

ACC secondary submission

**Review of the Way in which Physiotherapy Services are
Funded and Accredited by ACC**

03 May 2007

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Purpose

The Confidence and Supply Agreement between the Government and New Zealand First includes a requirement to conduct a review of the way in which physiotherapy services are funded and accredited by ACC. The Government has agreed to address this issue during this term of Parliament.

ACC recognises that physiotherapy plays an important role in helping people to recover their quality of life and return to work or independence following injury. ACC purchases physiotherapy services under Regulations and through contracts aimed to achieve more timely and effective rehabilitation for claimants.

In purchasing physiotherapy services for claimants, ACC is aware that it needs to ensure that claimants achieve effective rehabilitation outcomes that are cost effective and contribute to maintain fair and stable levies for levy payers.

To achieve these objectives, ACC works closely with the physiotherapy sector on a broad range of issues, such as addressing claimant specific needs, providing education and support to the sector, and addressing issues through dialogue. More formally, ACC also monitors physiotherapy services against the ACC/New Zealand Society of Physiotherapists' jointly agreed treatment profile, undertaking practice audits and auditing against standards required by particular service agreements, and randomly monitoring providers for compliance with contracts and legislation.

ACC welcomes this opportunity to make a second submission. This submission:

- provides information not included in ACC's first submission
- responds to concerns and clarifies inaccurate statements made by other parties in the first round of submissions, and
- answers the additional questions put to ACC by the Reviewer.

Introduction

The initial round of submissions to the Review of the Way in Which Physiotherapy Services are Funded and Accredited by ACC generated a number of themes. These submissions followed closely the terms of reference of the review.

ACC acknowledges a number of claimant submissions were received that outlined specific concerns they have with ACC. ACC is reviewing these concerns and is identifying opportunities to improve our practices and processes.

Some of the concerns raised in the submissions to the Review were addressed in ACC's primary submission. However, two concerns addressed in this submission were not covered in the primary submission.

This submission will focus, in the main, on the Deloitte Touche Tohmatsu (Deloitte) Physiotherapy Costing and Pricing Model that was designed to assist ACC with determining an appropriate payment schedule for physiotherapy services. Background information is provided on both the rationale for the costing and pricing exercise and the development process of the subsequent model, including the opportunity for review of the initial drafts.

ACC also responds to the issues raised in the Occupational Health Physiotherapy Group (OHPG) submission and outlines the steps that ACC is taking to improve the issues concerning vocational rehabilitation services.

There are two appendices in this submission. There were a number of inaccurate statements relating to ACC within the initial round of public submissions. These are addressed in a table in Appendix 1. The second appendix is ACC's response to 23 additional questions raised by the Reviewer, David Goddard QC.

Costing and pricing model development process

Timeline of Deloitte model development as part of the costing and pricing exercise

This is a brief list of the order of events, which are covered in more detail later in this submission.

- In April 2005, the New Zealand Society of Physiotherapists (NZSP) expressed a desire for a review of the fees paid by ACC for physiotherapy services.
- ACC suggested engaging an independent accounting firm to undertake a review of the market price of running a physiotherapy business.
- In June 2005, Deloitte were engaged to develop a model that would inform the costing and pricing exercise. The model used actual financial information from a range of physiotherapists, which included urban, metropolitan, and rural areas; public and private practices; North and South Islands; and operating under the Endorsed Provider Network (EPN) contract and Regulations.
- Deloitte gathered the data, and created a model which was presented to ACC in late 2005. ACC reviewed this model and provided feedback to Deloitte.
- A revised model was produced by Deloitte and submitted to ACC in March 2006.
- NZSP requested to review and comment on the model before it was accepted by ACC. NZSP engaged KPMG to undertake this review in April 2006. This process took approximately five months.
- KPMG produced a report titled 'Response to Deloitte Second Draft Physiotherapy Pricing Report', which expressed concerns about the methodology and content of the Deloitte report. The KPMG report was discussed between Deloitte and ACC, with ACC submitting a response to Deloitte on each of the points raised.
- The final Deloitte draft report took account of the points raised by NZSP and ACC, and was delivered in December 2006.
- Subsequent discussions took place between ACC, Deloitte, and NZSP about which inputs should be included in the final report. The final Deloitte report was released in March 2007.

Inception

The idea for engaging Deloitte to produce a costing and pricing model was initially conceived by ACC in early 2005. This was based on feedback from NZSP. A record of this is held in the minutes of the NZSP meeting held on 14 April 2005. These minutes state:

Members of the NZSP expressed the need for the fee amount to be reviewed due to rises in overheads, inability to increase staff salaries over a prolonged period of time etc. \$90.00 an hour is no-longer realistic and compares very unfavourably with the fee of \$165 paid to GPs.

David Rankin (the then General Manager, Healthwise) proposed ACC contracting Deloitte to do an evaluation of the costs of running a physiotherapy practice to determine an appropriate current hourly rate.

The NZSP agreed for the need for an evaluation. David invited NZSP to be jointly involved with ACC in developing and agreeing the 'terms of reference' for the project.

The NZSP raised the need to have urban, metropolitan and regional differences taken into account in relation to the pricing.

David will make available to the NZSP the report that Deloitte has produced when working with IPAC and their evaluation.

Engagement process

Several planning workshops were held between Deloitte and ACC to discuss the provider situation, list stakeholders, and outline the relationship management process. Deloitte completed a terms of reference document in June 2005. NZSP was present at some of these meetings.

Internal correspondence from July 2005 notes that ACC's perspective on the purpose of the exercise was to determine:

1. The real cost of operating an accredited (EPN) practice in NZ;
2. If there is a variance between EPN practices in metropolitan, rural and urban areas; and
3. The cost of accreditation.

Data gathering

Deloitte began the process to develop the model by asking for practices throughout the country that were willing to be involved in the process. This was done through an NZSP newsletter, with an advertisement written by Deloitte, and reviewed by both NZSP and ACC.

Once the sample practices had been engaged (from ACC's perspective) Deloitte was the sole point of contact. ACC was not informed (nor has it subsequently been advised) which practices were engaged to provide the sample financial data.

Model development

Deloitte produced the first version of the model in late 2005. The review of this first version of the model was completed by ACC. The points ACC raised with Deloitte were predominantly around treatment of tax, ACC/Regulation revenue splits and weightings, consultation duration estimations, weighting of costs, and business owner rates.

All of these issues were either clarified, or addressed in the second version of the model (and report), which was released in March 2006. During the subsequent consultation on this version of the model, NZSP engaged KPMG to review the model methodology and assumptions.

NZSP submitted a response to the second draft model and report, 'Response to Deloitte Second Draft Physiotherapy Pricing Report, August 2006'. ACC and Deloitte considered this document. As a result of this additional input, Deloitte reviewed and amended some of the assumptions on which the model was based. (In the final report

Deloitte acknowledged that there were points of disagreement between themselves and NZSP/KPMG).

Before the pricing model and associated report were finalised NZSP (and KPMG) entered into consultation with Deloitte. During this consultation, KPMG had access to all of the underlying data, information, and methodology behind the model. ACC has not seen this information.

Final report

Discussions took place between ACC, Deloitte and NZSP before the release of the final Deloitte report. These discussions centred on concerns raised by NZSP and the assumptions they wanted Deloitte to include in the final report and model. NZSP also expressed to ACC that they wanted their draft summary to be included in the final Deloitte report. Deloitte chose not to include the NZSP summary in their report.

Other issues raised by NZSP were around NZSP seeking a disclaimer from Deloitte to release the report to their members, a date the final report would be released, and ACC's process going forward.

The final Deloitte report was released in March 2007 to ACC and NZSP. Throughout the report Deloitte referred to NZSP's comments in relation to a number of the assumptions that form the basis of the model and suggested areas that ACC should consider in the future.

NZSP accepted Deloitte's decision not to include their changes in the final version of the model and report. To date, this model has not been used in any capacity and there have been no further discussions with the physiotherapy sector about the assumptions behind the final model.

ACC response to Occupational Health Physiotherapy Group submission

The Occupational Health Physiotherapy Group (OHPG) submission raised some issues about the way ACC purchases vocational rehabilitation services. The main concerns raised by OHPG were:

- Inequitable travel rates;
- Funding of equipment-related time of physiotherapists;
- 'Did not arrive' patients;
- Anomalies in funding for national contracts/remuneration;
- Liaison costs; and
- Contract gaps.

ACC acknowledges and is aware of the issues raised by OHPG in their submission. We are working to resolve these inconsistencies and are making the necessary changes to rectify the issues identified, and streamline systems and contracts.

