a new package of care if the client is not currently receiving Nursing Services – see re-entry into the service.

Examples for Treatment of Subsequent Injuries

1) You are providing wound care to a client under a Long Term Package when your organisation receives a referral for treatment of a new injury requiring additional wound care. Your treating nurse visits the client and assesses the new injury, updates the assessment and treatment plan for both injuries and provides wound care to both the original and the subsequent injury. Following the consultation you submit the new assessment and treatment plan together with an ACC179 from notifying ACC of the subsequent injury.

   You can invoice for this visit under Treatment of Subsequent Injury (NS06) straight after the consultation and count the consultation towards the package of care for the original injury.

2) You are providing supra pubic catheter cares to a client as Ongoing Nursing when your organisation receives a referral for a new burn injury requiring wound care in addition to catheter cares. You assess the client needs and submit an ACC 179 to notify ACC of the subsequent injury. You can invoice ACC for Treatment of Subsequent Injury (NS06) for treating the burn and Ongoing Nursing (NS05) for the catheter care.

3) You have been providing treatment for a client for two wounds from two separate injuries using a package of care for the original injury and Treatment for Subsequent Injuries (NS06) for the second injury.

   When injury for the first injury is completed you invoice for the applicable package of care. At the next consultation with client, the treating nurse re-assesses the remaining injury and estimates the duration of treatment and number of consultations still required for this wound. The date of this reassessment is considered Day 1 of the package of care for the new “primary” injury. Following this reassessment you provide a further eight consultations over four weeks to the client before treatment is completed and can invoice for a Medium Term Package for these consultations.

ACC179 Nursing Services Notification form

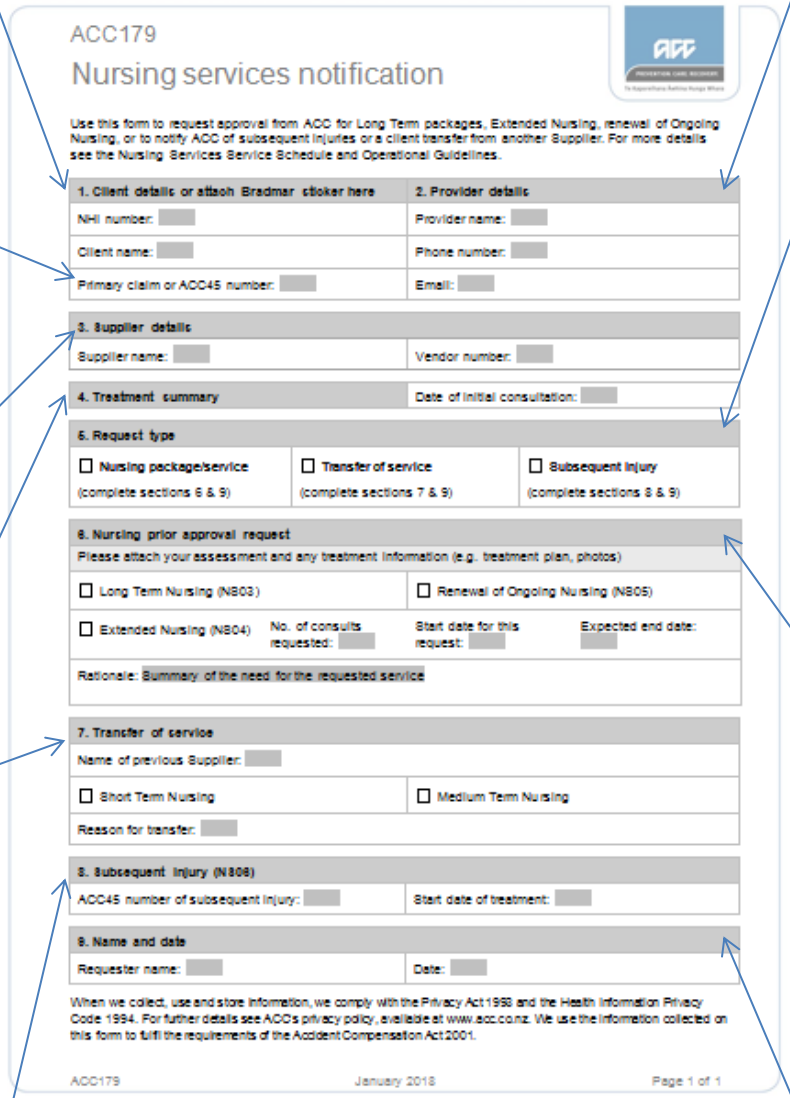
An ACC179 is a cover page for your assessment and treatment plan and clinical notes. It assists ACC staff to identify your request and react timely.

