He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Nursing Services

Operational Guidelines for Providers

March 2025

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Prevention. Care. Recovery.

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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 EPM team via the form on our website: Contact our provider relationship team (acc.co.nz).	
Website	For more information about ACC, please visit: https://www.acc.co.nz	

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 Health providers (acc.co.nz).

Services must be provided in accordance with the Guidelines unless there is a conflict between the Guidelines and the contract (Standard Terms and Conditions and/or Service Schedule), 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 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).

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

Service objectives

Nursing Services should be client centred and flexible to meet the diverse needs of our clients, while also being cost effective to achieve an optimal outcome for the best value.

Service eligibility and exclusions

To be eligible for Nursing Services, the client must have an accepted ACC claim and treatment provided must be directly related to the covered injury.

Clients must also meet one or more of the following eligibility criteria:

- the client's nursing needs are too complex to be managed by the GPT, or
- the client is physically unable, or unsafe to travel to their GPT, or
- the client requires nursing treatment outside of usual GPT opening hours, and/or
- the client is not enrolled with a GPT.

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. Residents can
✓	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.		

			access Nursing Services for more significant injuries.
✓	Where the client requires nursing treatment but is unable to access timely care from a GPT, e.g. if the client is not enrolled or not able to enrol with a GPT.	✗	The client has recovered from an ACC-covered wound but requires ongoing skin integrity checks.

Referral into Nursing Services

Clients can access Nursing Services via referral from one of the following:

- A medical practitioner, Nurse Practitioner, or a Registered Nurse under the supervision of a medical practitioner or Nurse Practitioner.
- Community-Based Health Service Provider e.g. community pharmacist, paramedic, physiotherapist, rongoā Māori practitioner.
- Self-referral where a Client lives in a rural nursing services area either permanently or temporarily (e.g. tourist or visitor), as defined in clause 6.9.
- Self-referral where there are barriers to accessing a General Practice Team (e.g. the client is unable to enrol with a general practice).

ACC Claims Management staff may also refer clients, however most referrals will come from hospital teams, GP teams or other community-based providers as above.

Suppliers can refer clients into their own service when:

- They are a Health New Zealand hospital and the referral follows discharge from inpatient care.
- A Client who is currently receiving services from the supplier either for health-related issues or a previous injury sustains a new injury that requires Nursing Services treatment.

However, clients should still be given the choice between the supplier's 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 can refer themselves for Nursing Services when:

- The client lives in or is temporarily visiting a rural area where the Nursing Services base is 50km or 30 minutes away from the nearest hospital or general practice with a doctor in regular attendance.
- The client experiences barriers to accessing a GPT, e.g. the client is unable to enrol with a general practice.

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 Health New Zealand).
- You don't have the capacity or capability to provide the required services in a timely manner.

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.

ACC will not approve travel costs (e.g. taxis) for a client to attend the clinic if there are barriers to transport for the client. In these cases, the service provider must travel to the client to provide Nursing Services.

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.

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 completed 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 with other providers.

Designated Providers

A Designated Provider (DP) is a Registered Nurse or Nurse Practitioner, with applicable postgraduate qualifications and work experience. From 1 March 2025, Designated Providers are not required to be approved by ACC, however the Supplier is responsible for ensuring they have at least one DP on staff who meets the Designated Provider criteria.

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
- reviewing 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 clause 7.7 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.

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) 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..