ACC is making significant steps towards improving vocational rehabilitation services, such as:

- Commencing a full review of all vocational rehabilitation contracts this year as part of a major ACC review of vocational rehabilitation services.
- Working to an outcome-based purchasing model to be applied to all rehabilitation contracts. This initiative is currently being piloted.
- Resolving issues around delays and errors in processing invoices. For the vocational rehabilitation services, ACC has centralised the processing of invoices and problem resolution, and case managers have also been given training in purchasing procedures.
- Streamlining travel codes within all national contracts. ACC is aware that there are differences in travel codes across all national contracts and is currently streamlining its travel policy as and when contracts come up for renewal. The contribution to travel costs of 60c/km is based on Inland Revenue Department recommendations. In 2006, ACC reviewed its travel costs and amended the threshold from 40km to 20km. ACC is implementing this policy to all contracts as they come up for renewal.
- ACC acknowledges that there are inconsistencies within contracts in relation to 'did not arrive' patients. ACC has agreed this will be addressed as contracts come up for renewal so there is consistency. Where it is appropriate for a 'did not arrive' component, a new service code will be introduced to cover this component as part of a review of the service.
- ACC has also identified the need for improved communication and collaboration with the sector and is working to establish a Vocational Rehabilitation Liaison Group. Members of this group, including representatives from OHPG, will play a significant role in vocational rehabilitation service development.

Appendix 1 Clarifying inaccurate statements

Submission Number	Submission Statement	Correction
2 New Zealand Private Physiotherapists Association p2	'The EPN ...certification/accreditation requirements are unique to the physiotherapy profession'	ACC also requires certification/accreditation in contracts with other health provider groups e.g. radiologists, and Accident and Medical Clinics
4 Murray Hing 3.b. p3	'ACC32 staff under-qualified' to assess ACC32s. 'ACC should be employing people in these roles with the medical experience and qualifications to make decisions on treatment...'	Clinical advisors provide clinical expertise into the ACC32 decision process. They are registered health professionals and are usually physiotherapists
4 Murray Hing 4.a. p3	Under the EPN contract, practitioners are 'to treat their injuries in a simplistic way as dictated by ACC'	Schedule 3 of the EPN service agreement requires practitioners to meet organisational quality standards. This includes clause 7.1 (c) 'Provide the Services in accordance with all current clinical, ethical and professional standards and guidelines, including the Health and Disability (Safety) Act 2001, and with the degree of professional skill, care and diligence expected of an appropriately qualified person experienced in providing the same or similar services'
8 The Physiotherapy Trust of New Zealand p10	The Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRC Act) Part 1 Schedule 1 section 2 (2) is quoted in relation to where 'fees to be paid are based on'	This part of the IPRC Act relates to the treatment and is not a basis for fees that are to be paid
8 The Physiotherapy	'ABP programmes are an ACC contracted programme held by	There are 169 vendors ¹ holding Activity-based Programme

¹ As at 13 April 2007

Submission Number	Submission Statement	Correction
Trust of New Zealand p11	a small number of Physiotherapists who are endorsed by ACC (EPN'ers)'	(ABP) contracts. Of these 169 vendors, 109 also hold an EPN contract (Note a vendor may be a single practitioner or a practice with several practitioners)
8 The Physiotherapy Trust of New Zealand p44	'No medical people on ACC Board – ever.'	Dr David Bratt was an ACC Board Member from 1997 to 1999. Dr Marie Bismark was appointed to the Board in March 2007. She is also a registered medical practitioner, although practising as a lawyer
22 New Zealand Society of Physiotherapists 178-188 pgs 37-39	ILO Convention 17 updated by ILO 121 so ACC should adopt 'a consistent reading of ILO 121 with ILO 130'	New Zealand has ratified ILO 17 but has not ratified ILO 121 or ILO 130

Appendix 2 ACC's response to Reviewer's questions

Questions – Review of the way in which Physiotherapy Services are Funded and Accredited by ACC

Please find below answers to the 20 questions that you put to ACC in your letter to Dr Kevin Morris on 4 April 2007, and also answers to the three subsequent questions in your letter dated 19 April 2007.

Question 1

Is there any evidence of undersupply of physiotherapy services as a result of current ACC fee levels – e.g. unavailability of services in some areas, or significant waiting times for ACC-funded services? What data (current and historical for comparison purposes) can be made available to shed light on this?

ACC is not aware of any undersupply of physiotherapy services as the result of the current ACC funding levels. ACC and Deloitte asked the NZSP to substantiate this claim during the modelling process. No evidence has been presented to support this claim. ACC does not collect waiting times data for this service.

Question 2

Is there any evidence of quality of services changing in response to changes in the real value of ACC regulated fee payments? What other factors have influenced any trends identified?

Measurement of the quality of physiotherapy services has not been possible in any meaningful manner. Although ACC can monitor treatment numbers and costs, such figures do not allow any conclusion to be drawn on quality.

Question 3

What data are available on trends in patient appointment durations, daily treatment number averages, and working hours in both private and public sector?

ACC expects that treatment provided to claimants by physiotherapists is guided by the ACC/NZSP jointly agreed treatment profiles and clinical best practice. Although ACC does monitor the number of treatment consultations provided per day (this information was provided in response to NZSP questions), it does not collect data on appointment durations, or working hours.

Question 4

What data are available on the relationship between on the one hand seniority/experience/post-graduate qualifications, and on the other hand treatment durations/costs/outcomes?

ACC has never attempted to correlate treatment durations/costs/outcomes to seniority/experience/post graduate qualifications. To date ACC has purchased these services based on the treatment provided by a registered physiotherapist with a current Annual Practising Certificate.

Question 5

What reasons can be identified for setting different rates for payments as between the EPN contract regime and the Regulations? What level of difference is justified by the reasons identified? How would the answers to these questions be affected if co-payments were not prohibited under the EPN regime?

The legislation provides the framework for payment to physiotherapists under Clause 1, Schedule 1 of the Injury Prevention, Rehabilitation and Compensation (IPRC) Act 2001, ACC is liable to pay or contribute to the cost of a claimant's treatment for personal injury for which the claimant has cover –

- to the extent permitted under contract or agreement with any person for the provision of treatment; (as in the EPN)
- if no such agreement or contract applies, to the extent required or permitted by Regulations made under the IPRC Act 2001; (as in regulated services) or
- if no agreement, contract or Regulations apply, the cost of the treatment.

The objective of the EPN service agreement is to give claimants access to quality physiotherapy treatment that brings a prompt, cost-effective, and sustainable return to independence, work, and education. Another objective of the EPN service agreement is to provide quality treatment that is accessible at no cost to claimants. In addition, removing co-payments helps ensure progress towards compliance with International Labour Organisation (ILO) Convention 17.

Different rates are justified because the EPN service agreement establishes a quality standard within the physiotherapy sector. ACC pays higher rates to physiotherapy practices holding an EPN service agreement because they are required to attain certification against the NZS 8171:2005 Allied Health Services Sector Standard, interact electronically with ACC, and work according to the ACC Physiotherapy Treatment Profiles.

This contrasts with Regulation-based payments where ACC contributes \$24.48 per treatment visit, or \$61.57 per hour, towards treatment provided by a physiotherapist, as set out in the Injury Prevention, Rehabilitation and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003. Funding for this level of contribution was agreed by Cabinet as part of Budget 2006. In order to invoice ACC under the Cost of Treatment Regulations, physiotherapists must only be registered with the Physiotherapy Board of New Zealand as a practitioner of the profession of physiotherapy and hold a current practicing certificate. No additional quality requirements are placed on physiotherapists invoicing under Regulations.

If co-payments were not prohibited under the EPN regime, ACC would still contribute a higher rate, as there are additional requirements for providers under the EPN contract.

Question 6

Are the costs of delivering the same physiotherapy services materially different in different geographical locations? What data are available on this issue (apart from cost data for the sample of firms in the Deloitte Report)?

The work that ACC commissioned Deloitte to develop the model demonstrates ACC's commitment toward addressing issues of pricing and costing of physiotherapy services. ACC has no further geographical data other than that which was used in the Deloitte Report.

Question 7

In respect of other treatment providers (e.g. GPs, radiologists, chiropractors, osteopaths), please provide information on:

- a) ACC's approach to co-payments (including any recent internal analysis of the pros and cons of prohibiting co-payments, and any reasons for differentiating between occupational groups in this respect);*

ACC has begun working on a purchasing strategy. One of the issues to be addressed is the mixed situation of charging co-payments. The mixed situation comes from paying for services through regulations and through contracts.