It is used when you:

1. request a Long Term Package and/or Extended Nursing
2. request renewal of Ongoing Nursing
3. notify ACC of a subsequent injury
4. notify ACC of a transfer of services

Diagram Two explains the ACC179 form and how to complete it in detail.

Diagram Two – ACC179 Nursing Services Notification form



ACC179

Nursing services notification

Use this form to request approval from ACC for Long Term packages, Extended Nursing, renewal of Ongoing Nursing, or to notify ACC of subsequent injuries or a client transfer from another Supplier. For more details see the Nursing Services Service Schedule and Operational Guidelines.

1. Client details or attach Bradmar sticker here	2. Provider details
NHI number:	Provider name:
Client name:	Phone number:
Primary claim or ACC45 number:	Email:

3. Supplier details	
Supplier name:	Vendor number:

4. Treatment summary	Date of initial consultation:

5. Request type

☐ Nursing package/service (complete sections 6 & 9)	☐ Transfer of service (complete sections 7 & 9)	☐ Subsequent injury (complete sections 8 & 9)

6. Nursing prior approval request

Please attach your assessment and any treatment information (e.g. treatment plan, photos)

☐ Long Term Nursing (N803)	☐ Renewal of Ongoing Nursing (N805)
☐ Extended Nursing (N804) No. of consults requested:	Start date for this request: Expected end date:

Rationale: Summary of the need for the requested service

7. Transfer of service

Name of previous Supplier:

☐ Short Term Nursing	☐ Medium Term Nursing

Reason for transfer:

8. Subsequent injury (N808)	
ACC45 number of subsequent injury:	Start date of treatment:

9. Name and date	
Requester name:	Date:

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.

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Section 1 – Client details

Please fill in client details or attach a Bradmar sticker here.

If the Bradmar sticker does not have the ACC45 number, please place the Bradmar sticker high enough so you are able to fill in the ACC45 number on the form.

Section 1 – Primary claim or ACC45 number

Please advise the claim number of the primary injury and not the claim number of any subsequent injury that you might be notifying ACC of with this form.

Section 3 – Supplier details

Please provide the name and vendor number of the organisation holding the Nursing Services contract.

Section 4 – Date of initial consultation

Please advise the date of the first treatment the client received from your organisation for the primary injury under Nursing Services contract (Day 1).

Section 7 – Transfer of service

This does not require prior written or verbal approval from a case owner. A case owner will raise a purchase order for payment.

Please advise the name of the previous treating supplier, reason for transfer, e.g. client moved regions, and the package required to treat the client.

Please only use the Transfer of Service section if you're providing a short or medium term package. If you're providing services that require prior approval, e.g. Long Term Nursing, please use section 6.

If you don't know who the previous supplier was, please put "unknown".

Section 8 – Subsequent Injury

Please indicate ACC45 number of the subsequent injury and the day you started treating the subsequent injury under the Nursing Services contract.

Section 2 – Provider details

Please provide the name of the nurse, who made the decision that an ACC179 is required, and the best contact details for ACC to use if we need to discuss the client's injury. This may be a general phone number for your team.

Section 5 – Request type

Please use this section to indicate whether you are:

- requesting approval for a Nursing package or service,
- advising of a transfer of services to you from another supplier, or
- notifying ACC of a subsequent injury for a client, who you are already treating under the contract.

The additional sections that you still need to complete are listed under the respective request types.

Section 6 – Nursing prior approval request

Please indicate the type of service(s) you are requesting and provide a brief rationale why the requested service(s) are required, e.g. delayed wound healing due to infection.

If you are requesting Extended Nursing, please indicate the number of consultations, start date for this request, and expected end date of the Extended Nursing you are requesting.

The Renewal of Ongoing Nursing option is for you to prompt the Case Owner to renew a client's Ongoing Nursing. The Case Owner will determine the start date and the approved hours.

Section 9- Name and date

Please provide the name of the treating nurse and the date the ACC179 was completed.