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

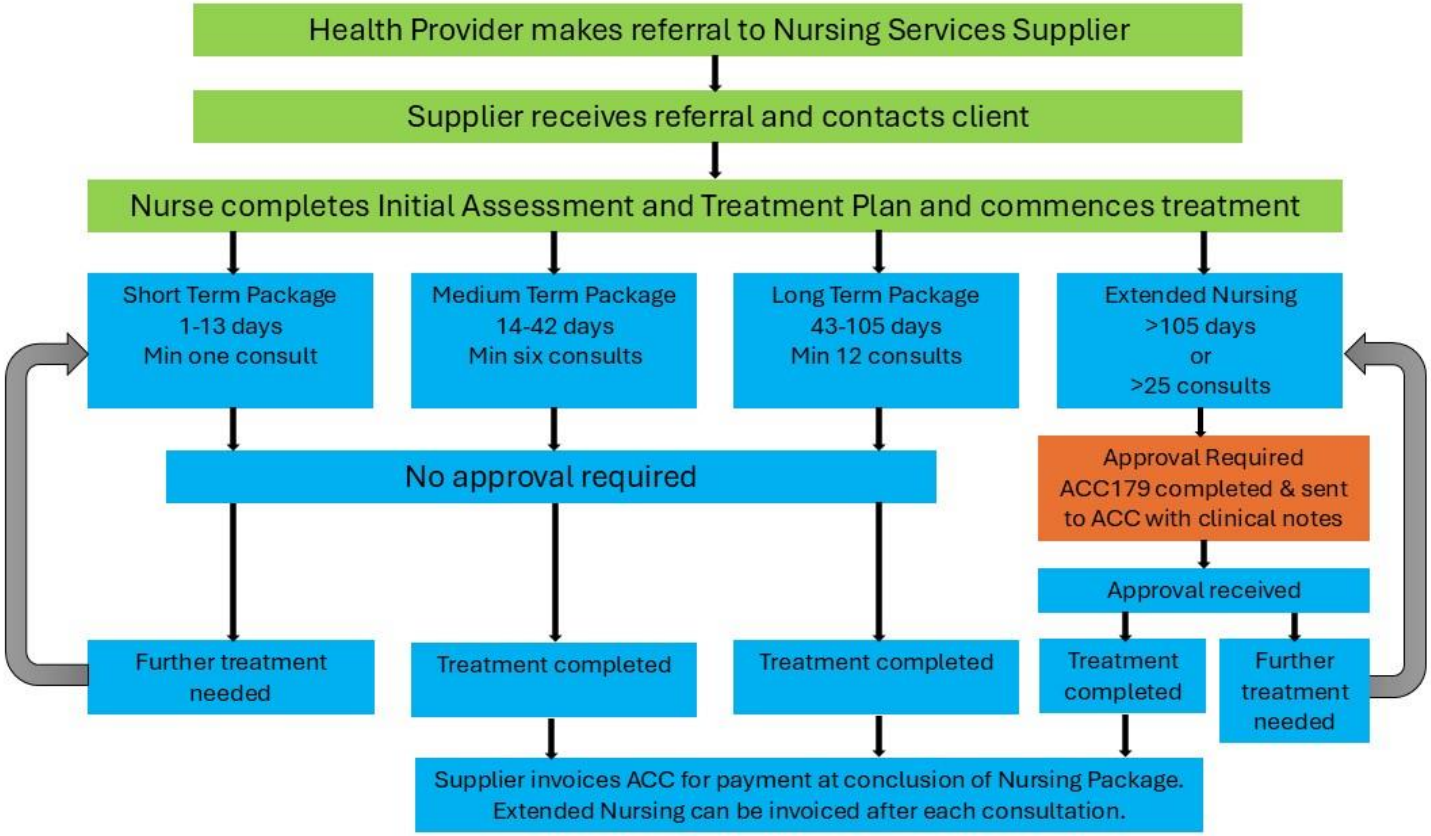
Type of service	Service code and description	Used for...	See section...
Treatment	NS01 – Short Term Nursing Package	Non-permanent nursing needs	Treatment for non-permanent nursing needs
	NS02 – Medium Term Nursing Package		
	NS03 – Long Term Nursing Package		
	NS04 – Extended Nursing		
	NS05 – Ongoing 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
	NS20T – Comprehensive Nursing Assessment - Telehealth	In-depth assessment conducted by the Designated Provider of a secondary supplier via telehealth where clinically appropriate.	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



Initial assessment and treatment plan

Once you have received a referral or identified a need for non-permanent treatment, you should arrange for a Registered Nurse or Nurse Practitioner 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 initial assessment and treatment plan template that includes 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 • 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) • risk assessment and prevention plan for falls, pressure injuries, healthcare acquired infections, medication adverse events and any other risks	• 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 • 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	one	No
Medium Term Package (NS02)	14 to 42 days	six	No
Long Term Package (NS03)	43 to 105 days	12	No

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 Extended Nursing, please submit an ACC179 Nursing Services Notification form to ACC to request approval for these services.

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 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 though 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. As the client will require a total of 13 treatments over 48 days, a Long Term Package is now appropriate.

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 a Short, Medium or Long Term Package has already been used for the previous episode of care and require the same package of care for the new episode, complete the ACC179 form to request a purchase order for the new package. This is because our payments system only allows payment for one Package of care per claim without a purchase order number.

Example for service re-entry

A client receiving a package of care temporarily moves to a different area, and their care is transferred to a different Nursing Services supplier. The original package ends when the client transfers to the new supplier. After four weeks, the client moves back to their home area and the first supplier resumes treatment. This 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 or Nurse Practitioner 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.