Over recent years ACC has considered internal and external analysis on the pros and cons of co-payments. ACC commissioned the New Zealand Institute of Economic Research (NZIER) to undertake a literature review on the effectiveness and efficiency of removing co-payments. The May 2005 NZIER literature review, 'Co-payments, utilisation, and health outcomes', found the following:

Reasons for removing co-payments include:

- Improving access and rehabilitation outcomes - co-payments represent a significant barrier to accessing health care generally. In particular, research suggests that direct charges put the heaviest burden on the poor. Such a barrier compromises ACC's ability to facilitate a claimant's return to independence and manage scheme costs, as people delay treatment, possibly exacerbating their condition;
- ACC scheme's philosophical underpinnings - the underlying goal of the ACC scheme is to recompense for harm done (or loss) from personal injury. This goal is premised on the common law indemnity principle of injured people being reimbursed in full for their losses and costs, both economic and non-economic. The Woodhouse Report recommended that as part of compensation and for the promotion of rehabilitation, all medical and specialist services should be provided free of charge;
- ACC scheme's legislative history - the Accident Compensation Act 1972 and the Accident Compensation Act 1982 specified that ACC would pay all medical treatment costs for personal injuries where those costs were 'reasonable by New Zealand standards';
- International obligations - International Labour Organisation (ILO) Convention 17, Article 9 ratified by New Zealand in 1938 requires that employees injured in work accidents receive all necessary treatment at no cost. Cabinet agreed that moving towards seeking ILO 17 compliance is a more realistic objective [CAB Min (00) M 30/2 refers]; and
- Primary health care sector developments to improve access and affordability - a key objective of the Primary Health Care Strategy is to improve accessibility, affordability and appropriateness of services.

Reasons for keeping co-payments include:

- Significant fiscal cost to Government and levy payers if co-payments were removed;

- Results of the New Zealand Health Survey found that six per cent of people didn't see a GP because of cost. Eleven per cent of Maori and eight per cent of Pacific Peoples didn't see a GP because of cost. Only two per cent of people who were injured reported foregoing a GP visit due to cost. Analysis of New Zealand utilisation data found that there is no statistically significant relationship between patient fees and utilisation - health status was the strongest predictor. Other reasons for not visiting a GP were lack of time or unsuitable appointments, transport, cost of taking time off work, waiting times, language, culture and provider gender;
- Studies indicate that co-payments tend to decrease utilisation for minor or non-urgent injuries and conditions;
- Co-payments affect the number of visits per episode more than the initial visit. NZIER found that changing the relative price of Accident and Emergency (A&E) services reduced the inappropriate use of A&E;
- Free medical care leads to overuse of care, less preventative behaviour and exercise of due care, or non-appointment attendance so that increased expenditure has little or no impact on health and disability outcomes;
- Impact of ethnicity - some factors for Maori, Pacific Peoples and the poor that explain differences in utilisation include the inability of mainstream providers to identify patient preferences or concerns, to communicate well, or to engage patients in care decisions;
- The Health Insurance Experiment carried out in the United States showed that increases in services as a result of zero co-payments had little or no measurable effect on health status for the average adult, but did improve the health of the very sick poor;
- Canadian research (2004) found that middle and upper income groups will use free health care services unnecessarily;
- Over utilisation of health care services can be provider induced; and
- Price variability in New Zealand - many providers already charge lower co-payments to Maori, Pacific Peoples, and people living in high deprivation areas so providing free ACC treatment to these groups may have little impact on co-payments, subsequent access and return to work outcomes.

Experience with co-payments – including frequency, size, proportion of overall fee;

Since 2005 ACC has conducted two surveys of 10 different treatment provider groups to establish the level of co-payment charges for a set of common injury treatments. The latest available data is from July 2006, and the 2007 collection is set to begin shortly.

Detailed reports are available for each provider type as well as comparative reports that provide an overview of year on year changes in the levels of co-payments. While these can be readily supplied, a more effective mechanism for dissemination of the information you require may be to devise a full list of the data analyses required, and to generate an appropriate set of statistics from our extensive source datasets. For example, co-payment values are collected for adults (over 18 years), adolescents (6 – 18 years), and children (under 6 years) should separate analysis be required.

With respect to the proportion of the total fee that the co-payment represents, ACC can derive the total fee by adding the ACC contribution.

For July 2006 results for the following provider types are available:

Provider Type	Effective Sample size (n=) (#'s actually interviewed)	Response Rates
Accident and Medical (contract/non-contract)	18 / 10	58% / 71%
Acupuncture	128	57%
Chiropractors	188	70%
Counsellors	381	67%
Dentists	638	52%
GP and Nurses – urban	303	42%
GP Rural	87	64%
Osteopaths	166	54%
Physiotherapists (Endorsed/non-endorsed)	53 / 294	65% / 56%
Radiologists	61	75%

(c) Trends in rates/levels of ACC payment over time, since 1989;

Since 1989 the trends in rates/levels of payment over time have differed between rates paid under Regulations and those paid under contracts. For Regulations, rates decreased in 1992 by 15 per cent and remained at those levels throughout the 1990s. Since 2001, rates for these various provider groups have been increased following Government funding decisions.

For contracts, ACC applies more regular increases either as a result of an indexation clause within a contract or following a service price review. For more detail on indexation please refer to part (d) of this question which is located on page *of this submission.

Table 1 summarises adjustments made to Regulations regarding treatment costs since 1989.

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
Audiologists	1 December 1989	Accident Compensation (Audiologists Costs) Regulations 1989 - All amounts are GST exclusive	\$20 per consultation - plus other procedures listed in the Schedule
	15 October 1990	Accident Compensation (Audiologists Costs) Regulations 1990 - All amounts are GST inclusive	\$22.50 per consultation - plus other procedures listed in the Schedule
	1 February 1992	Accident Compensation (Audiologists Costs) Regulations 1990, Amendment No. 1 - All amounts are GST inclusive	Reduced maximum amounts payable by 15% \$19.15 per consultation - plus other procedures listed in the Schedule
Counsellors	1 July 1999	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999	\$78.75 per hour for consultation provided by a counsellor who is a registered specialist \$56.25 per hour for consultation provided by a counsellor
	1 July 1999	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Amendment Regulations 1999	The first amendment provides for ACC to pay, for an insured's treatment and services, either the prescribed amounts or the amounts ACC has agreed to pay under contracts that cover the treatment and service providers, whichever is better for the insured. The second amendment sets out the circumstances in which an insurer is liable to pay for counselling provided to an insured on other than a face-to-face basis.
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST	\$97.55 per hour provided by a counsellor who is a specialist \$76.50 per hour provided by a counsellor

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		inclusive	
	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$97.55 to \$99.99 per hour provided by a counsellor who is a specialist \$76.50 to \$78.41 per hour provided by a counsellor
Dental Specialists	16 July 1990	Accident Compensation (Dental Specialist Costs) Regulations 1990 - All amounts are GST exclusive	\$70 per examination and assessment for oral and maxillofacial surgical procedure and periodontal procedure - plus other procedures listed in the Schedule
	15 October 1990	Accident Compensation (Dental Specialist Costs) Regulations (No 2) 1990 - All amounts are GST inclusive	\$78.75 per examination and assessment for oral and maxillofacial surgical procedure and periodontal procedure - plus other procedures listed in the Schedule
	1 February 1992	Accident Compensation (Dental Specialists Cost) Regulations (No 2) 1990, Amendment No 1 (SR 1991/283) - All amounts are GST inclusive	Reduced maximum amounts payable by 15% - \$66.75 per examination and assessment for oral and maxillofacial surgical procedure and periodontal procedure - plus other procedures listed in the Schedule
Dentists	1 December 1989	Accident Compensation (Dentists Costs) Regulations 1989 - All amounts are GST exclusive	\$30 per examination and assessment - plus other procedures listed in the Schedule - The above specified costs are reduced by 25% where the tooth has been previously heavily restored and by 50% where the tooth has been previously crowned.
	16 July 1990	Accident Compensation	\$33 per examination and

