PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

Urgent Care Clinic Service

Operational Guidelines for Providers

August 2017

This is a living document and will be updated as required

ACC contact details

Provider Contact Centre (PCC)	If you have a general query or need assistance regarding a specific invoice, please contact the Provider Contact Centre: Phone: 0800 222 070 Email: providerhelp@acc.co.nz	
Client Contact Centre	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 (EPMs)	EPMs can help you to provide the services outlined in your contract. Contact the Provider Contact Centre for details of the supplier manager in your region.	
Website	For more information about ACC, please visit: www.acc.co.nz	

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Introduction

The Urgent Care Clinic (UCC) contract is the result of ongoing collaboration between ACC, the UCC sector and the broader primary care sector. The UCC contract replaced the Accident & Medical (A&M) service effective 1 July 2016.

We recognise the important role UCCs play in providing ACC clients with timely access to treatment for their injuries, and how this service compliments the client's general practice team (GPT). We are committed to working together with the UCC sector to improve integration across the broader primary and secondary care continuum, and to support clinics to continue delivering high quality services.

These Operational Guidelines aim to support clinicians and administration staff at Urgent Care Clinics (UCCs) to implement the Urgent Care Clinic (UCC) contract.

They are designed to further explain the Urgent Care Clinic service schedule ('the UCC contract') and ensure clinic staff are aware on how and when to invoice ACC for UCC services.

The Guidelines should be read in conjunction with:

- the *Accident Compensation Act 2001 (AC Act)*
- the *Standard Terms and Conditions*
- the *UCC contract* and
- the *Urgent Care standard 2015*.

The *ACC Treatment Provider Handbook* is another guide available to you to support your delivery of service for ACC clients.

This is a living document. Updated versions will be made available as the need arises.

Service purpose

The primary purpose of UCCs is to provide episodic care on a no-appointment basis; meaning they are well positioned to provide treatment for people who might otherwise present to an Emergency Department (ED) either due to complexity of the injury or because the client's injury requires treatment more urgently than can be accommodated by their GPT.

UCCs also provide services for ACC clients that cannot usually be met in a general practice setting, e.g. management of fractures. The UCC contract supports clinics providing continuity of injury management for specific presentations like simple fractures, Achilles tendon tears and ruptures, severe sprains, and more complex wounds.

Invoicing under the Urgent Care Clinic service

Clinics can invoice ACC for one consultation per visit or a combination of consultation, procedure and/or consumable codes depending on what treatment they provided to the client. Detailed lists of the service codes can be found in Table 1 – 4 of the Appendix, as well as in the UCC contract.

Table 1 – Consultation Codes: Initial and follow-up consultation codes for various lengths of consultations and ACC funded surcharges for clients that are under 13 years of age.

Table 2 – Procedure Codes: Procedure codes that cover both time and material costs for specified procedures.

Table 3 –Consumable Codes: Codes that only cover the cost of materials for crutches, simple orthotics and moonboots.

Table 4 – Procedures to be completed as part of consultation: List of examples of procedures that determine the consultation level.

Prices related to the consultations and procedures include materials, consumable equipment, pharmaceutical items used during treatment and the short-term loan of orthotics and equipment (other than those listed in Table 3 of the Appendix).

Invoicing for consultation codes

Initial and follow-up consultations

When a client is first seen at a specific UCC, the clinic can invoice for an initial consultation. Follow-up consultations are used for any subsequent visits at that same clinic regardless of whether the visits are unplanned or scheduled appointments.

Example 1:

A client presents with a fractured radius and ulna requiring a below elbow cast. The clinic invoices for an initial consultation as well as the applicable procedure code (see below for details on determining consultation level and invoicing for procedure codes).

The next day, the client returns to the clinic for a planned plaster check. This is invoiced under a follow-up code.

Three days later the client returns for an unplanned visit because they got their plaster wet. The clinic again invoices a follow-up consultation as well as applicable procedure code.

An initial consultation can be used for a client's first presentation at your clinic, even if they have previously presented at another clinic for the same injury. This is regardless of how many consultations the client had at the previous clinic(s) or whether the clinic(s) are in the same city as your own.

Example 2:

A client lacerates their foot while on holiday in Nelson and receives medical attention at the local UCC, which invoices an initial consultation. After returning home to Whangarei they visit the local UCC for a wound check. The UCC in Whangarei can also invoice for an initial consultation as it is the first visit to their clinic.

Determining consultation level

The consultation codes are outlined in Table 1 of the Appendix. The initial and follow-up consultation codes are time based – meaning that the time spent by doctors and nurses to treat the client is added up to determine the applicable consultation code.

In order to assist you to manage the administration it takes to track the time-base consultation codes, a list of procedures that should be invoiced as part of a specific consultation level has been developed. These procedures are listed in Table 4 of the Appendix.

However, it was agreed with the sector that if one of the procedures listed in Table 4 is applicable, then the associated consultation level should be invoiced regardless of the time taken to treat the client. This approach recognises that more experienced clinicians will usually take less time to complete some of those procedures listed.

Triage

Time spent triaging the client does not count towards the time to determine the appropriate consultation level. This is because payment for triage has already been included in all consultation payments.

Example 3:

A client presents to the UCC for the first time with a back strain. The nurse triages the client and obtains information about how the injury occurred, and their movement restrictions, taking five minutes. The doctor then reviews the client, discusses exercises and functional limitations for work. Non steroidal anti-inflammatories are also prescribed. This doctor's consultation takes 18 minutes.
The Clinic can invoice ACC for an initial consultation level 1 (UC01) because the nurse triage time is not added to consultation time and the doctor took less than 21 minutes to treat the client.

Example 4:

A client presents to the UCC for the first time with difficulty breathing following a bee sting. The nurse triages the client and obtains information about the sting and history of allergic reactions. This triage takes three minutes. The doctor then assesses the client, administers adrenalin and monitors the response. This takes 17 minutes of the doctor's time. The clinic calls an ambulance to transfer the client to the hospital for a period of observation in accordance with that clinic's protocols. The client is under constant, active observation by the nurse for 11 minutes until the ambulance arrives.
This consultation is invoiced to ACC as an initial consultation level 2 (UC02) because the combined treatment time (excluding triage) for the nurse and the doctor is 28 minutes.

Example 5:

A 25 year old man from out of town presents with a clean cut in his eyebrow that was sutured with five stitches by his GP a week ago. The nurse takes two minutes to triage him. The nurse removes the stitches and applies a simple wound cover. Because the stitches are difficult to see in the eyebrow and somewhat embedded in the dry and crusted wound this takes 21 minutes. This is an intitial consultation level 1 (UC01) because removal of sutures is listed under level 1 (or simple follow-up consultation) in Table 4.

Example 6:

A 14 year old boy presents having knocked a tooth out while playing cricket. The nurse triages obtaining history and assessing the airway. The doctor then cleans and re-implants the tooth taking 19 minutes.
The clinic can invoice an initial consultation level 2 (UC02) because re-implantation of tooth is listed under level 2 (or complex follow-up consultation) in Table 4.

Invoicing for procedure codes

Table 2 of the Appendix outlines procedures that can be claimed in conjunction with a consultation code. Procedure codes (Table 2) include time and material taken to complete the procedure in the price for the procedure. Therefore, any time taken to perform a procedure cannot be added to determine the consultation level.