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 Package per claim without a Purchase Order Number, and this may have already be used by the first supplier.

If the client requires 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 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 or a new referral, but the Client's GP team should be notified of the new injury.

Once a subsequent injury has been identified, 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.

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 you identify the client has a new burn injury requiring wound care in addition to catheter cares. You assess the client needs and lodge an ACC45 claim for the new burn injury, and submit an ACC 179 to notify ACC of the subsequent injury. You can invoice ACC for an appropriate Nursing package for treating the burn (billing under the new ACC45 claim number) and Ongoing Nursing (NS05) for the catheter care (billing under the original ACC45 claim number).

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 treatment for the first injury is completed you invoice for the applicable package of care. At the next consultation with the 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.

Subsequent vs. consequential injuries

Subsequent injury	Consequential injury
There is a new accident / mechanism of injury causing a new injury.	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.

Please note: If your client has 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 must have a new ACC45 claim lodged (noting that the injury is a consequence of the already covered injuries) and be treated under this claim number. If the client is currently receiving a Nursing package for another non-permanent injury need, treatment for the consequential injury can commence under Treatment of Subsequent Injury (NS06), or under a new package of care if the client is not currently receiving Nursing Services.

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 Extended Nursing
2. request renewal of Ongoing Nursing
3. notify ACC of a subsequent injury
4. notify ACC of a transfer of services
5. request a purchase order for a package where there has already been a package invoiced under the same claim

Use the ACC179 form found on our website and follow the instructions below on how to complete it.

Section 1 – Kiritaki (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 2 – Vendor/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 3 – 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 4 – Request type

Please use this section to indicate whether you are:

- requesting approval for a Nursing service,
- requesting a purchase order for a Nursing Package (only required if there has already been a package invoiced under the same claim number),
- 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 5 – 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 Recovery Team member to renew a client's Ongoing Nursing. The Recovery Team member will determine the start date and the approved hours.

Section 6 – Nursing Package purchase order / Transfer of service

This does not require prior written or verbal approval from a Recovery Team member. A Recovery Team member will raise a purchase order for payment.

Please advise the name of the previous treating supplier, reason for the request, and the package required to treat the client.

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

Section 7 – 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 8 - 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 Recovery Team member. However, if you have identified a client with ongoing nursing needs, please contact the client's Recovery Team 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 Recovery Team member will work with the discharging hospital or rehabilitation facility to determine the client's Nursing Services needs, when they first return home.

Recovery Team members 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.

The client's nursing needs should be reviewed regularly, and on an annual basis. A Comprehensive Nursing Assessment may be requested for the annual review if the client hasn't had an independent assessment of their Nursing needs in the last 12 months.

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 Recovery Team member 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.

Recovery Team members will review their approval for Ongoing Nursing services on an annual basis and may request a Comprehensive Nursing Assessment 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 Recovery Team member 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 spends 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 must be lodged as a new claim and treated under this claim number.

Your Registered Nurse or Nurse Practitioner should complete an updated assessment and treatment plan including the consequential injury. An ACC45 claim lodgement form must be submitted, noting that the injury is a consequence of the already covered injuries. See below section Lodging claims for consequential injuries for more details on what information to include on the ACC45 form.

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. If the client is currently receiving a package of care for a non-permanent injury, treatment for the consequential injury should commence under Treatment of Subsequent Injury (NS06), otherwise a new package of care can be started for the consequential injury.

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, but 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.

Lodging claims for consequential injuries

Including detailed information about the injury on the ACC45 will help us to assess the claim and make a decision on cover quickly without needing to gather further information. The information we need includes:

- That this injury is a consequence of a covered injury
- How the consequential injury has come about
- In what context was the injury sustained (eg "recovering in own home", or "in hospital level care")
- The affected body site and side (if applicable)
- Accident date is the date the injury was diagnosed or identified (if a pressure injury)
- Use a read code that includes the stage of pressure injury or include in the injury comments
- What level of care the person is in e.g. hospital level care (if a treatment injury)
- If the person has been in care since before the pressure injury was diagnosed (if a treatment injury)

See below for examples of what a good quality claim lodgement might look like.

Example 1: Consequential pressure injury

Injury description – *"Bed ridden from #NOF - claim XX12345, recovering at home, consequential pressure injury of left buttock"*

Injury diagnosis – 39C0. Pressure injury stage II – Left

Accident date - date the pressure injury was identified

Example 2: Consequential treatment injury

Injury description – *"Bed ridden from #NOF - claim xx12345, in hospital level care since 01/02/2025, consequential pressure injury of left buttock"*

Injury diagnosis - 39C0. Pressure injury stage II - left

Accident date - date pressure injury identified

Is this a claim for an injury caused by treatment? – tick "Yes" on the form

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.