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		(Dentists Costs) Regulations 1990 - All amounts are GST exclusive	assessment - plus other treatment listed in the Schedule to the Regulations
	15 October 1990	Accident Compensation (Dentists Costs) Regulations (No 2) 1990 - All amounts are GST inclusive	\$37.15 per examination and assessment - plus other treatment listed in the Schedule to the Regulations
	1 February 1992	Accident Compensation (Dentists Costs) Regulations (No 2) 1990, Amendment No 1 (SR 1991/284) - All amounts are GST inclusive	Reduced maximum amounts payable by 15% \$31.60 per examination and assessment - plus other treatment listed in the Schedule to the Regulations
	1 July 1999	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999	\$31.60 per examination and assessment \$66.95 per examination and assessment by a dentist working in his or her speciality - other procedures such as x-rays, extractions, etc set out in the Schedule to the Cost of Treatment Regulations
	15 October 1999	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Amendment Regulations (No 2) 1999	ACC is liable to pay for 75% of the amount specified in the Schedule for treatment on a tooth that has previously been heavily restored (was 25%)
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	DE1 - \$61 Consultation including examination DY1 - \$63 consultation including examination for claimant under the age of 18 Other procedures set out in the Schedule to the Cost of Treatment Regulations
	1 April 2005	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment	DE1 - \$61 Consultation including examination DY1 - \$63 consultation including examination for claimant under the age of

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		Regulations 2005 - Part of 2004 Budget package - All amounts are GST inclusive	18 - increases the amounts payable for dental procedures for ACC treatment for claimants over 18 years and for claimants under 18 years where treatment is not provided for on the list that relates to claimants under 18 years - changes the descriptions of certain dental procedures to better align them with current clinical practice
	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$61 to \$62.53 per consultation non-specialist consultations with claimants 18 years of age and over <hr/> \$63 to \$64.58 per consultation consultations with claimants under the age of 18 years
General Practitioners	1 December 1989	Accident Compensation (General Practitioners Costs) Regulations 1989 - All amounts are GST exclusive	\$28 (less any Social Security benefit) per consultation - Plus additional treatments regarding wound care listed in the Schedule
	1 September 1990	Accident Compensation (General Practitioners Costs) Regulations 1990 - All amounts are GST inclusive	\$30.50 (less any Social Security benefit) per consultation - Plus additional treatments regarding wound care listed in the Schedule
	1 February 1992	Accident Compensation (General Practitioners Costs) Regulations 1990, Amendment No. 1 - All amounts are GST inclusive	Reduced maximum amounts payable by 15% \$26 per consultation - Plus additional treatments regarding wound care listed in the Schedule

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
Hyperbaric Oxygen	1 December 1989	Accident Compensation (Hyperbaric Oxygen Treatment Costs) Regulations 1989 - All amounts are GST exclusive	\$50 per hour for in-chamber treatment supervision \$20 per hour for out-of-chamber treatment supervision
	15 October 1990	Accident Compensation (Hyperbaric Oxygen Treatment Costs) Regulations 1990 - All amounts are GST inclusive	\$114.75 per hour for in-chamber treatment supervision \$56.25 per hour for out-of-chamber treatment supervision
	1 February 1992	Accident Compensation (Hyperbaric Oxygen Treatment Costs) Regulations 1990, Amendment No 1 (SR 1991/287) - All amounts are GST inclusive	Reduced maximum amounts payable by 15% \$97.55 per hour for in-chamber treatment supervision \$47.80 per hour for out-of-chamber treatment supervision
	1 July 1999	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Regulations 1999	\$97.55 per hour for in-chamber treatment supervision \$47.80 per hour for out-of-chamber treatment supervision
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	H3 - \$97.55 per hour for in-chamber treatment supervision H4 - \$47.80 per hour for out-of-chamber treatment supervision
	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$97.55 to \$99.99 per hour for in-chamber treatment supervision \$47.80 to \$49 per hour for out-of-chamber treatment supervision
Radiologists	1 December 1989	Accident Compensation	- \$41 per sternum x-ray,

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		(Radiologists Costs) Regulations 1989 - All amounts are GST exclusive	for example - plus other procedures listed in the Schedule to the Regulations
	15 October 1990	Accident Compensation (Radiologists Costs) Regulations 1990 - All amounts are GST inclusive	- \$46.15 per sternum x-ray, for example - plus other procedures listed in the Schedule to the Regulations
	1 February 1992	Accident Compensation (Radiologists Costs) Regulations 1990, Amendment No 1 (SR 1991/285) - All amounts are GST inclusive	Reduced maximum amounts payable by 15% - \$39.25 per sternum x-ray, for example - plus other procedures listed in the Schedule to the Regulations
	1 July 1999	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Regulations 1999	Procedures set out in the Schedule to the Cost of Treatment Regulations
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	Pricing for radiology services is based on assigning Relative Value Units (RVU) to services. The value of one RVU was \$31.21 (including GST)
	19 September 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2004 - technical amendments	Amendments are technical amendments to make terminology consistent with the Health Practitioners Competence Assurance Act 2003; in most cases the word ‘registered’ has been removed
	1 April 2005	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations (No 2) 2004 - Part of 2004 Budget package - all amounts are GST	Pricing for radiology services is based on assigning Relative Value Units (RVU) to services. Increase in value of RVU to \$44.94 (including GST) – was \$31.21 so increase of about 44% for all radiologists’ costs in

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		inclusive	Schedule
Registered Medical Practitioners	1 July 1999	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Regulations 1999	\$32.50 per treatment visit consultations with claimants <i>under</i> the age of 6 years old
			\$26 per treatment visit consultations with claimants 6 years of age and <i>over</i>
	10 January 2002	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Amendment Regulations 2001	Amendment clarified the descriptions of some items in the Schedule relating to wound and fracture care. The amounts payable for each amended item did not change.
	1 July 2002	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Amendment Regulations 2002	\$32.50 to \$35.00 per treatment visit consultations with claimants <i>under</i> the age of 6 years old
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	\$35 per treatment visit consultations with claimants <i>under</i> the age of 6 years
			\$26 per treatment visit consultations with claimants 6 years of age and <i>over</i>
	19 September 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2004 - technical amendments	Amendments are technical amendments to make terminology consistent with the Health Practitioners Competence Assurance Act 2003; in most cases the word ‘registered’ has been removed
(Medical Practitioners)	1 April 2005	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations (No 2) 2004 - Part of 2004 Budget package - all amounts are GST inclusive	\$26 to \$32 per treatment visit consultations with claimants 6 years of age and <i>over</i> (under 6s unchanged at \$35 per visit)
	1 April 2006	Injury Prevention,	\$35 to \$35.88 per visit

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	consultations with claimants <i>under</i> the age of 6 years \$32 to \$32.80 per visit consultations with claimants 6 years of age and <i>over</i>
Registered Medical Practitioner/Registered Nurses combined	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	\$38 per treatment visit consultations with claimants <i>under</i> the age of 6 years
			\$29 per treatment visit consultations with claimants 6 years of age and <i>over</i>
	19 September 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2004 - technical amendments	Amendments are technical amendments to make terminology consistent with the Health Practitioners Competence Assurance Act 2003; in most cases the word 'registered' has been removed
(Medical Practitioner/Nurse combined)	1 April 2005	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations (No 2) 2004 - Part of 2004 Budget package - all amounts are GST inclusive	\$29 to \$35 per treatment visit consultations with claimants 6 years of age or <i>over</i> (under 6s unchanged at \$38 per visit)
	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers]	\$38 to \$38.95 per visit consultations with claimants <i>under</i> the age of 6 years
			\$35 to \$35.88 per visit consultations with claimants 6 years of age or <i>over</i>

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		- all rates are GST inclusive	
Registered Nurses	1 July 1999	Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Regulations 1999	\$11 per hour for each consultation
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	\$15 per treatment visit
	19 September 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2004 - technical amendments	Amendments are technical amendments to make terminology consistent with the Health Practitioners Competence Assurance Act 2003; in most cases the word ‘registered’ has been removed
(Nurses)	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$15 to \$15.38 per visit
Registered Specialists	1 December 1989	Accident Compensation (Specialists Costs) Regulations 1989 - All amounts are GST exclusive	- \$102 (less any Social Security benefit) for initial consultation by a registered specialist registered as a physician, paediatrician, psychiatrist, neurologist, or neurosurgeon working in that specialty \$40 (less any Social Security benefit) for subsequent consultation - \$80 (less any Social

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
			<p>Security benefit) for initial consultation with specialists practising other branches of medicine</p> <p>\$40 (less any Social Security benefit) for subsequent consultation</p> <p>- plus procedures listed in Specialists Procedure list in Schedule</p>
	15 October 1990	<p>Accident Compensation (Specialists Costs) Regulations (No 2) 1990</p> <p>- All amounts are GST inclusive</p>	<p>\$114.75 for initial consultation by a registered specialist registered as a physician, paediatrician, psychiatrist, neurologist, or neurosurgeon working in that specialty</p> <p>\$90 for initial consultation with specialists practising other branches of medicine</p> <p>\$45 for subsequent consultation</p> <p>- specialists procedure list</p>
	15 October 1999	<p>Accident Insurance (Insurer’s Liability to Pay Cost of Treatment) Amendment Regulations (No 2) 1999</p>	<p>\$97.55 per visit with specialists practising in named branches of medicine²</p> <p>\$76.50 per visit with specialist practising within any other recognised branch of medicine</p> <p>\$38.25 per visit for follow up visits with specialists</p>
	1 April 2004	<p>Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003</p> <p>- All amounts are GST inclusive</p>	<p>\$97.55 per visit with specialists practising in named branches of medicine²</p> <p>\$76.50 per visit with specialist practising within any other recognised branch of medicine</p> <p>\$38.25 per visit for follow</p>

² For visits with specialists practising in the following recognised branches of medicine: internal medicine, neurosurgery, occupational medicine, paediatrics, psychological medicine or psychiatry, or rehabilitation medicine.