Most of the time, clinics should invoice an initial level 1 (UC01) or simple follow-up consultation (UC10) in conjunction with a Table 2 procedure. If the clinical record reflects that the clinic took longer than 20 minutes to assess the client and to provide treatment over and above what is expected for the procedure in Table 2, then the clinic is able to invoice a higher consultation level.

Example 7:

A 33 year old builder presents with an eight centimetre long laceration on the right forearm which is filled with dirt. Following triage the doctor cleans, debrides and sutures the wound. Subsequently the nurse applies dressing while the doctor writes the prescription for antibiotics. In this circumstance the clinic would invoice for an initial consultation level 1 (UC01) and the procedure code for a significant laceration >7 cm requiring sutures (UC31).

There are times when Table 2 procedures are completed at the same visit as a procedure specified in Table 4. In those cases, the consultation level in Table 4 can be invoiced with the procedure in Table 2.

Example 8:

A client presents for the first time at a UCC with a fractured radius and ulna. The client is seen initially and is then referred to have an X-ray. They then return for a consultation afterwards where radiology findings and treatment options are discussed. A nurse then applies a below elbow cast and discusses cast care with the client.

The clinic invoices an initial consultation level 2 (UC02) because the radiology investigation meets the description of procedure no. 15 under level 2 in Table 4 in combination with a procedure code from Table 2 for below elbow cast (UC41).

Claiming for two or more procedures

If, during one visit, two or more procedures are required on **a single** body site as specified in Appendix 7 – Body Site Map for Multiple Procedures, ACC will pay for:

- the full consultation price
- plus the full price of the most expensive procedure and
- half the price for the second or subsequent procedure(s)

To make invoicing for half of the price of a procedure easier, the UCC contract includes primary and secondary service codes for procedures in Table 2. The primary codes start with "UC" and are priced at 100% and the secondary codes start with "U2" and are priced at 50%.

Example 9:

A man presents at a UCC after falling off his bike. He has a fractured right radius and ulna requiring a cast. On the same arm he has a large abrasion below the elbow of more than 4 sq cms requiring significant cleaning. Managing this presentation requires two procedures on one site (the right lower arm).
In this case the clinic can claim an initial consultation level 2 (UC02) – because of the radiological investigation for the arm fracture – as well as the full price of the application of the below elbow cast (UC41) and half price for the wound dressing (U221).

If, during one visit, two or more procedures are required on **separate** body sites, ACC will pay for:

- the full consultation price
- plus the full price for the procedures

Example 10:

A man presents at a UCC after falling off his bike. He has a large abrasion on his right hand of more than 4 sq cms requiring significant cleaning and dressing. He also has a six centimetre long dirty flap laceration on the right leg.
In this case the clinic can claim an initial consultation level 1 (UC01) as well as the full price for the wound dressing of the right hand (UC21) and full price for the treatment of the right leg laceration (UC30).

Please note that the body map in Appendix 6 is only used for burns and abrasion service codes (UC20, UC21, U220 and U221) and varies from the Body Site Map for Multiple Procedures in Appendix 7.

Claiming for significant burns and abrasion codes

If a client has multiple significant burns and/or abrasions on the same body site, as defined in Appendix 6 – Body Site Map for Burns and Abrasions (UC20 &

UC21), then the clinic can invoice procedure codes for burns and abrasions ≤4 sq cm (UC20) or >4 sq cm (UC21) depending on the total surface area of all significant burns and/or abrasions on that body site. This means that there can only be one burns and abrasion code (UC20, UC21, U220 or U221) invoiced per body site.

The secondary codes (half price codes) for burns and abrasions (U220 for ≤4 sq cm and U221 for >4 sq cm) given in the service schedule are to be used in case where there is another procedure code invoiced for an injury to the same injury site as defined in Appendix 7.

Example 11:

A chef has fat splatter burns to the outside of the right arm, which is defined as one body site. The total surface area of all the significant burns is added together to determine the appropriate procedure code. For example, two burns of two square centimetres each would be claimed as initial consultation level 1 (UC01) plus Burns ≤4 sq cm (UC20). Three burns of two square centimetres each would be claimed as initial consultation level 1 (UC01) plus Burns >4 sq cm (UC21).

If the chef has two burns of two square centimetres each to the outside of the right arm and three burns of two square centimetres each to the outside of the left arm, then the clinic invoices an initial consultation level 1 (UC01) plus 1x Burns ≤4 sq cm (UC20) for the right arm and 1x Burns >4 sq cm (UC21) for the left arm.

Invoicing for Consumable Codes in Table 4

Table 3 of the Appendix outlines consumables that can be claimed in conjunction with a consultation code. The price for Consumable codes (Table 2) are for material only and any time taken for treatment is considered to be part of the consultation. Therefore, any time taken to apply, fit or educate the client about the consumable is added to the time used to calculate the consultation level. For example, the time taken to fit a moonboot is used to determine the consultation level because the moonboot consumable code (UC82) only covers cost for materials.

Consumable codes (Table 3) can be claimed in combination with procedure codes (Table 2) for the same body site, though there are some restrictions around what Procedure codes can be claimed in conjunction with UC81 Simple Orthotics for the same body site. Consumable codes are always invoiced at full price as they only cover the cost of materials.

Example 12

A woman presents with a four centimetre long laceration across the back of her left hand and her index finger. The doctor sutures the wound and fits the client with a hand splint to immobilise the finger and protect the wound.

The clinic can invoice for a UC30 for the wound repair and the actual and reasonable cost for the splint using UC81 plus a Level 1 initial consultation (UC01).

Example 13

A construction worker presents with a wrenching injury to his thumb following a fall in to a pot hole. X-rays confirm there is no fracture. He is diagnosed with a partial ligamentous tear. He is managed in a moulded splint. An invoice can be submitted for either UC61 OR UC81, but not both.

Clients seen more than once on the same day

ACC only pays for one consultation per day (on the same calendar day) for a particular claim. If a client is required to be seen by a clinician more than once during the same visit (e.g. before and after radiology), that is considered a single consultation invoiced to ACC according to the total amount of time taken or the consultation level specified in Table 4.

There are **exceptions were ACC will pay for a second consultation on the same day** if it is clinically justified and supported by documentation.

For example, ACC would consider paying for two consultations in one day when:

- reassessing the client later in the day is clinically justifiable, the client's condition has deteriorated, or a significant wound requires re-dressing
- the client is treated for one injury, leaves the clinic and has another accident, in which case a second claim would be appropriate
- the client returns to the clinic of their own volition and requires further treatment for their covered injury.

Clients presenting with both accident and health related conditions

If a client presents with both accident and health related conditions, ACC will pay for the consultation time and procedure(s) required to treat the client's personal injury, provided the injury-related need is significant enough for the client to have sought treatment for it independant of their health treatment needs. Your clinical records should reflect clearly the injury and medical component of the consultation. The recor should be of sufficient detail to support the invoicing.

Example 14:

A client presents acutely with pneumonia and at the time of the consultation the doctor enquires about his historical back injury claim. ACC will not pay for this consultation because no treatment was required and there is no indication that the client would have sought treatment or advice for the back injury on their own.

Example 15:

A client presents acutely with pneumonia and a new cat scratch that has become infected and requires treatment. ACC will only pay for the ACC related portion of the consultation, not for the time taken to assess and treat the pneumonia.