Treatment for permanent nursing needs / Ongoing Nursing

This service is for clients with permanent, often life long, nursing needs. This service is usually accessed by clients with Serious Injuries such as spinal cord or moderate to severe traumatic brain injuries. However the service is open to any client with ongoing Nursing Services needs. Diagram Three outlines the process for permanent treatment and this is explained in detail in the sections below.

Diagram Three: Overview permanent needs

Referral into Ongoing Nursing

Ongoing Nursing (NS05) can only be accessed via a referral from an ACC Case Owner. However if you have identified a client with ongoing nursing needs, please contact the client's Case Owner to recommend a referral into this service.

The need for Ongoing Nursing for new Serious Injury clients is usually identified as part of their discharge planning. The ACC Case Owner will work with the discharging hospital or rehabilitation facility to determine the client's Nursing Services needs, when they first return home.

Case Owners are able to approve Ongoing Nursing for up to 12 months at a time. However the first approval may only cover the time until a Supports Needs Assessment is completed with the client (usually around six months post discharge) as this may identify a different level of service need than initially approved.

Declining referrals

You can decline a referral under the following circumstances:

- The client doesn't meet the eligibility criteria.
- Another supplier is already providing Nursing Services.
- There is a conflict of interest.
- You don't have the capacity or capability to provide the required services in a timely manner.

Initial assessment and treatment plan

Once you have received a referral, you should arrange for a Registered Nurse to meet with the client within two business days to complete an initial assessment and treatment plan.

For detail regarding the initial assessment and treatment plan please refer to the section under non-permanent treatment above.

Once the Case Owner receives your initial assessment and treatment plan they will review the approved level of Ongoing Nursing and amend the purchase order number if appropriate.

Reassessment of Nursing Services

The Assessment and treatment plan for each client should be reviewed and updated whenever there is a change in the client's needs, but at least annually.

Case Owners will review their approval for Ongoing Nursing services on an annual basis and may request an updated assessment and treatment plan for this purpose.

You should receive a further approval before expiry of the current purchase order number. But you can also use the ACC179 Nursing Services Notification form to request renewal of the NS05 approval. You don't have to specify the start date or number of hours as the Case Owner will determine these as part of their review of the client's needs.

Invoicing for Ongoing Nursing

You can invoice for Ongoing Nursing after each visit with the client.

Ongoing Nursing (NS05) is an hourly rate, not a per consultation rate. Please ensure you only invoice for the time your nurse actually sends treating the client and not one hour per visit.

Nursing Services for consequential injuries

A consequential injury is a new injury that has been caused as a direct consequence of the original injury or as a consequence of treatment for the original injury such as a pressure injury. Consequential injuries are covered under the same claim number as the original injury.

Your Registered Nurse should complete an updated assessment and treatment plan including the consequential injury. You do not need to submit an ACC45 claims lodgement form as the injury is a consequence of the already covered injuries.

However, if the consequential injury is a direct result of treatment, this will need to be lodged as a treatment injury by the client's GPT.

Nursing Services treatment for consequential injuries is provided using the service items for non-permanent needs. You therefore have to determine the appropriate service level to treat

the consequential injury. For more details on this process please refer to the section on treatment for non-permanent nursing needs above.

Where possible, Ongoing Nursing and treatment for the consequential injury should be delivered concurrently. Please ensure you **only invoice under Ongoing Nursing for the time spent addressing the client's permanent nursing needs,** and not the time spent treating the consequential injury.

There are some situations where the client sustains an injury due to an accident that wouldn't have happened if it weren't for the covered injury, e.g. client sustains a graze to their leg when being transferred from their wheelchair into bed. the injury is not a consequential injury, it is caused by a new accident and is covered under a new claim. If a client requires Nursing Services for an injury like this, services are provided under Treatment for Subsequent Injuries (NS06) as outlined above.

Pressure injury guidelines

The *Guiding Principles for Pressure Injury Prevention and Management in New Zealand* (the guide) provides New Zealand healthcare professionals and organisations with a high-level framework for best-practice care in preventing and managing pressure injuries.
At its heart are six principles of best practice that are applicable to healthcare settings of all types, including hospitals, hospices, residential care facilities, primary healthcare settings and home-care situations. These principles are:

1. **People first**: People have access to care, and receive information and participate in shared decision-making about the care needed to prevent and manage pressure injuries.

2. **Leadership**: Healthcare organisations demonstrate leadership by ensuring that they have systems and resources to prevent and manage pressure injuries.