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
			up visits with specialists
	19 September 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2004 - technical amendments	Amendments are technical amendments to make terminology consistent with the Health Practitioners Competence Assurance Act 2003; in most cases the word ‘registered’ has been removed
(Specialists)	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$97.55 to \$99.99 per visit with specialists practising in named branches of medicine² \$76.50 to \$78.41 per visit with specialist practising within any other recognised branch of medicine \$38.25 to \$39.21 per visit for follow up visits with specialists
Treatment providers including acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists, and speech therapists.	1 December 1989	Accident Compensation (Referred Treatment Costs) Regulations 1989 - All amounts are GST exclusive	- \$20 for all treatment (other than provided by a counsellor) - \$50 for treatment provided by a counsellor on group or individual basis - \$16 per film for x-ray services provided by a chiropractor - claimants must be referred to these treatment providers by a general practitioner
	15 October 1990	Accident Compensation (Referred Treatments Costs) Regulations 1990 - All amounts are GST inclusive	- \$22.50 for all treatment - \$18 for x-ray services provided by a chiropractor - \$56.25 per hour (if the treatment provider elects to receive the hourly rate) - claimants must be referred to these treatment providers by a general practitioner or a registered specialist
	1 February 1992	Accident Compensation (Referred Treatments Costs)	Reduced maximum amounts payable by about

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
		Regulations 1990, Amendment No 3 (SR 1991/288) All amounts are GST inclusive -	15% - \$19 for all treatment - \$15.30 for x-ray services provided by a chiropractor - \$47.80 per hour (if the treatment provider elects to receive the hourly rate)
(Specified Treatment Providers³)	1 July 1999	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999	\$19 per treatment visit An insurer that receives a written notice of election is liable to pay the cost of the treatment given by the specified treatment provider at the lesser of— (a) The rate of \$47.80 an hour; or (b) The rate the specified treatment provider would have charged the insured if the insurer were not to pay the cost.
	1 April 2004	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 - All amounts are GST inclusive	\$47.80 per hour \$19 per visit
	1 April 2006	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2006 2.5% increase for all consultations - part of 2005 Budget package [CAB Min (05) 14/3 refers] - all rates are GST inclusive	\$47.80 to \$49 per hour \$19 to \$19.48 per visit

³ Specified Treatment Providers include Specified Treatment Providers include acupuncturist, chiropractor, occupational therapist, osteopath, physiotherapist, podiatrist, or speech therapist.

Table 1 – Adjustments to Cost of Treatment Regulations by Provider type since 1989			
Provider Type	Date of adjustment	Changes	Adjusted rate (treatment visit/hourly rate)
(Specified Treatment Providers)	1 April 2007	Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Amendment Regulations 2007 25.67% increase - part of 2006 Budget package [CAB Min (06) 11/7 (1) refers]	\$19.48 to \$24.48 per treatment visit \$49 to \$61.57 per hour (both rates are GST inclusive)
N/A	2000 review of the Cost of Treatment Regulations	Broad goals for treatment costs framework agreed by Cabinet [POL Min (01) 9/10 refers]	No change
N/A	1 April 2004	Accident Insurance (Insurer's Liability to Pay Cost of Treatment) Regulations 1999 revoked by the Injury Prevention, Rehabilitation, and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (SR 2003/388)	N/A

Note:

- The Government of the day regulates ACC's contributions towards the cost of treatment.
- Effective from 1 February 1992,⁴ there was a Government initiative to mitigate rising health care costs by reducing ACC's contribution towards treatment costs by approximately 15%.

Table 2 summarises adjustments to contracts with health providers since their inception.

Table 2. Contract adjustments since 1989			
Contract Name	Contract Live date	Criteria required	Price adjustment
Rural GP	2004	Completion of Primary Response in Medical Emergency (PRIME) training or alternative approved by	LCI (Labour Cost Index)

⁴ This change to the Cost of Treatment Regulations was announced by Hon WF Birch, Minister of Labour in his paper on *Accident Compensation – a fairer scheme*, 30 July 1991.

		ACC (e.g. ACLS level 5). Rural ranking scale of 40 and above.	
Accident & Medical (A&M)	1999	Accreditation against standard NZS 8151: 2001 (Standard for Accident and Medical Clinics).	CPI (Consumer Price Index)
High Tech Imaging	1999	IANZ (International Accreditation New Zealand) accreditation for Radiology Services. Fellowship of, or educational affiliation to, the Royal Australia and New Zealand College of Radiologists. Licence under the Radiation Protection Act 1965.	Combination of LCI and PPI (Producers Price Index) index using a 60:40 ratio
Endorsed Provider Network (EPN)	2004	Accreditation against standard NZS 8171: 2005 (Allied Health Sector Standard). Membership to New Zealand College of Physiotherapists by principal provider.	LCI

Note:

Department of Statistics definition for:

- LCI: Labour Cost Index (All Labour Costs) - June 2006 quarter. The Labour Cost Index measures movements in base salary and ordinary time wage rates, and overtime wage rates and the following non-wage costs: annual leave and statutory holidays, superannuation, ACC employer premiums, medical insurance, motor vehicles available for private use, and low interest loans.
- CPI: A measure of the price change of goods and services purchased by private New Zealand households.
- PPI: A measure of the change of the general level of prices for the productive sector of New Zealand.

The following tables provide detail on the service items and prices for the four contracts listed in Table 2.

EPN Prices - effective 1 April 2007

Service Item Code	Service Item Description	Service Item Definition	Price (excl GST)	Price (incl GST)
PT01	Level A - Initial physiotherapy consultation	First consultation for a single site injury specific injury without complications	43.56	49.01
PT02	Level A - Follow-up physiotherapy consultation	Follow-up consultation for a single site injury specific injury without complications	35.03	39.41
PT03	Level B - Initial extended duration physiotherapy consultation	First consultation where there are 2 or more injury sites, or where there is complex injury or first consultation post surgery. Where the injury related clinical factors indicate extended physiotherapy consultation duration.	76.69	86.28
PT04	Level B - Follow-up extended duration physiotherapy consultation	Follow-up consultation where there are 2 or more injury sites, or where there is complex injury. This service item price includes funding for second opinion consultations. Where the injury related clinical factors indicate extended physiotherapy consultation duration.	56.81	63.91
32A	ACC32	Request for Additional Treatment as an assessment	34.09	38.35
32R	ACC32	ACC32 Request for Further Treatment	34.09	38.35
TT5 (TRAVT5)	Travel Time – first hour	ACC will pay for the Service Provider's travel time to deliver Services to a Claimant, if: <ul style="list-style-type: none"> • the travel is necessary, and • the Service Provider travels via the most direct, practical route available between their base/facility and the Claimant's address, and • the distance the Service Provider travels exceeds 20km and/or the time the Service Provider travels exceeds 30 minutes TRAVT5 is payable for: <ul style="list-style-type: none"> • the first hour or less of travel time on any one day 	46.66	52.49

Service Item Code	Service Item Description	Service Item Definition	Price (excl GST)	Price (incl GST)
TT1 (TRAVT1)	Travel Time – subsequent hours	TRAVT1 is payable for: <ul style="list-style-type: none"> • the additional hours required after payment for the first hour through TRAVT5 • for the total travel time after the first hour of travel on any one day 	93.32	104.98
TD10 (TRAVD10)	Travel Distance	Where return travel via the most direct, practicable route from the facility base or worker residence to claimant contact point (whichever is the closest) exceeds 20 km. Payment is for the total distance travelled including the 20km. If travel includes more than one claimant payment is on a pro-rata basis.	0.62	0.70