Public holidays

ACC has agreed to pay a public holiday rate for children under 13. Where those holidays fall on a weekend and are observed on the following Monday, ACC will only pay the public holiday rate for treatment on the actual day, not for treatment on the Monday.

Example 16:

Waitangi day fell on a Saturday and is observed on the following Monday. ACC will pay the public holiday rate on the Saturday, not on the Monday.

Extension process for additional treatment

Treatment under the UCC service is generally limited to eight weeks from first treatment at any contracted UCC. We have also introduced trigger numbers for consultation codes and cast procedure codes.

When a trigger number or the eight week treatment period is reached there will be a system stop on payment and an automatic message will be sent to the clinic requesting further information to clinically justify that treatment and any further treatment(s).

The clinic will complete an ACC7398 (see Appendix 8) and will send it to ACC32@acc.co.nz. The form prompts clinics to provide the following information:

- Relevant clinical records (to be attached to the form)
- Initial and current diagnosis
- Rationale why further treatment under the UCC contract is required
- Expected duration of treatment at the UCC
- Number of treatments given to date
- Number of treatments and / or duration of treatment over eight weeks requested

Clinics can also submit requests for further treatment proactively, for example if they become aware after four weeks of treatment that management of a fracture will extend post eight weeks due to complications.

The clinic will then be notified whether further treatment will be funded under the UCC contract. If payment under the UCC contract is declined, then the clinic can resubmit the invoice for treatment under the Cost of Treatment Regulations (CoTR).

Clients need to be made aware of any co-payments before treatment commences. If you are providing treatment outside of the eight weeks or above the trigger numbers and think ACC is likely to decline an extension under the contract, you should make your client aware of any additional co-payments the clinic will charge them if payment under the UCC contract is not approved.

Trigger numbers

Trigger numbers are outlined in Table 5 of the Appendix. The purpose of trigger numbers is to identify use of the contract which lies outside of expected norms. They are an administrative control which applies to consultation codes and cast procedure codes. The trigger number is the number of consultations or procedures that can be invoiced before a request for further treatment needs to be submitted. For example, if the trigger number is three then the fourth payment is stopped and the clinic is asked to submit an ACC7398.

The following two examples relate to situations where a request for further treatment has been received by ACC.

Example 17:

A child presents at a UCC after falling onto her outstretched hand. She has a fractured left radius and ulna requiring a cast. The trigger for upper limb casts is three. At a follow-up consultation, the fracture alignment is poor and requires a cast change. At a further follow-up consultation to check fracture alignment, adequate visualisation of the fracture is not achieved without removal and replacement of the cast. Three days later, she presents again with a damaged cast that needs to be replaced.

In this example, ACC would accept the fourth cast as adequate clinical justification for the cast replacement was provided.

Example 18:

A 25 year old man presents at a UCC after falling off his skateboard. He has a fractured right radius and ulna requiring a cast. The trigger for upper limb casts is three. At a follow-up consultation, the fracture alignment is poor and requires a cast change. At a further follow-up consultation to check fracture alignment, adequate visualisation of the fracture is not achieved without removal and replacement of the cast. Optimal positioning of the fracture is now confirmed. However, at follow up this cast is removed for routine x-ray rather than for clinical indication or due to the condition of the cast.

In this example, ACC would not approve payment for the fourth cast under the UCC contract as the clinical justification did not indicate that it was necessary to remove the plaster.

Extended treatment beyond eight weeks

We recognise that some clients require UCC services outside of the eight weeks period. In response we have introduced an exception process for treatment extending beyond eight weeks. The eight week treatment period commences from the client's first visit to any contracted UCC. This doesn't mean that all presentations within eight weeks are appropriate for invoicing under the UCC contract, as the majority of clients will be referred on or have completed treatment after the first visit to the UCC.

The following examples relate to situations where a request for further treatment has been received by ACC.

Example 19:

An elderly woman fell up some steps causing a flap laceration to her right shin. She presents at a UCC and the wound is cleaned, the flap is pulled down and secured with steristrips. Over the next four weeks the wound appears to be healing well. However, at a later consultation the wound appears to have ulcerated requiring extended treatment. This treatment is now expected to go beyond the eight weeks since her initial presentation. The UCC provides ACC with sufficient clinical justification detailing the progression of the wound breakdown.

In this example, ACC would approve payment under the UCC contract for the extended treatment.

Example 20:

A 27 year old woman presents with a dog bite to her right arm. The wound is cleaned, redressed and IV antibiotics are given. On follow-up consultations, the wound is documented as healing as expected. A request is submitted to ACC for further treatment beyond eight weeks since initial presentation. On review of the clinical documentation, there is no indication that the wound remains complex and requires any further treatment at the UCC.

In this case ACC would not approve further treatment under the UCC contract, but the clinic could submit an invoice for the treatment under CoTR.

Example 21:

A man fell out of a tree and sustains a spiral fracture of the fibula requiring a lower limb cast. He re-presents to the clinic six weeks after the initial presentation. Non-union of the fracture is noted, because the cast achieved inadequate immobilisation of the fracture. The UCC submits an application for further treatment beyond the eight weeks since initial presentation to ACC. This request includes details around the complicated healing of the fracture and a follow-up plan for treatment beyond eight weeks.

In this example, adequate clinical justification is provided and ACC accepts further treatment under contract.

Interaction with other services

Co-location with general practice

Clinics have a responsibility to determine the most appropriate service for clients attending their clinics, particularly where there is no physical differentiation between the general practice and UCC services. The responsible use of the UCC contract is vital for the sustainability of both the general practice and the UCC services.

Example 22:

An enrolled client presents to a co-located clinic as a walk-in with on-going pain attributed to back injury that occurred six weeks earlier. This is no longer acute. Therefore, he should be seen under the general practice service as opposed to the UCC service.

Visiting specialists

Many UCCs have visiting specialists run clinics from rooms in the clinic and use UCC staff to support them. ACC supports UCCs and specialists working together in this fashion where appropriate, especially since it often means that clients can see the specialist closer to home.

As these specialist appointments are separately funded by ACC under the Clinical Services contract, the UCCs can not charge ACC for the support they are providing to the specialist. Reimbursement for the UCC's resources must be sought directly from the specialist.

Example 23:

A client has a specialist appointment which is held at the UCC. On arrival, the client has the cast removed by the UCC staff prior to seeing the specialist. Following the consultation, the UCC staff re-apply a cast. The procedure is part of the visit to the orthopaedic surgeon and the specialist can invoice ACC for it. The UCC invoices the specialist for the UCC staff's time and/or consumables relating to the removal and reapplication of the cast.

This only applies to services supporting the specialist consultation. If the client has treatment at the UCC independent of the specialist appointment, the UCC is able to invoice for those services. For example, if the client first presents at the UCC for treatment and requires referral to the specialist who can see the client that day.

Given the specialist nature of the UCC service we expect that most uncomplicated fractures are managed entirely under the UCC contract.

Pharmaceuticals

Where pharmaceuticals are prescribed, ACC expects that subsidised pharmaceuticals, as listed in the Pharmaceutical Schedule, will be prescribed where possible. If non-subsidised pharmaceuticals are prescribed, in order to avoid disappointment, the client should be advised that ACC may not reimburse the prescription costs.