3. **Education and training**: Healthcare workers at all levels have access to and support for acquiring current knowledge and skills that enable them to prevent and manage pressure injuries.

4. **Assessment**: Pressure injury risk assessments are completed as part of admission, referral and transfer processes, with reassessments when people's health status changes. At-risk areas are checked regularly and whenever the opportunity arises.

5. **Care planning and implementation**: Individualised, person-centred care plans employing evidence-based care bundles are developed, documented and implemented to reduce the risk of pressure injuries.

6. **Collaboration and continuity of care**: Care support, information and resources move seamlessly with people transferring between healthcare settings.

Download a free copy of the Guiding principles for pressure injury prevention and management in New Zealand and other useful evidenced based resources;

https://www.acc.co.nz/assets/provider/acc7758-pressure-injury-prevention.pdf

https://www.nzwcs.org.nz/resources/stop-pi-day

Service Exit

Clients usually exit the service for one of the following reasons:

- The injury has resolved and no further treatment is required.
- The injury is no longer of a complexity that requires nursing services input and can now be managed by the client's GPT.
- The client no longer requires treatments outside of their GPT's opening hours.
- The client is now able to travel to receive treatment and can therefore be seen at their GPT.
- The injury is no longer wholly or substantially caused by the covered accident and therefore the client is no longer eligible to treatment funding from ACC (e.g. some non-healing wounds may be deemed no longer caused by the covered accident).

Once you have competed Nursing Services for a client we expect you send the client's GPT a discharge summary as part of your commitment to maintaining effective linkages to other providers.

Consumables

Consumables are medical items (that are not pharmaceuticals), which are required for the treatment of an injury. The cost of some consumables is built into the treatment service items while others can be invoiced to ACC or ordered through ACC's contracted consumables supplier, OneLink.

Consumables for non-permanent treatment

The Nursing Services contract distinguishes between low cost and high cost consumables in regards to non-permanent treatment.

High cost consumables are defined as items that have a total cost of at least $25 per consultation (meaning all consumables used during a single consultation together cost $25 or more) with a minimum cost per unit of $10.

All other consumables are considered low cost consumables and are included in the price of the packages of care, Extended Nursing and Treatment of Subsequent Injury. Low cost consumables can therefore not be invoiced for or ordered through Onelink.

ACC wants to ensure that clients receive appropriate, effective wound care, using consumables that facilitate the healing of their wounds or injuries in a timely manner. To encourage the use of high quality, healing promoting consumables, the contract gives you the option to either invoice ACC directly for high cost consumables or order these consumables through OneLink.

High cost consumables process

1. The treating nurse should identify any high-cost consumables and rationale for the use of these consumables in their clinical notes.

2. The Designated Provider reviews the clinical records and the rationale and either agrees or alters the selection. This needs to be documented in the clinical notes. Only high-cost consumables that have been signed off by a DP will be reimbursed or ordered through OneLink.

3. ***Reimbursement:*** If you would like to use your own stock of consumables and be reimbursed by ACC you need to submit invoices using the NS10 service item code. Reimbursement doesn't require approval from an ACC Case Owner.
   The invoice needs to detail the date of consultation, product/s, units, actual cost and Designated Provider number.
   You need to invoice for the consumables on a per consultation basis rather than for all consumables used throughout a package of care.

4. ***Order through OneLink:*** You can request delivery of consumables to the client's home via Onelink by submitting an ACC178 Consumables Order Form to ACC.
   Consumables can be delivered for up to one month at a time. If the client requires consumables for longer than one month, you can submit a recurring order (at a frequency that suits the client best, e.g. weekly or monthly).
   Consumables should generally be delivered directly to the client's home, but ACC Case Owners can approve delivery to a supplier clinic or base address on a case by case basis if there are compelling reasons for this.

Consumables for Ongoing Nursing

All consumables, that are required as part of Ongoing Nursing treatments, can be ordered through OneLink. For details of the ordering process please see section on the High-cost consumables process above.

Consumables reimbursement using the NS service item code is not available for Ongoing Nursing.

Negative Pressure Wound Therapy (NPWT)

A request to ACC for NPWT can only come from a Specialist, Surgeon, GP, Nurse Practitioner, or Designated Provider.

A Nurse Practitioner is a nurse with a "Nurse Practitioner" scope of practice as per their annual practicing certificate. It is not to be confused with Clinical Nurse Specialists, whose scope of practice is "Registered Nurse". For more information on the difference between these scopes of practice, please contact the Nursing Council of New Zealand.