Other useful pressure injury prevention resources can be found on our website Helping prevent pressure injuries – acc.co.nz.

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 (excluding GST).

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 ACC.
   The invoice needs to detail the date of consultation, product/s, units, actual cost and Vendor ID number.
   You need to invoice for the consumables on a per consultation basis rather than for all consumables used throughout a package of care. ACC may request clinical notes to verify the appropriate use of high cost consumables.

4. ***Order through OneLink:*** You can request delivery of consumables to the client's home via OneLink by submitting an order through the Community Client website or sending 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 Recovery Team members 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, must be ordered through OneLink. For details of the ordering process please see section on the High-cost consumables process above.

Consumables reimbursement using the NS10 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.

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 Recovery Team member assigned to their claim.

Subsequent Oversight consultations on the same claim **require prior approval** from ACC . This can be requested informally, e.g. over the phone or via email, or via the ACC179.

Please send the Designated Provider's 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 ACC

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

This will usually be the case where the Recovery Team member 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 Recovery Team member submitted with the referral as part of the clinical notes you submit following the Oversight Consultation.

Comprehensive Nursing Assessment (NS20 / NS20T)

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

ACC Recovery Team members 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,
- there are concerns whether the client's current condition is still caused by the covered accident or not, or
- the client has been receiving Nursing Services for 12 months or more without an independent assessment.

Often the referral for a CNA will be triggered by a request for approval of further treatment, but a Recovery Team member 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 Recovery Team member 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 Recovery Team member would like the DP to answer in their report.

Please follow up with the Recovery Team member 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 has 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 Recovery Team member to discuss travel costs before accepting the referral.

Comprehensive Nursing Assessment reports

There is currently 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 Recovery Team member 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 Recovery Team member 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.

Telehealth

Comprehensive Nursing Assessments may be completed via telehealth e.g. by telephone conversation or videoconferencing, if it is clinically appropriate and the client has consented to a telehealth consultation.

When providing Comprehensive Nursing Assessments via telehealth, Designated Providers should ensure that they follow the requirements of the ACC Telehealth Guide and any guidelines from their regulatory body.

Comprehensive Nursing Assessments completed via telehealth are invoiced under the NS20T service code.

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 requirements 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 nurse's 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 Health NZ hospital's Nursing Services. The client broke their leg in the same accident and has an outpatient appointment at the Health NZ hospital's nurse-led fracture clinic for a cast check. The Health NZ hospital 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.
- 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 nurse's 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 you may start providing Nursing Services – a new referral from the GPT is not required. Day 1 of the package of care for this client is the first consultation, at which time a full assessment and treatment plan needs to be completed.

Invoicing

You must be billing ACC electronically. If you are not sure of how to do this, please contact the eBusiness Team on 0800 222 994 option 1.

All invoices must include the information detailed in the Standard Terms and Conditions of your contract. A Provider ID number is required for invoicing under the Cost of Treatment Regulations.

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.

Invoices for High Cost consumables must include the date of consultation, details of the product/s used, number of units/quantity used, and actual cost.

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

Provider registration and claims lodgement

To be able to lodge claims and deliver some services under Cost of Treatment Regulations, your nurses need to be individually registered as treatment providers with ACC.

Provider Registration

Only Registered Nurses and Nurse Practitioners can be registered as ACC treatment providers. Enrolled Nurses are unable to lodge claims or invoice for treatment provided under CoTR.

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

- a completed ACC24 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.

You can complete the registration form online at Register with us as a health provider, or send your paper form to us by email to registrations@acc.co.nz or 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 nurse needs to sign their ACC24

Need assistance?

For further information about the registration process please refer to our website Register with us as a health provider.

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

Claims lodgement

Registered Nurses and Nurse Practitioners, who are registered as treatment providers with ACC, 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.**

If you don't use a patient management system (PMS) with a claims lodgement function, you can get set-up to lodge claims using our online tools. Please refer to our webpage for details.

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 Recovery Team member 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 Recovery Team member 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 Recovery Team member to arrange the security guard. Guards can be arranged at any initial or subsequent consultation.
- 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. See our webpage for further information - Reporting health and safety incidents.

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 Recovery Team member.

Notify the client's Recovery Team member 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 https://www.acc.co.nz/for-providers/third-party-health-and-safety-form.