Rehabilitation

ACC views the planning and management of on-going treatment and rehabilitation to be part of the GPT's role in collaboration with the client's rehabilitation providers, rather than being the responsibility of the UCC. Except in situations where the clinic is providing continuity of injury management, where responsibility during this time would sit with the UCC.

We value the role UCCs can play in initiating rehabilitation and in identifying opportunities for enhancing rehabilitation as well as setting appropriate expectations of recovery and return to work and usual activities.

Certification

There is evidence that working improves general health and improveswellbeing. Many health problems including musculoskeletal injuries have been shown to benefit from early return to suitable work and activity-based rehabilitation. On the other hand long term absence from work is harmful for physical and mental wellbeing of the person.[1] The likelihood of returning to work decreases the longer the person is absent from work.

Therefore an early return to safe and appropriate work and/or normal daily activities is essential to achieve the best outcomes for our clients.

To support this we expect UCCs to take a 'fitness' rather than a 'sickness' approach to certification. This means concentrating on what the client is able to do even though they may have limitations from their injury. The medical certificate needs to clearly state the limitations to the client's activities to ensure that they do not return too early to activities that might impact their recovery.

We expect UCCs will issue primarily 'Fit for Selected Work' (FFSW) medical certificates rather than 'Fully unfit' (FUF) certificates where possible as the vast majority of clients will have some capacity to work. If a fully unfit certificate is clinically appropriate for example at initial consultation, we expect this to be a certificate of short duration with any further FFSW time on an ACC18 medical certificate given to the patient at the time, or a re-assessment of the client after a few days.

Currently, the ACC45 only allows one line for incapacity. For clients who are FUF for a few days but are then FFSW, clinicians can submit an ACC45 and an eACC18 at the initial consultation to reflect this. This is an interim measure while ACC revises the ACC45.

Given the importance of certification for ACC clients' recovery, we will be monitoring and reporting back to clinics on their performance in this area.

[1] The Australasian Faculty of Occupational & Enviromental Medicine, Reaising the Health Benefits of Work – A Position statement, October 2011. ACC, NZ Nurses Organisation, Royal NZ College of Urgent Care and Royal NZ College of GPs and RNZCGP are signatories to this position paper.

Injury Prevention

There is an opportunity to make injury prevention a part of every consultation. This will be done by:

- Identifying clients who are at risk of future injuries and providing them with some immediate recommendations where the opportunity arises
- Advising ACC if the client requires assistance to ensure their safety while recovering from injury – see *ACC Induction and Orientation Material*[2]

There is an opportunity for a more active injury prevention role for those clients for whom clinics are providing extended injury management.

Health literacy and self-management

Health literacy refers to the client's ability to obtain, process and understand basic health information and services to make appropriate health decisions[3].

According to an Institute of Medicine (2004) report, low health literacy negatively affects the treatment outcome and safety of care delivery. Clients with low health literacy have a higher risk of hospitalisation and longer hospital stays, are less likely to comply with treatment, are more likely to make errors with medication, and are more ill when they seek medical care.

A health literate population requires high quality services that are easy to access and navigate and gives clear and relevant health messages so that everyone can effectively manage their own health, keep well and live well[4].

Because health literacy has such a big impact on health outcomes it is important that UCCs contribute to the health literacy of clients.

UCCs need to enable clients to understand the nature and impact of their injury and how they can actively contribute to their treatment plan to support rapid healing. Clients need to know how to access care (including other ACC funded services) when they need it. They also need to understand the risks of not following their treatment plan.

UCCs will empower clients to self-manage their injury, taking into consideration the clients understanding of their injury, what is required to look after it, as well as the client's personal circumstances which might impact on their ability to self-manage their injury.

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[2] If you require a copy of the *ACC Induction and Orientation Material* please contact us on primarycare@acc.co.nz

[3] Ministry of Health. 2010. Kōrero Mārama: Health Literacy and Māori. Wellington: Ministry of Health.

[4] Ministry of Health. 2015. A Framework for Health Literacy. Wellington: Ministry of Health.

ACC forms

ACC45 Injury Claim form

The ACC45 injury claim form is the primary form used to lodge a claim for cover, and should be used wherever possible. This is because it:

- has a unique identifier number for security reasons, which we also use to monitor claims, and
- provides sufficient prompts within the form to ensure all of the necessary information is provided.

You can certify a client either fit for selected work or fully unfit for up to 14 days using the ACC45. If your patient requires further time off work, you'll also need to complete an eACC18 Medical Certificate.

ACC2152 Treatment Injury Claim form

Use this form in addition to the ACC45 when lodging a treatment injury claim. For details on what ACC covers as a treatment injury and how to lodge a claim please refer to the ACC Treatment Provider Handbook.

eACC18 Medical Certificate

Use the eACC18 Medical Certificate if you are a medical practitioner or a nurse practitioner and you need to describe a person's ability to work. This is the only certificate we accept for compensating clients for time off work – with the exception of the first 14 days if an ACC45 is used. An eACC18 can also be used to request ACC to change or add a diagnosis to an already existing claim.

For further information and guidance about the above forms, refer to the UCC contract or the *ACC Treatment Provider Handbook*.

Urgent Care standard

ACC requires suppliers' clinics to be accredited against the *Urgent Care standard 2015*. The UCC must maintain compliance with the standard at all times. If the clinic foresees that they will not comply with the standard, they must advise us as soon as possible. If the clinic is no longer compliant then they must advise us within five business days.

Clinical records and follow-up plans

Clinical records should give a detailed description of the accident event and the injury including how the accident caused the injury.

They also need to provide enough details of the treatment provided and of the injury to justify the procedure codes and level of consultation code claimed by the clinic. This is specially the case where clinics invoice for a Level 2 or 3 or a complex follow-up consultation in combination with a procedure code or where the clinic claims for a higher consultation code than indicated in Table 4.

The UCC contract also requires clinicians to record their follow-up plan for the client in their records. A follow-up plan needs to include adequate information to enable seamless transition of care and to ensure the client's GPT is aware of the UCC's treatment plan for the client in those cases where the UCC is planning to provide continuity of injury management. The follow-up plan needs to be accessible within the clinic and needs to be made available to the GPT.

Monitoring and reporting

The purpose of monitoring and reporting is to ensure consistent service delivery across the contracted clinics and to collect data that will establish a baseline for future performance measures in the contract.

ACC will provide six monthly feedback reports to clinics summarising ACC monitoring and information supplied from the clinics' annual reporting. Clinics will initially receive deidentified reports showing how clinics are tracking against each other, against their previous performance and against performance measures once they have been developed.

Suppliers whose invoicing patterns do not fit within the normal patterns of their peers will be contacted by a Engagment and Performance Manager (EPM) to explore the reasons behind the variations.