A Designated Provider is able approve the **consumables** required for Negative Pressure Wound Therapy. These consumables must come from OneLink, with the exception of extenuating circumstances.

Please refer to ACC's Operational Guidelines for Negative Pressure Wound Therapy for further information. They are available on www.acc.co.nz under Resources.

Assessment Services

Oversight Consultation (NS07)

An Oversight Consultation is a face to face consultation carried out by the treating supplier's Designated Provider to support the treating nurse in cases where the client's recovery from their injury lacks progress. The treating nurse should be present for the Oversight Consultation and complete the scheduled treatment at the same time. This is invoiced as a consultation or counted towards the visits under a package of care the same as any other treating nurse visit for that client.

The **first** Oversight Consultation per claim **doesn't require prior approval** from ACC. This allows DPs to arrange a face to face with the client much quicker especially in cases where the

client doesn't have a Case Owner assigned to their claim.

Subsequent Oversight consultations on the same claim **require prior approval** from an ACC Case Owner. This can be requested informally, e.g. over the phone or via email.

Please send the Designated Providers clinical records to ACC within three working days of the Oversight Consultation being completed by the DP. These notes should cover the following:

- Reason why the Oversight Consultation was required
- Current status of the client's injury and recovery
- Change to the treatment plan following the Oversight Consultation and the rationale for the change or rationale why the treatment plan was not changed.

Oversight Consultations initiated by case owners

Sometimes an ACC Case Owner may initiate an Oversight Consultation in order to address their or the client's specific concerns or questions around the client's recovery. Case owners may ask you to answer specific questions around treatment, progress and recovery timeframes.

This will usually be the case where the Case Owner deemed that a Comprehensive Nursing Assessment (see section below for details on CNAs) is not required, but still has some questions that warrant DP input.

Please answer any questions the Case Owner submitted with the referral as part of the clinical notes you submit following the Oversight Consultation.

Comprehensive Nursing Assessment (NS20)

A Comprehensive Nursing Assessment (CNA) is an independent and objective clinical assessment completed by a Designated Provider from supplier, who is not currently providing treatment to the client ("secondary supplier").

ACC Case Owners refer for CNAs when an independent review of the current state of the client's injury(ies) and of the treatment plan is required, because:

- the client's recovery lacks progress,
- the injury doesn't seem to be responding to the current treatment plan, or
- there are concerns whether the client's current condition is still caused by the covered accident or not.

Often the referral for a CNA will be triggered by a request for approval of further treatment, but a Case Owner may refer for a CNA at any point during Nursing Services.

You are not required to have the treating supplier present when you conduct the assessment. However you shouldn't disrupt a wound unnecessarily and therefore it will often be appropriate to align your assessment with a scheduled treatment visit.

Referral for Comprehensive Nursing Assessments

The ACC Case Owners will provide the following information with the referral:

- history of the client's injury,
- all relevant clinical notes, including the assessment and treatment plans of the treating supplier,
- information on any health and safety issues in regards to the client,

- client consent form for the collection and release of clinical notes, and
- any specific questions the Case Owner would like the DP to answer in their report.

Please follow up with the Case Owner if you have not received enough information to proceed with the assessment.

Before accepting the referral, please ensure you have an appropriate qualified and skilled Designated Provider to complete the assessment. Please consider:

1. whether the DP requires a specific skill set (e.g.. stoma, continence, compression bandaging), and
2. whether the DP have more experience and/or qualifications than the treating nurse in the relevant area.

If you receive a referral for a CNA in a TA (or district) where you don't have a local DP, please contact the Case Owner to discuss travel costs before accepting the referral.

Comprehensive Nursing Assessment reports

There is no ACC template for CNA reports. You can use a report template that you developed for your organisation or the report can be provided in form of a letter. If the injury is a wound, please attach a wound assessment.