High Tech Imaging Prices – effective 31 May 2007

Service Code	Procedure description	2007-08 Total RVU	2007-08 CF (as at 31/5/2006)	Calculated 2007-08 Pricing (Excl GST)	Calculated 2007-08 Pricing (Incl GST)
Clause 3 or Part A	"The price for any anaesthesia and IV sedation"	-	38.06		
Magnetic Resonance Imaging					
R01	MRI Brain	15.20	52.95	804.84	905.45
R03	MRI Internal Auditory Meatus	15.20	52.95	804.84	905.45
R10	MRI Face/neck	15.20	52.95	804.84	905.45
R20	MRI Chest	15.20	52.95	804.84	905.45
R26	MRI Breast	15.20	52.95	804.84	905.45
R30	MRI Abdomen	15.20	52.95	804.84	905.45
R36	MRI Pelvis	15.20	52.95	804.84	905.45
R40	MRI Spine	15.20	52.95	804.84	905.45
R50	MRI Extremity	15.20	52.95	804.84	905.45
R51	MRI Upper Extremity	15.20	52.95	804.84	905.45
R55	MRI Shoulder Girdle	15.20	52.95	804.84	905.45

Service Code	Procedure description	2007-08 Total RVU	2007-08 CF (as at 31/5/2006)	Calculated 2007-08 Pricing (Excl GST)	Calculated 2007-08 Pricing (Incl GST)
R56	MRI Lower Extremity	15.20	52.95	804.84	905.45
R57	MRI Hip	15.20	52.95	804.84	905.45
R60	MRI Arthrogram	20.70	52.95	1096.07	1233.08
R61	MR Arthrogram Upper Extremity	20.70	52.95	1096.07	1233.08
R65	MR Arthrogram Lower Extremity	20.70	52.95	1096.07	1233.08
R70	MR Angiography Unspecified	20.70	52.95	1096.07	1233.08
R71	MR Angiography Head	20.70	52.95	1096.07	1233.08
R72	MR Angiography Face or Neck	20.70	52.95	1096.07	1233.08
R73	MR Angiography Chest	20.70	52.95	1096.07	1233.08
R74	MR Angiography Upper Limbs	20.70	52.95	1096.07	1233.08
R75	MR Angiography Abdomen/Pelvis	20.70	52.95	1096.07	1233.08
R76	MR Angiography Pelvis and Lower Extremities	20.70	52.95	1096.07	1233.08
R78	MR – Venography	20.70	52.95	1096.07	1233.08
R80	MR Interventional Procedure	20.70	52.95	1096.07	1233.08
R98	MRI Other Region/Miscellaneous	17.40	52.95	921.33	1036.50
R99	MRI Additional Region	12.00	52.95	635.40	714.83
<u>Computerised Tomography</u>					
T01	CT Brain	8.50	52.95	450.08	506.34
T10	CT Face/Neck	9.70	52.95	513.62	577.82
T11	CT Sinuses	8.50	52.95	450.08	506.34
T12	CT Salivary Gland	9.70	52.95	513.62	577.82
T13	CT Orbits	9.70	52.95	513.62	577.82
T20	CT Chest	11.40	52.95	603.63	679.08
T21	CT High Resolution Lungs	11.40	52.95	603.63	679.08
T30	CT Abdomen	11.40	52.95	603.63	679.08
T31	CT Abdomen and Pelvis	11.40	52.95	603.63	679.08
T35	CT Pelvis	9.70	52.95	513.62	577.82
T40	CT Spine	11.40	52.95	603.63	679.08
T41	CT Cervical Spine	11.40	52.95	603.63	679.08
T42	CT Thoracic Spine	11.40	52.95	603.63	679.08

Service Code	Procedure description	2007-08 Total RVU	2007-08 CF (as at 31/5/2006)	Calculated 2007-08 Pricing (Excl GST)	Calculated 2007-08 Pricing (Incl GST)
T43	CT Lumbar Spine	11.40	52.95	603.63	679.08
T45	CT Myelogram (sole charge-includes fluoroscopy)	18.10	52.95	958.40	1078.20
T46	CT Discogram (sole charge- includes fluoroscopy)	21.10	52.95	1117.25	1256.91
T50	CT Extremity	9.70	52.95	513.62	577.82
T51	CT Shoulder/Thoracic Outlet	9.70	52.95	513.62	577.82
T55	CT Hips	8.50	52.95	450.08	506.34
T60	CT Arthrogram	12.50	52.95	661.88	744.62
T61	CT Arthrogram Upper Extremity	12.50	52.95	661.88	744.62
T65	CT Arthrogram Lower Extremity	12.50	52.95	661.88	744.62
T70	CT Angiography unspecified	18.10	52.95	958.40	1078.20
T71	CT Angiography Intracranial	18.10	52.95	958.40	1078.20
T72	CT Angiography Neck	18.10	52.95	958.40	1078.20
T73	CT Angiography Upper Extremities	18.10	52.95	958.40	1078.20
T75	CT Angiography Chest	18.10	52.95	958.40	1078.20
T77	CT Angiography Abdomen and/or Pelvis	18.10	52.95	958.40	1078.20
T78	CT Angiography Pelvis and Lower Limbs	18.10	52.95	958.40	1078.20
T80	CT Guided Injection/ Aspiration	18.10	52.95	958.40	1078.20
T90	CT Pelvimetry	5.90	52.95	312.41	351.46
T91	CT Digital Radiograph/ Scanogram	5.90	52.95	312.41	351.46
T92	CT Leg Lengths	5.90	52.95	312.41	351.46
T93	CT Bone Densitometry	5.70	52.95	301.82	339.55
T94	CT Rotational Profile	5.90	52.95	312.41	351.46
T97	CT Additional 3D reconstruction	5.90	52.95	312.41	351.46
T98	CT Other region (not otherwise specified)	11.40	52.95	603.63	679.08
T99	CT Additional Region (second region)	8.50	52.95	450.08	506.34
<u>Scintigraphy</u>					
N01	Nuclear Scan Brain	17.00	52.95	900.15	1012.67
N10	Nuclear Scan Lung	12.00	52.95	635.40	714.83
N20	Nuclear Scan- Bone Triphasic	8.10	52.95	428.90	482.51

Service Code	Procedure description	2007-08 Total RVU	2007-08 CF (as at 31/5/2006)	Calculated 2007-08 Pricing (Excl GST)	Calculated 2007-08 Pricing (Incl GST)
N21	Nuclear Scan Bone – Whole Body	9.50	52.95	503.03	565.91
N22	Nuclear Scan Bone – SPECT	9.80	52.95	518.91	583.77
N30	Nuclear Scan Renal Tracts	9.80	52.95	518.91	583.77
N40	Nuclear Scan Liver- Sulphur Colloid	9.10	52.95	481.85	542.08
N41	Nuclear Scan Biliary Tree	9.80	52.95	518.91	583.77
N50	Nuclear Scan Cardiac (myocardial perfusion	18.60	52.95	984.87	1107.98
N60	Nuclear Scan Blood Pool	9.80	52.95	518.91	583.77
N80	Nuclear Scan Thyroid	7.20	52.95	381.24	428.90
N90	Nuclear Scan Other Region/Miscellaneous			1000.00	1125.00
N91	Nuclear Scan Additional Region SPECT	3.00	52.95	158.85	178.71
<u>Ultra Sound Vascular</u>					
U50	Duplex/Doppler US of Carotid arts	4.90	52.95	259.46	291.89
U51	Duplex/Doppler US of Chest	4.90	52.95	259.46	291.89
U52	Duplex/Doppler US of Abdomen/Pelvis	4.90	52.95	259.46	291.89
U53	Duplex/Doppler US of Limb Veins for DVT (one limb)	4.10	52.95	217.10	244.24
U54	Duplex/Doppler Vein Mapping Lower Extremity (one limb)	6.10	52.95	323.00	363.38
U55	Duplex/Doppler US of Limb Arteries (one limb)	4.90	52.95	259.46	291.89
U58	Duplex/Doppler Echocardiography	4.90	52.95	259.46	291.89
U59	Duplex/Doppler US Miscellaneous	4.90	52.95	259.46	291.89
U56	Duplex/Doppler US of Additional Limb Arterial or Venous	3.90	52.95	206.51	232.32
<u>Special Procedures</u>					
D40	IVP incl plain film + tomos.	5.90	52.95	312.41	351.46
D45	Urethrogram	10.20	52.95	540.09	607.60
D46	Micturating Cystourethrogram	10.20	52.95	540.09	607.60
S12	Bone densitometry	2.80	52.95	148.26	166.79
S20	Fluoroscopy (per half hour)	5.00	52.95	264.75	297.84
S41	Sinogram	5.90	52.95	312.41	351.46