APPENDIX

Table 1 – Consultation Codes

Service Item Code	Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
Initial Consultation				
UC01	Level 1 Consultation	An initial consultation of up to 20 minutes.	$70.53	Per visit
UC02	Level 2 Consultation	An initial consultation of 21 – 40 minutes.	$123.07	Per visit
UC03	Level 3 Consultation	An initial consultation of over 40 minutes.	$221.79	Per visit
Follow-up Consultation				
UC10	Simple Follow-up Consultation	A follow up consultation of up to 20 minutes.	$60.90	Per visit
UC11	Complex Follow-up Consultation	A follow up consultation of 21 minutes or longer.	$116.49	Per visit
Under 13s Consultation additional payment				
UC13	Urgent Care Consultation - child under 13yrs additional payment	Free visits for all children under 13 years of age. (Note: (1) No co-payment will be charged for consultations. (2) Can only be charged once per consult, and; (3) cannot be charged in conjunction with PH13)	$24.22	Per visit
PH13	Urgent Care Consultation - child under 13yrs additional payment on public holidays	Free visits on public holidays for all children under 13 years of age. (Note: (1) No co-payment will be charged for consultations (2) Can only be charged once per consult, and; (3) cannot be charged in conjunction with UC13 (4) Can only be charged for services provided on public holidays)	$40.37	Per visit

Table 2 – Procedure Codes

Service Item Definition	Primary Service Item Code	Primary Service Item Price (excl. GST)	Secondary Service Item Code	Secondary Service Item Price (excl. GST)	Pricing Unit
Dressing of significant burns or abrasions (excluding those covered in Initial Consult 1 / Simple follow-up) of a total surface area of up to 4 sq cm per body site (as indicated in the body map in Appendix One). May be invoiced once per affected body site.	UC20	$32.93	U220	$16.47	Per procedure
Dressing of significant burns or abrasions (excluding those covered in Initial Consult 1 / Simple follow-up) of a total surface area greater than 4 sq cm per body site (as indicated in the body map in Appendix One). May be invoiced once per affected body site.	UC21	$71.47	U221	$35.74	Per procedure
Repair of significant wound ≤ 7 cm. Skin and subcutaneous tissue or mucous membrane, repair of wound (not more than 7cm long) requiring skin closure by suture, clips, skin adhesive strips or glue including cleaning, debridement, irrigation, local anaesthetic and dressing.	UC30	$97.86	U230	$48.93	Per procedure
Repair of significant wound > 7cm. Closure of open wound(s) of skin and subcutaneous tissue or mucous membrane >7cm by sutures, clips, skin adhesive strips or glue; any necessary care and treatment including cleaning and debridement, exploration, administration of anaesthetic and dressing.	UC31	$132.78	U231	$66.39	Per procedure
Above elbow cast immobilisation of fracture or significant soft tissue injury of upper limb where this meets best practice.	UC40	$131.68	U240	$65.84	Per procedure
Below elbow cast immobilisation of fracture or significant soft tissue injury of upper limb where this meets best practice	UC41	$101.50	U241	$50.75	Per procedure

Lower limb cast immobilisation of fracture or significant soft tissue injury including Achilles tendon ruptures and partial ruptures where this meets best practice	UC42	$204.66	N/A	N/A	Per procedure
Relocation of dislocated joint of finger or toe under anaesthetic. Reduction of fracture of proximal, middle or distal phalanx of hand or foot, requiring reduction under anaesthetic.	UC50	$63.29	U250	$31.65	Per procedure
Relocation of dislocated joint of wrist, ankle or elbow under anaesthetic. Relocation of dislocated shoulder under procedural sedation and/or analgesia. Includes splinting where necessary, but does not include casting. This item will generally involve radiological investigation.	UC51	$138.66	U251	$69.33	Per procedure
Soft tissue injury management-simple soft tissue injuries (other than splinting dislocation of fractured digit) unless specified elsewhere; management of simple sprain of wrist/ankle/knee/elbow or other soft tissue injury requiring crepe bandage, sling or similar immobilisation or padded splint or specific strapping with agreed guidelines (includes splinting ankle sprains).	UC60	$32.93	U260	$16.47	Per procedure
IV medication - Administration of intravenous medication requiring insertion of intravenous cannula, immobilisation of limb (for purposes of IV medication), IV infusion and/or IV injection of medication. Includes consumables and administration time.	UC70	$76.89	N/A	N/A	Per procedure

Table 3 – Consumable Codes

Service Item Code	Service Item Definition	Price (excl. GST)	Pricing Unit
UC80	Crutches hire – Limited to one pair per claim.	$33.56	Per claim
UC81	Simple orthotics such as off the shelf or pre-made wrist & finger splints, foot and ankle splints including any requirement for slings in combination with these. Includes immobilisation by sling, collar and cuff or U-Slab. This procedure code cannot be invoiced in conjunction with UC40, UC41, UC42, UC51, UC60 or UC82 for the same injury site. Limited to one orthotic per injury site per claim.	Actual and reasonable cost	Per orthotic
UC82	Moonboot – limited to one moonboot per claim.	Actual and reasonable cost	Per claim

Table 4 – Procedures to be completed as part of consultation

Level	Description	Other Procedures
1	An initial consultation of up to 20 minutes	1. Clean and dress simple wounds, e.g. superficial lacerations, abrasions, burns and single contusions with application of elastoplasts or simple dressings 2. Simple removal of non-embedded foreign body from eye or ear, nose, mouth, skin or subcutaneous tissue site (excluding rectum or vagina) without incision. 3. Simple irrigation of eye (with or without ocular anaesthetic) or wound with small volumes of saline not requiring formal re-assessment or other treatment 4. Re-application of simple splint to dislocated or fractured digit 5. Removal of dressing 6. Removal of sutures and application of sticking plaster, not requiring more complex redressing 7. Follow-up check of simple abrasions or lacerations or sprains 8. Perform plaster check 9. Removal of plaster casts and below elbow fibreglass casts 10. Aspiration or incision, without use of infiltrated anaesthetic, of small abscess or haematoma (including dressing) 11. Application of strapping to dislocated or fractured digit 12. Removal or debridement of nail or nails without anaesthetic 13. Removal of packing of nose, or packed abscess or haematoma.

Level	Description	Other Procedures
2	An initial consultation of 21 – 40 minutes	1. Removal of embedded or impacted foreign body from cornea or conjunctiva, or from auditory canal, or nasal passages, from skin or subcutaneous tissue with incision with or without anaesthetic. Including formal Saline irrigation with 500ml Saline 2. Drainage of abscess or haematoma with incision (with or without infiltration of local anaesthetic agent) 3. Application of splint (other than splinting of dislocated or fractured digit) unless specified elsewhere 4. Nail, simple removal of 5. Removal of nail requiring the use of digital anaesthesia 6. Closed reduction of dislocated patella without anaesthetic (plaster cast not required) 7. Closed reduction of fracture of nasal bones 8. Removal of fibreglass cast above elbow, above or below knee 9. Reduction of dislocated shoulder without anaesthesia and/or sedation 10. Application of pressure dressing 11. Injection of steroid into joint, tendon, bursa, or other subcutaneous tissue or space 12. Repositioning and splinting of displaced tooth 13. Re-implantation of tooth 14. Sedative dressing (or anaesthetic) for emergency dental treatment. 15. Performing radiological investigation where this includes pre-assessment of injury, discussion with Client on reasons for investigation, ordering of investigation(s), interpretation of radiology, discussion with Client of radiological findings, options for treatment, and documentation in the clinical record that reflects this. 16. Slit lamp review of eye injury
3	An initial consultation of over 40 minutes	1. Resuscitation of patient including any procedure such as defibrillation, prolonged monitoring, or emergency needle decompression, and patient transfer. 2. Prolonged assessment and treatment of patient with multiple and/or complex injuries (e.g. head injuries requiring complete neurological assessment and observation) where the clinical record clearly reflects the time taken.