The CNA report needs to include the following information:

- Details of the client's accident and diagnosis.
- The progress made to date including the types and durations of assessments and treatments carried out to date.
- Current health status.
- Co-morbidities and past history that may be relevant to the treatment of the covered injury (e.g. history of slow healing wounds).
- Medications.
- Natural supports and strengths.
- Details of the ongoing causation of the presenting condition and relevance to the covered injury.
- Recommendations for ongoing management/treatment and any further investigations required.
- Comprehensive wound assessment for all wounds.
- Answers to specific questions listed in the referral

The Case Owner may also wish to know:

- the expected timeframe for the injury to heal
- the expected number of consultations needed for the injury to heal
- Reason/s why an injury might be slow healing (e.g. co morbidities, age, treatment type, non compliance, infection, delays in receiving treatment)
- anything further ACC can do to assist the client
- if the client has sufficient home support and nutrition
- if ACC should consider seeking a specialist opinion (e.g. vascular or plastics)

A Case Owner can request further information, clarification or answers to questions within 10

working days of receipt of the report. The request for additional information does not attract an additional fee.

A copy of the assessment report will be provided to the treating supplier and the client's GPT.

Travel

The prices for non-permanent treatment service items (NS01 to NS04 and NS06) include travel costs and therefore you cannot invoice separately for travel in relation to delivering these services.

Ongoing Nursing, Oversight Consultation and Comprehensive Nursing Assessment service item codes do not include travel, and this can be invoiced separately when you deliver these service items. Please refer to the Service Schedule for details of the travel reimbursement service item codes and minimum travel time and distance thresholds for travel reimbursement.

If your treating nurse delivers a package of care or Extended Nursing consultation concurrently with Ongoing Nursing, you cannot invoice for travel under Ongoing Nursing, as this is already paid for through the package of care or Extended Nursing.

If a Designated Provider shares travel with the treating nurse to complete an Oversight Consultation, you cannot invoice for the Designated Provider's travel distance as this is included in the treating nurses travel.

Interaction with Cost of Treatment Regulations

A supplier cannot provide services under this contract and Cost of Treatment Regulations (CoTR) for the same claim, except for in the two circumstances outlined below.

Treatment for other injuries on the same claim

Occasionally a client, who is receiving Nursing Services for an injury, may have other injuries that were caused by the same accident and are therefore covered under the same claim.

If the client requires nurse-led treatment from your organisation outside of the Nursing Services for one of their injuries, you can invoice for these nurse treatments under CoTR.

Example: A client receives home-based Nursing Services for a complex wound through a DHB's Nursing Services. The client broke their leg in the same accident and has an outpatient appointment at the DHB's nurse-led fracture clinic for a cast check. The DHB can invoice for the cast check under CoTR and this visit doesn't count towards the package of care for the wound management.

Initial treatment for a new injury prior to referral into the Nursing Services contract

In some instances one of your nurses may discover a new injury caused by an accident when they are visiting a client to either treat a health related condition or a previous injury.

If the following criteria are met the nurse can lodge a claim[1] for the new injury and you can invoice for the initial treatment of the injury under CoTR:

- The nurse has the practising scope of a Registered Nurse or Nurse Practitioner.

[1] Please refer to section on claims lodgement below.

- The nurse is registered as a treatment provider for CoTR with ACC under your organisation as a Vendor. Please refer to the section on provider registration below.
- The diagnosis for the new injury falls within the nurses scope of practice and ACC's claims lodgement framework for nurses.
- The injury requires nurse level treatment, not just first aid that a client would usually not seek treatment for.

Following the initial treatment you need to advise the client's GPT of the new injury. If the injury meets eligibility criteria for Nursing Services the GPT may refer the client into your Nursing Services. Day 1 of the package of care for this client is the first consultation after receipt of the referral, at which time a full assessment and treatment plan needs to be completed.

Invoicing

You must be billing ACC in the form of XML transactions. If you are not doing this, please contact the eBusiness Team on 0800 222 994 option 1.

Invoices for Oversight Consultations (NS07), Comprehensive Nursing Assessments (NS20) and high cost consumables (NS10) need to state the ACC Provider ID of the Designated Provider who completed the assessment or approved the consumables. Please use the "Provider ID" column for the DP's ID.

If that Provider ID is not set up in your XML builder, this can be done by clicking on "Set/Edit" button found at the top left hand side of the XML builder screen. This will open up a new window where on the right hand side you can add a new Designated Provider.

The service date for packages of care is Day 1 of the package. If possible please provide the end date of the package in the comments.

Provider registration and claims lodgement

Apart from your Designated Providers, nurses delivering treatment under the Nursing Services contract don't have to be individually registered as treatment providers with ACC.

However if you would like to deliver some services under Cost of Treatment Regulations and lodge ACC claims (e.g. initial treatment for a new injury discovered by one of your nurses), your nurses need to be individually registered with ACC.