Service Code	Procedure description	2007-08 Total RVU	2007-08 CF (as at 31/5/2006)	Calculated 2007-08 Pricing (Excl GST)	Calculated 2007-08 Pricing (Incl GST)
S70	Arthrogram	5.90	52.95	312.41	351.46
S76	Tenogram	5.90	52.95	312.41	351.46
S83	Herniagram	10.20	52.95	540.09	607.60
S79	Injection or Aspiration under fluoroscopy	5.90	52.95	312.41	351.46
X30	IV Sedation/General Anaesthetic			1224.66	1377.74
<u>Interventional Procedures</u>					
These and other complex interventional procedures will be charged at fair and reasonable market prices.					
X81	Day Bed Stay Rate			133.71	
P05	Interventional under fluoroscopy unspecified	Variable	n/a		
P11	Abscess drainage	Variable	n/a		
V18	Angiogram unspecified	Variable	n/a		

Accident & Medical prices - effective 1 Feb 2007

Service Item Code	Code	Description - consultations	Contribution (GST exclusive)	Current Prices GST Inclusive
GPCON1	A003	Level A Consultation	\$20.73	\$23.32
GPCON2	A023	Level B Consultation	\$37.42	\$42.10
GPCON3	A036	Level C Consultation	\$80.75	\$90.84
GPCON4	A044	Level D Consultation	\$162.17	\$182.44
GPP90	A050	Structured Rehabilitation Visit 48-72 hours post injury. Review of the injury, confirmation of diagnosis, and may involve input from other Health Professionals. A rehabilitation plan will be developed in consultation with the claimant, and agreed by both parties (no additional consultation fee)	\$80.75	\$90.84
MB5	B024	Significant burns and abrasions (not including fractures) at multiple sites (<4cm.sq); necessary wound cleaning, preparation and dressing.	\$56.79	\$63.89
GPP60	B040	Treatment of burn <4 sq cm (in conjunction with a Level B consultation)	\$26.17	\$29.44
GPP61	B041	Treatment of significant abrasions <4 sq cm at a single sight (in conjunction with a Level B consultation)	\$26.17	\$29.44
GPP01	B026	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.	\$77.79	\$87.51
GPP02	B038	Closure of open wound (or wounds) of skin and subcutaneous tissue or mucous membrane >7cm; any necessary care and treatment including clean and debride, exploration, administration of anaesthetic and dressing.	\$105.54	\$118.73
GPP04	F015	Shoulder, treatment of dislocation of, requiring active reduction with IV or IM sedation and analgesia. Including splinting where necessary. (This item will generally involve radiological investigation)	\$112.90	\$127.01
GPP70	F400	Fractured clavicle (in conjunction with a Level C consultation)	\$26.17	\$29.44
GPP05	F018	Elbow, treatment of dislocation of, requiring active reduction with IV or IM sedation and analgesia. Includes splinting where necessary. (This item will generally involve radiological investigation)	\$104.68	\$117.77
GPP08	F354	Carpal fractures, including scaphoid, treatment of fracture of, not requiring reduction. Maximum number of plasters = 3.	\$77.79	\$87.51

Service Item Code	Code	Description - consultations	Contribution (GST exclusive)	Current Prices GST Inclusive
GPP09	F360	Radius and/or ulna, distal end of, treatment of fracture of, by cast immobilisation. Maximum number of plasters = 3.	\$77.79	\$87.51
GPP11	F378	Radius and/or ulna, shaft of, treatment of fracture of, by cast immobilisation. Maximum number of plasters = 3.	\$104.68	\$117.77
GPP12	F444	Humerus, proximal or shaft of, treatment of fracture of, requiring cast immobilisation. Maximum number of plasters = 2.	\$104.68	\$117.77
GPP71	F445	Fractured proximal or shaft humerus, immobilisation by collar and cuff, or U-slab (in conjunction with a Level C consultation)	\$26.17	\$29.44
GPP13	F453	Humerus, distal (supracondylar or condylar) or proximal radius and ulnar, treatment of fracture of. Maximum number of plasters = 3.	\$104.68	\$117.77
GPP14	F561	Tibia shaft and/or fibula, treatment of fracture by cast immobilisation. Maximum number of plasters = 5.	\$178.80	\$201.15
GPP72	F562	Fractured fibula (without tibial fracture), immobilisation with soft tissue strapping (in conjunction with a Level C consultation)	\$26.17	\$29.44
GPP15	F594	Distal tibia and/or fibula, treatment of fracture of, not requiring reduction, includes immobilisation. Maximum number of plaster = 3.	\$161.86	\$182.09
GPP16	F606	Calcaneum or talus, treatment of fracture requiring cast immobilisation. Maximum number of plasters = 6.	\$161.86	\$182.09
GPP17	F627	Tarsus, (including tarsal or metatarsals and excluding calcaneum or talus), treatment of fracture of, requiring cast immobilisation. Maximum number of plasters = 3.	\$161.86	\$182.09
GPP06	F300	Closed reduction of fracture or dislocation of proximal, middle or distal phalanx of hand, requiring injection of anaesthetic. Maximum number of plasters = 3.	\$50.31	\$56.60
GPP07	F336	Metacarpal(s), treatment of fracture by closed reduction requiring injection of anaesthetic. Maximum number of plasters = 2.	\$74.85	\$84.21
GPP10	F363	Radius or ulna, distal end of, treatment of fracture by closed reduction. Requiring ischaemic limb block anaesthesia or other form of regional anaesthesia. (Generally proven radiologically). Maximum number of plasters = 5.	\$166.26	\$187.04
GPP18	G721	Ankle, Achilles' tendon rupture managed by non-operative treatment.	\$161.86	\$182.09

Service Item Code	Code	Description - consultations	Contribution (GST exclusive)	Current Prices GST Inclusive
GPP03	C677	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both.	\$74.85	\$84.21
GPP80	G800	Simple soft tissue injuries; management of simple sprain of wrist/ankle/knee/elbow or other soft tissue injury requiring crepe bandage or similar immobilisation not requiring formal strapping (in conjunction with a Level B consultation)	\$26.17	\$29.44
GPP81	G801	Soft Tissue Injury (other than splinting dislocated or fractured digit), unless specified elsewhere; application of plaster or padded splint or specific strapping with agreed guidelines (includes splinting achilles tendon injury and serious ankle sprains) (in conjunction with a Level C consultation)	\$26.17	\$29.44
GPP19	X001	Administration of activated charcoal	\$25.77	\$28.99
GPEQ3	GPEQ	Crutches Hire	\$26.67	\$30.00

Rural GP prices - effective 1 April 2007

ACC code	Consultation description	Contribution (GST exclusive)	Contribution (GST inclusive)
RP01	Level A Consultation. A short consultation of up to 5 minutes. This includes providing Other Procedures, such as those listed in Table 3 of this Part A (without limitation).	\$19.94	\$22.43
RP02	Level B Consultation. Normal general practice Consultation. Expected range treatment time is 5–20 minutes. The clinical record will demonstrate that the Consultation and/or treatment involve appropriate professional activities commensurate with service of such duration. Such activities may include taking a problem focused history, detailed examination, discussion of treatment alternatives, counselling, communication of other information connected with clinical practice, arriving at a diagnosis and decision relating to the Claimant's need to undertake a procedure, and performing the procedure if it is an Other Procedure. Examples of Other Procedures that may be invoiced for as a Level B Consultation includes (without limitation) those procedures listed in Table 3. Other Procedures may be performed by any appropriate member of the practice and are included in the contribution to the cost of the Consultation.	\$41.01	\$46.14
RP03	Level C Consultation. Extended general practice Consultation. Expected range of treatment time is 21–40 minutes. The clinical record will demonstrate that the Consultation and/or treatment involve appropriate professional activities commensurate with service of such duration. Such activities may include comprehensive consultative and or counselling process, comprehensive physical examination, detailed evaluation of the Claimant's condition, arriving at a diagnosis and decision relating to the Claimant's need to undertake a procedure, and performing the procedure if it is an Other Procedure. Examples of Other Procedures that may be claimed as a Level C Consultation that includes (without limitation) those procedures listed in Table 3. Other Procedures may be performed by any member of the treatment team and are included in the contribution to the cost of the Consultation.	\$78.83	\$88.68
RP04	Level D Consultation. Extended and complex rural general practice Consultation. Expected range of treatment time is more than 40 minutes, including any time provided by either the registered nurse or registered medical practitioner. The clinical record will demonstrate that the Consultation and/or treatment involve appropriate professional activities of complexity and/or work commensurate with service of such duration. Such activities may include comprehensive consultative and or counselling process, comprehensive physical examination, detailed evaluation of the Claimant's condition, arriving at a diagnosis and decision relating to the Claimant's need to undertake a procedure, performing the procedure if it is an Other Procedure, management and stabilisation of patient prior to transfer to a hospital, if required. Examples of Other Procedures that may be claimed as a Level D Consultation that includes (without limitation) those procedures listed in Table 3. Other Procedures may be performed by any member of the treatment team and are included in the price of the Consultation. Level D Consultation may be claimed ONLY when: a Claimant requires continuing one-on-one supervision.	\$158.30	\$178.09