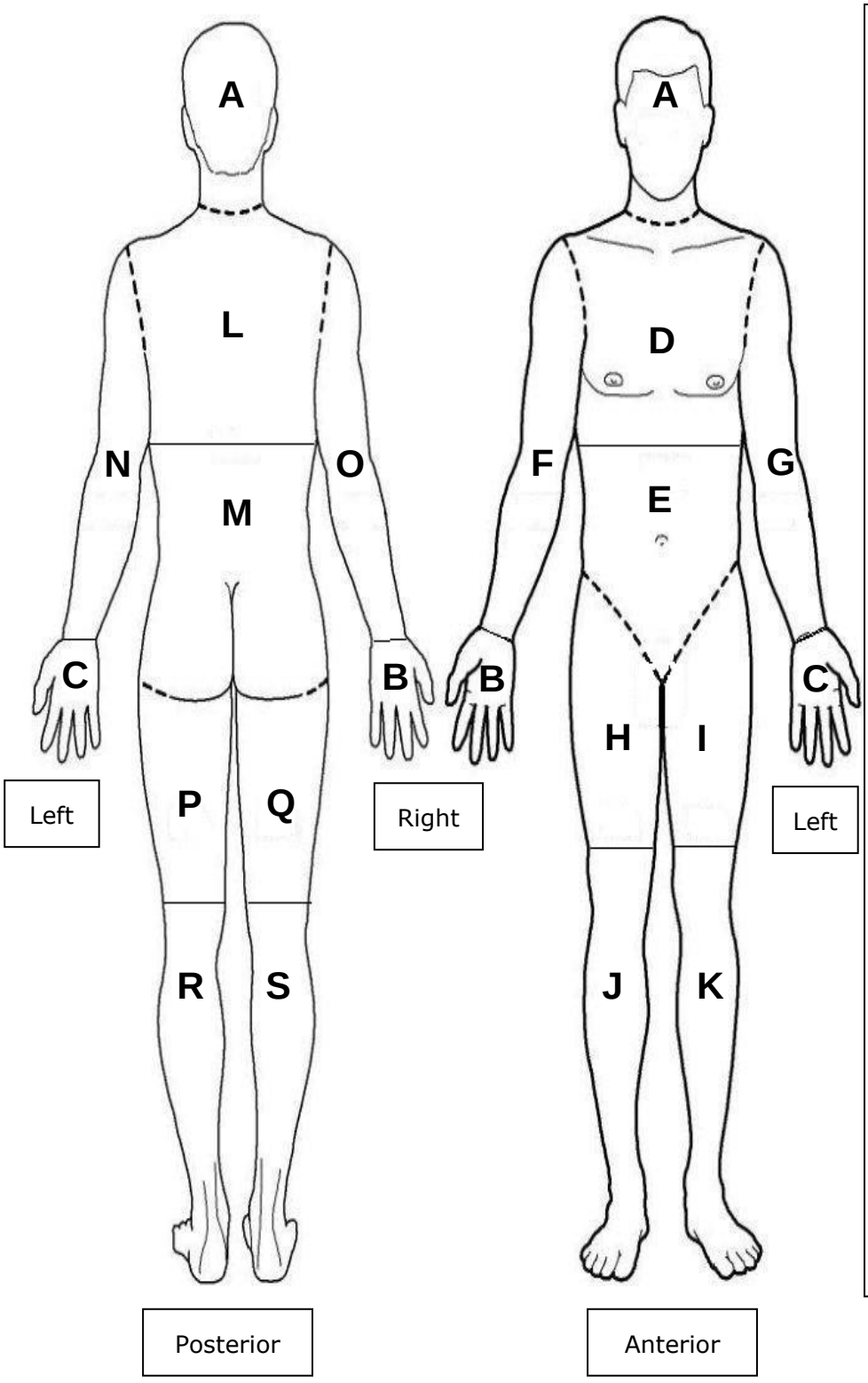
Level	Description	Other Procedures
Simple Follow-up	Simple Follow-up Consultation	All procedures listed under Initial Consultation Level 1
Complex Follow-Up	Complex Follow-up Consultation	All procedures listed under Initial Consultation Level 2 and 3 A Structured Rehabilitation Consultation may occur for those clients that have suffered a significant injury when a detailed rehabilitation plan is required to assist their recovery as part of continuity of injury management for specific presentations. The consultation includes: • Review of history (including injury, medical and social history), confirmation of diagnosis, functional assessment and treatment plan • May involve other health professionals in a multidisciplinary consultation • Rehabilitation plan will include setting expectations around return to work or independence and realistic timeframes, a discussion around functional outcomes, partial fitness and alternate duties. • Where the client is employed, this should include co-ordination with the employer • Client may be referred to other treatment providers as a result of this consultation • The rehabilitation plan will be developed in conjunction with the client and will be agreed by both parties. • The GP should be consulted where appropriate and the plan should be communicated to them • Clinical notes will evidence the need for this consultation and plan

Table 5 – Trigger numbers

The trigger numbers identified below signify after how many payments a systematised stop payment notice will be sent to clinics, seeking more information before payment will be released or declined.

Service Item Code	Service Item Description	Trigger Number
UC01, UC02, UC03, UC10 and UC11	Consultation Codes (trigger applies across all five service codes)	15
UC40	Above elbow cast	3
UC41	Below elbow cast	3
UC42	Lower limb cast	5