Provider Registration

Only Registered Nurses and Nurse Practitioners can be registered as ACC treatment providers under CoTR. You can't register your Enrolled Nurses for CoTR.

If you would like to register your Registered Nurses as treatment providers you need to supply the following to ACC:

- a completed ACC024 Application for ACC Health Provider Registration form
- a copy of the nurse's current annual practising certificate
- a copy of **your bank account**, either on pre-printed bank deposit slip or via bank verification.

Please email the signed and scanned forms and additional information to registrations@acc.co.nz. Alternatively you can submit this information by post to

ACC Provider Registration PO Box 30823 Lower Hutt 5040.

How to fill out the ACC24

1. Please fill out a ACC24 for each individual nurse you would like to register and fill in your vendor name as the "practice name".
2. The profession is "Registered Nurse" or "Nurse Practitioner".
3. The individual nurses needs to sign their ACC24

Need assistance?

For further information about the registration process please refer to our webpage or the Treatment Provider Handbook available on www.acc.co.nz under Resources.

If you have any questions or need assistance with completing applications please contact our Provide Helpline on 0800 222 070 or email to providerhelp@acc.co.nz.

Claims lodgement

Registered Nurses, who are registered to provide services under CoTR, can lodge ACC claims for injuries that fall within their scope of practice and the ACC's claims lodgement framework for nurses. **Enrolled Nurses are not able to lodge claims.**

You can get set-up online to lodge claims, please refer to our webpage for details. Alternatively you can order paper ACC45 lodgement forms and complete these manually. To order forms please call ACC's provider order line on **0800 802 444**.
Please submit completed ACC45 forms to your nearest ACC branch.

Working with clients who may pose a health and safety risk

ACC clients who meet **two** or **more** of the following criteria are considered to pose a potential risk to safety, and will have a Care Indicator activated by ACC:

- have continued to demonstrate intimidating and/or offensive behaviour (e.g. body language and verbal dialogue has made employees feel unsafe)
- been abusive, verbally or in writing
- made racist or sexist comments
- the current actions being undertaken on their claim by ACC are known to have caused, or are expected to cause a significantly negative response from the client. For example, Prosecution, Fraud Investigation, cessation of Weekly Compensation.

Clients who meet any one of the following more serious criteria are also considered a risk and will also have a Care Indicator activated:

- Have been or are physically violent (this unacceptable behaviour may not have occurred directly towards ACC employees)

- Have a history of violence or aggressive behaviour, have known convictions for violence
- Made threats previously against ACC, ACC employees, or agents acting on ACC's behalf
- Intimidated an employee through written abuse or verbal abuse (face-to-face or over the telephone) to the extent they felt unsafe
- Exhibited homicidal ideation.

ACC may not always have a Case Owner assigned to clients receiving Nursing Services. However, if you identify a client / situation that may pose a risk, please call Provider Helpline. They will be able to provide you with information relevant to your role in managing the claim. This will help mitigate health and safety risks to service providers and others.

Communication regarding care indicated clients

The Case Owner of a care indicated client will advise you in writing, either:

- Prior to your initial contact with the client, or
- If you are already providing services to the client, as soon as possible when ACC receives new information about client risk.
- If you make a decision that a security guard is required because of concern about your own or your employees' safety please contact the Case Owner to arrange the security guard. Guards can be arranged at any initial or subsequent assessment.
- Please report any threatening behaviour to the police immediately if you feel that it is warranted in the circumstances, and advise ACC and any other parties that are at risk as soon as possible.
- All threats by ACC clients or their representatives must be reported to ACC in writing using the online form on our website. We ask that you report these to us so that we can do our part to protect the safety of our staff and other providers that are working with the client.

Stopping a treatment or assessment

Your safety is the highest priority and any treatment or assessment should be terminated if the client or their representatives cause you to feel threatened or unsafe.

If you choose to continue with the assessment or treatment of a care indicated client, and wish to employ a security guard then please contact ACC's Provider Helpline or the client's Case Owner.

Notify the client's Case Owner as soon as possible and fully document the reasons for the termination of the assessment or treatment in your report or clinical notes. Please report to ACC in writing using the online form on ACC's website.

Reporting health and safety risks and incidents

Health and safety risks and incidents including notifiable events (as defined by WorkSafe); threats and other health and safety risks must be reported to ACC using the procedure and online form on our website www.acc.co.nz/for-providers/report-health-safety-incidents.