Appendix 6 – Body Site Map for Burns and Abrasions



A = Head

B = Right Hand

C = Left Hand

D = Upper torso front

E = Lower Torso front

F = Right arm inside

G = Left arm inside

H = Upper right leg front

I = Upper left leg front

J = Lower right leg front

K = Lower left leg front

L = Upper back

M = Lower back

N = Left arm outside

O = Right arm outside

P = Upper left leg back

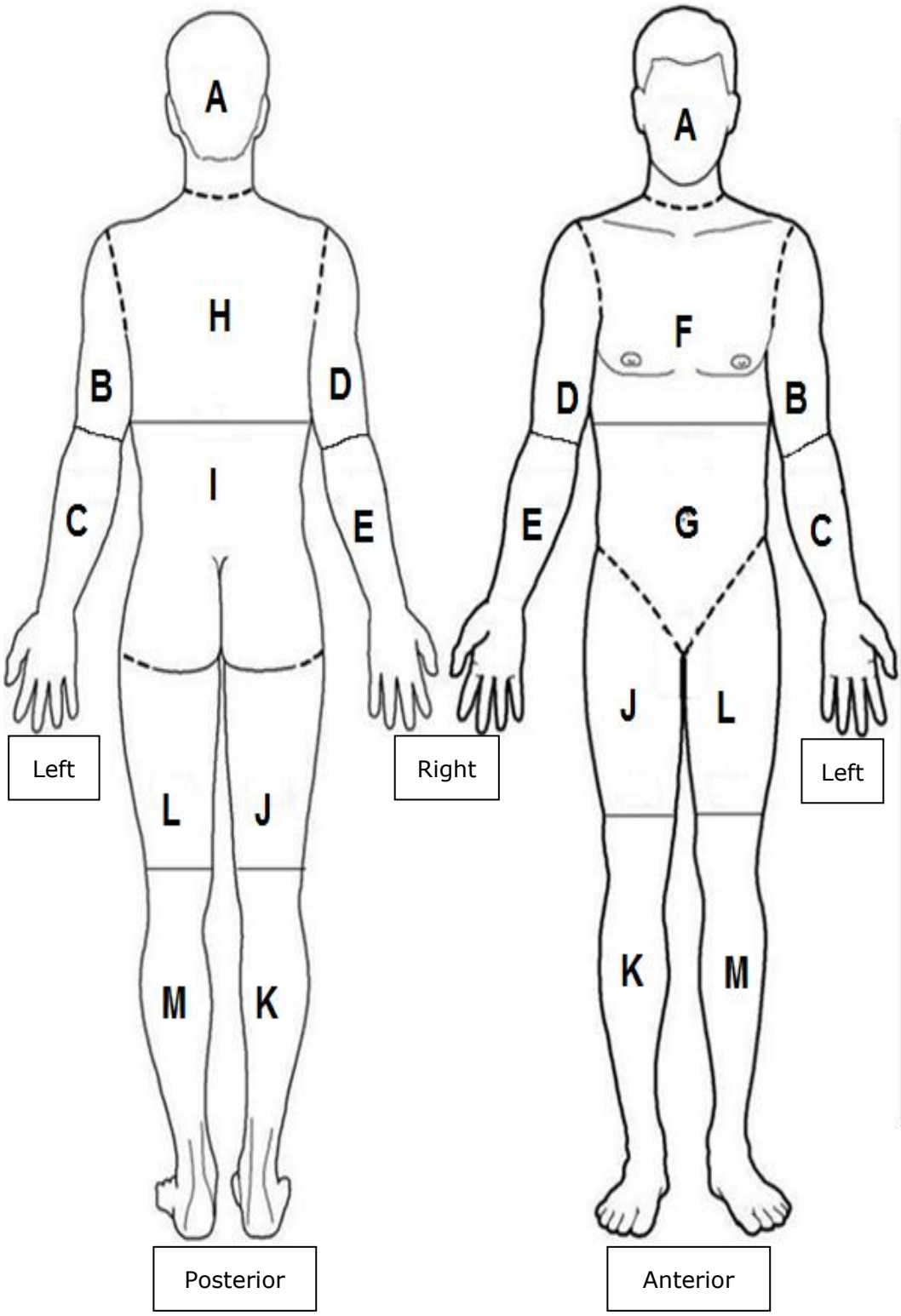
Q = Upper right leg back

R = Lower left leg back

S = Lower right leg back

Appendix 7 – Body Site Map for Multiple Procedures

This map of injury sites details what is defined as one injury site for the purpose of determining whether to use the secondary procedure code for the second and subsequent procedure codes on the same injury site.



Appendix 8 – Extension request

ACC7398

Request for further treatment

Complete this form to request and validate ongoing treatment of behalf of a client. When you've finished, please email this form to ACC32@acc.co.nz.

Please indicate: ☐Trigger number ☐ Treatment beyond 8 weeks only.

1. Client details

ACC45 number or ACC claim number:

Client name: Occupation:

Postal address:

Date of injury: Date of birth:

2. History, examination and diagnosis

What was the initial diagnosis?

What is the current diagnosis and read codes?

Please provide your rationale for requesting continued treatments under the Urgent Care contract:

Number of treatments given to date?

Please attach copy of relevant clinical records.

3. Treatment plan (What do you need approval for?)

Expected duration of treatment post 8 weeks: **Number of treatments requested:**

weeks

Simple follow up:

Complex follow up:

Casts (please specify service code):

Comments:

4. Provider details

Treating practitioner name: Or provider stamp here:

Address:

Provider type: ACC Provider ID:

ACC Vendor ID: Phone number:

Provider's signature: 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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Appendix 9 – Frequently Asked Questions

1. Do consultations need to be planned to be invoiced as a follow-up?

No.

The UCC contract doesn't make a distinction between planned and unplanned follow-up visits. There is always only one initial consultation per claim and clinic. If the client cannot be referred back to the General Practice Team (GPT) following the initial consultation, any and all subsequent visits to that clinic for that claim are follow-up consultations.

2. How does ACC pay for a period of observation of a client?

We pay for the time of direct patient care

– not for the client using a room or for a clinician observing the client whilst completing other tasks.

Time spent on direct patient care can be added together to determine the overall treatment time.

For example, a clinician observes a client with head injury over a period of four hours and completes neurological checks every half hour taking three minutes. Therefore, the overall treatment time for observation is 24 minutes. These 24 minutes are added to any other assessment and treatment time (outside of Table 2 procedure) to determine the applicable consultation level.

3. If an x-ray is part of a consultation, does this constitute a Level 2 initial consultation or a complex follow-up consultation? Table 4 states a radiological investigation is a Level 2 or complex follow-up.

No.

Not every consultation that includes an x-ray is a Level 2 or a complex follow-up. All criteria listed in Table 4 under radiological investigation need to be met. This is particularly important at planned follow-up consultations as there will not always be a pre-assessment of the injury, nor will the reason for the investigation be discussed with the client if the x-ray was planned and discussed at the previous visit.

4. Is it appropriate to invoice for a consultation under the UCC contract if the client was sent by their employer for a second opinion on the medical certificate they received from their GP?

No.

Giving second opinions on medical certificates is not a UCC service and should be invoiced under Cost of Treatment Regulations.

Employers should not question GPs' medical certificates and it is not the purpose of UCCs to provide second opinions on GPs' assessments of a client's work capacity.

We would appreciate it if you would let us know of any employers that ask you to provide medical certificates overwriting the one their employee already received from their GP. This will allow us to follow this up with the employers.

5. If a burn is across two different body sites, is this invoiced as two separate burns or as one?

One.

This is treated as one burn and you can only invoice one burns and abrasion procedure code for treating the injury.

6. What procedure code should clinics use when changing dressings for significant wounds that required skin closure at the initial visit (UC30 or UC31)?

Clinics cannot invoice a procedure code for these dressing changes after the first consultation when the procedure was performed.

Since the wound doesn't require skin closure on the follow-up visits you cannot invoice a UC30 or UC31 again for the wound – except for very rare cases where wound healing is complicated and requires additional suturing.

The Burns and Abrasion codes (UC20 and UC21) are only for burns and abrasions, not for dressings on other types of wounds.

Removal of sutures, simple dressings and checks of lacerations should usually be invoiced as a simple follow-up consultation. The prices for consultation codes include the cost of consumables used as part of a consultation.

7. Is explaining cast care to the client included in the consultation or the procedure time?

Procedure time.

Discussing cast care with the client is part of the casting procedure. Therefore, time spent doing this can't be used to determine the consultation level.

8. What defines significant versus simple injuries?

There is no UCC contract specific definition of simple and significant injuries. In regards to wounds, a simple abrasion, burn or laceration only requires simple dressing, like Elastoplast as described in Table 4.

9. How does ACC pay for the time taken in regards to consumable codes (Table 3)?

Through the consultation code.

The prices for consumables specified in Table 3 – Consumable Code Prices only include material. Therefore, any time taken to fit a client with a simple orthotic, moonboot or crutches and explain use of and care for the consumable is added to the time used to calculate the consultation level.

10. Does ACC pay per medication? For example, when two doses of medication are given as part of IV therapy.

No.

We don't pay separately for medication that is used during treatment. This is either paid for as part of the consultation or the procedure code. This is also the case for IV therapy even if you are administering more than one medication.

11. How are tetanus vaccinations paid for under UCC?

There is no separate reimbursement for tetanus vaccinations under the UCC contract. ACC has already funded tetanus vaccinations through the Ministry of Health.

12. How can UCCs find out if their client has been seen at another UCC and whether trigger numbers or the eight weeks treatment limit have been reached? What if the client comes through on the weekend?

You can ask Provider Contact Centre.

Regardless of how often a client has been seen at a UCC before or when UCC treatment started you should always ask yourself whether the client's presentation fits within the purpose of the UCC contract or if they should be seen under Regulations.

However, in order to avoid invoices being held and you needing to submit a ACC7398 extension request retrospectively it is of course important for you to know whether are request will be required or not.

Within eight weeks of the date of accident you can be sure that the client is still in the eight weeks from first UCC visit.

If you see a client more than eight weeks post accident or you are unsure if trigger numbers have been reached you can contact our Provider Contact Centre (0800 222 070) 7am – 7pm weekdays to ask when the first visit to a UCC was and if relevant triggers have already been reached. We acknowledge that the Provider Contact Centre doesn't operate during all opening hours of UCCs.

Outside of the opening hours of the Provider Contact Centre, if you believe a UCC response is required you should invoice under UCC. If it is outside of eight weeks or trigger numbers have been reached we will asked you to send an ACC7398 before releasing payment.

If the treatment is inappropriate under UCC and your request is not approved then you can invoice ACC under Cost of Treatment Regulations.

13. If a client sees a clinician at a UCC and has had three upper limb casts at another UCC which the clinician is unaware of, can the clinician still invoice under the UCC contract?

Yes, but you will have to complete an ACC7398 form.

Since the trigger for upper limb cast codes is three, the invoice will be held and the clinic will have to complete an ACC7398 to request funding for the additional cast. If the cast is required because it has been damaged or because it was necessary to remove the cast in order to x-ray the fracture again, then we will approve payment for the cast under UCC contract.

If the treatment is inappropriate under UCC and your request is not approved then you can invoice ACC under Cost of Treatment Regulations.

14. Why can't UCC staff charge for their time under the UCC contract when helping a specialist?

This is not a new expectation.

The Clinical Services contract states:

"The prices set out are the entire amount chargeable to ACC in relation to the Services and no additional amount may be charged to ACC, the Client or other person for Services under this agreement."

The historical practice whereby UCCs invoiced ACC for the procedures component of the specialist consultation was in breach of the Clinical Services contract. The consultation price in this contract includes any nurse time. In the UCC contract nurse time to complete a procedure is paid for as part of the procedure code. Therefore ACC would be paying twice for this time.

The information gathering phase of the A&M review identified a number of situations where ACC was invoiced by both the specialist and the A&M clinic for consultations on the same day of a follow-up appointment. Therefore ACC was paying twice.

Under the Elective Surgery contract all specialist follow-up care in the first six weeks post discharge after surgery is already paid for. Therefore any additional invoices from the UCC would represent a double payment.

15. If the UCC employs a specialist and the specialist doesn't fill out medical certificate forms, is it the UCC or ACC that needs to address this issue with the specialist?

The UCC.

Since in this example the specialist is employed by the UCC, this is an employee performance issue within the UCC. ACC Engagement & Performance Managers (EMPs) can support you working with the specialist as this is also a provider performance issue for us.

If the specialist is not working for the UCC but runs a clinic out of the UCCs rooms, we would appreciate if you would bring this to the attention of your local EPM so they can follow up with the specialist.

16. What happens if a client presents during the six weeks post their elective surgery?

You can invoice us for urgent presentations.

For six weeks after elective surgery, the specialist is responsible for care and this is paid for under the Elective Surgery contract.

However if the client is presenting at the UCC within these six weeks and it is an urgent, unplanned presentation appropriate under the UCC contract then payment will be released. However, if the specialist is referring clients to the UCC to provide standard follow-up care then this is not a UCC function and ACC should be advised so we can contact the specialist.

17. Does the UCC have to transfer a client's notes back to their GPT?

It's up to the client.

If they don't want their notes to be sent to their GPT, then the UCC shouldn't transfer them.

However, the expected standard process would be to transfer the clinical notes to the client's GPT so the client would need to opt out of this process.

18. Does the clinical record have to state the time taken for the consultations?

No.
The clinical record doesn't have to state the time. However, clinical notes need to clearly support the consultation level that has been invoiced. Recording the time taken may be a practical way for your clinic to do this. We would certainly welcome you recording the time taken for treatment as it would be very helpful for audits.

19. What is the expectation for co-located clinics regarding the use of the UCC contract?

Clinics have a responsibility to determine the most appropriate service for clients attending their clinics, particularly where there is no physical differentiation between the general practice and the UCC services and especially when the clinics operate under a no-appointment system. The responsible use of the UCC contract is vital for the sustainability of both the general practice and the UCC services.

Clinics cannot charge ACC under the UCC service when a client is or should be accessing the general practice service. Not every injury that presents to these clinics should be managed under the UCC if it could be managed under general practice.

If you are not sure if you should invoice for a client's treatment under UCC or Regulations asked yourself:
"If you didn't have the Urgent Care Clinic contract, would you see the client yourself or would you refer to a UCC, ED or another provider?"

20. If the same client needs on-going treatment and wants to see the same doctor again, should this be continued under UCC because that's where treatment started?

No.

Where the treatment starts, does not determine where on-going treatment is provided. If the client wants to continue treatment with the same doctor beyond the point where urgent care treatment is required, then an appointment should be booked through the general practice part of the business.

If the client requires continuity of injury management for a specific presentation that cannot be safely managed by the general practice, this treatment can be provided through the UCC and an appointment can be booked there with that doctor.

21. Is a non-embedded foreign body covered by ACC?

No.

Removal of non-embedded foreign bodies is not automatically covered by ACC. We only pay for the removal of foreign bodies if there was also a physical injury. For example, if the foreign body caused a scratch or graze. A peanut in the ear or nose canal would not be covered when there is no wound.

22. Can a client's fitness for work be discussed with the employer?

Only with client consent.

You should get the client's consent before discussing their injury with their employer. If the client has an ACC Case Manager, you could refer the client's employer to them as ACC obtains client's permission to discuss their injury and recovery with the employer.

23. If an ambulance brings a client to the UCC for treatment, but following assessment it is decided that the client needs to be transferred to hospital, does ACC fund a second ambulance from the UCC to the hospital?

Yes.

Transport is covered for both trips by ACC's agreements with St John and Wellington Free Ambulance. There is no surcharge for the client or charge for the UCC.

24. Can clinicians working at UCCs only bill under the UCC contract and not under Cost of Treatment Regulations?

No.

GPs, nurses and nurse practitioners can also register to charge under Cost of Treatment Regulations. Please refer to the Treatment Provider Handbook to find out more about registering to become an ACC provider under Cost of Treatment Regulations.

25. The ACC45 has three lines for diagnoses. How can we add further Read codes to the ACC45?

Use the comment section of the ACC45.

You can include extra diagnoses by detailing other injuries in the additional comments section of the ACC45. Within the additional comments section, please state that you would like to add further injuries and include the Read code, injury description and injury site.

The additional injuries will then be added to the claim.