ACC code	Procedure description	Contribution (GST exclusive)	Contribution (GST inclusive)
RP10	Skin and subcutaneous tissue or mucous membrane, repair of wound (not more than 7 cm long) requiring skin closure by suture, clips, skin adhesive strips or glue	\$75.92	\$85.41
RP11	Significant burns or abrasions (not including fractures) at multiple sites (<4 cm); necessary wound cleaning, preparation and dressing	\$55.45	\$62.38

ACC code	Procedure description	Contribution (GST exclusive)	Contribution (GST inclusive)
RP12	Closure of open wound (or wounds) of skin and subcutaneous tissue or mucous membrane >7 cm long; any necessary care and treatment including cleaning and debriding, exploration, administration of anaesthetic and dressing	\$101.45	\$114.13
RP13	Shoulder treatment for dislocation, requiring active reduction with IV or IM sedation and analgesia. Including splinting where necessary (this item will generally involve radiological investigation)	\$108.52	\$122.09
RP14	Elbow, treatment of dislocation, requiring active reduction with IV or IM sedation and analgesia. Includes splinting where necessary (this item will generally involve radiological investigation)	\$100.63	\$113.21
RP15	Carpal fractures, including scaphoid, treatment of fracture of, not requiring reduction	\$75.92	\$85.41
RP16	Radius and/or ulna, distal end of, treatment of fracture of, by cast immobilisation	\$75.92	\$85.41
RP17	Radius and/or ulna, shaft of, treatment of fracture of, by cast immobilisation	\$100.63	\$113.21
RP18	Humerus, proximal or shaft of, treatment of fracture of, requiring cast immobilisation	\$100.63	\$113.21
RP19	Humerus, distal (supracondylar or condylar) or proximal radius and ulnar, treatment of fracture of	\$100.63	\$113.21
RP20	Tibia shaft and/or fibula, treatment of fracture by cast immobilisation	\$171.88	\$193.37
RP21	Distal tibia and/or fibula, treatment of fracture of, not requiring reduction, includes immobilisation	\$155.58	\$175.03
RP22	Calcaneum or talus, treatment of fracture requiring cast immobilisation	\$155.58	\$175.03
RP23	Tarsus, (including tarsal or metatarsals and excluding calcaneum or talus), treatment of fracture of, requiring cast immobilisation	\$155.58	\$175.03
RP24	Closed reduction of fracture or dislocation of proximal, middle or distal phalanx of hand, requiring injection of anaesthetic	\$48.37	\$54.42
RP25	Metacarpal(s), treatment of fracture by closed reduction-requiring injection of anaesthetic	\$71.94	\$80.93
RP26	Radius or ulna, distal end of, treatment of fracture by closed reduction. Requiring ischaemic limb block anaesthesia or other form of regional anaesthesia (generally proven radiologically)	\$159.83	\$179.81
RP27	Ankle, Achilles' tendon rupture managed by non-operative treatment	\$155.58	\$175.03
RP28	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both	\$71.94	\$80.93
RP29	Administration of activated charcoal	\$24.78	\$27.88
GPEQ	Crutches Hire: One pair per Case	\$26.67	\$30.00

(d) ACC's approach to indexation of payments;

Refer to question 9 which is located on page 43 of this submission for ACC's approach to indexation of payments made under Regulations.

Historically a significant portion of contracts had some form of indexation included. The most common form of indexation is an increase on an annual basis based on movement in the Labour Costs Index (LCI).

The EPN contract has the following review clause:

“On 01 April during each year of the term of this contract (beginning 01 April 2005) ACC will adjust the prices to reflect the change in the LCI over the most recent 12-month period.”

As contracts have been developed over time, the trend has been to move away from a specific indexation increase automatically applied annually, towards a generic annual review clause:

“ACC will review prices annually for all Services described in this Service Schedule. In this pricing review, ACC will take into account general inflation, service component costs, and any substantial changes within the market for these Services. ACC and the Provider may agree to an adjustment to prices as a result of this price review. Any such adjustment must be agreed in writing by the parties. However, if ACC decides, in its sole discretion, that there have not been significant impacts on price, the prices will remain unchanged. Any adjustment in prices will take effect from a date agreed by the parties.”

As a rule, all contract prices are reviewed on an annual basis. Where we are contractually bound, the index specified is applied. Where the above clause is used within a contract, an analysis as to whether an increase should be applied or not is completed. This does not always result in an increase in price. If an increase is recommended and applied, it may or may not be based on an index.

(e) trends in overall fees received by physiotherapists for treatments for ACC patients (including ACC payments and any co-payments) and in fees for treatment for non-ACC patients, since 1989.

Please refer to earlier parts of question 7 located on page * of this submission for overall trends in ACC payments including any co-payments.

ACC has no means of making this comparison as we do not have access to information about fees for treatment of non-ACC patients.

Question 8

Please provide reports prepared for the purpose of the 2004 review of audit and investigation procedures, decision papers in relation to the new audit protocol launched on 1 March 2005, and any review subsequently conducted of outcomes of this process.

ACC is unable to identify the 2004 review of audit and investigation procedures that is referred to in this question.

The Audit Protocol was developed between the ACC and the New Zealand Medical Association (NZMA) following a request from the NZMA for a protocol during the negotiations relating to the rural general practice contract. The protocol was drafted based on a similar protocol used in the health sector. Several iterations were discussed with NZMA until agreement was reached.

The final version was sent out to the other groups listed below for them to provide input. NZSP were one group that provided a response. They stated that, in general, they agreed with the protocol, and had some clarifying questions. There was only one area they requested a change that was not made in the final document. This related to the timeframe of the written plan for the audit. NZSP requested this be provided at the same time as the notification of the audit, which is 10 days. The protocol states the plan will be provided within five days of the audit. It was explained that this timeframe was because the plan is high level, and the timing allows for some feedback from the provider/s to the audit.

Responses provided by the groups were discussed with NZMA before any changes were made. The final version was agreed with NZMA.

The Audit Protocol was produced and drafts were provided to the following groups for feedback:

- New Zealand Medical Association;
- New Zealand Society of Physiotherapists;
- Ambulance New Zealand;
- New Zealand Orthopaedic Association;
- New Zealand Register of Acupuncturists;
- New Zealand Chiropractic Association;
- College of Nurses Aotearoa (NZ);
- New Zealand Nurses Organisation;
- Nursing Council of New Zealand;
- Royal New Zealand College of General Practitioners;
- The Radiology Group;
- Osteopathic Association of New Zealand;
- The Society of Podiatrists; and
- Association of Salaried Medical Specialists.

The following organisations provided feedback:

- New Zealand Medical Association;
- New Zealand Society of Physiotherapists;
- Ambulance New Zealand;
- Royal New Zealand College of General Practitioners;
- New Zealand Orthopaedic Association; and

- New Zealand Register of Acupuncturists.

In 2006 ACC started a process to review the Audit Protocol. Once the process had started it became evident that as the protocol had not been used much to that date, it would be difficult to review. At that point, ACC decided to delay the review until there was sufficient experience to make the review worthwhile. ACC is committed to initiating a review of the Audit Protocol in 2007. ACC will work with NZMA and other professional groups to complete this review.

Question 9

Is there any legal barrier to providing for indexation of payments under the Cost of Treatment Regulations? What is the rationale for not providing for indexation of such sums?

The Cost of Treatment Regulations do not provide for indexation for contributions for treatment consultations. At the request of the Minister for ACC, the Department of Labour is preparing advice to her on options for reviewing and adjusting the regulated amounts that ACC contributes toward treatment.

Question 10

Please provide further information on the role of case managers, including:

- *The circumstances in which a case manager is appointed in respect of a case;*
- *The role and responsibilities of the case manager;*
- *The background and training of case managers;*
- *The circumstances in which case managers may encourage a claimant to use particular providers of services, or classes of providers (e.g. EPN physiotherapy providers rather than non-EPN physiotherapy providers).*

The circumstances in which a case manager is appointed in respect of a case

Note: That in response to this question ACC has included both case coordinators and case managers as both have direct interaction with claimants who receive physiotherapy.

All claims registered with ACC and accepted for cover, are streamed at the Registration Centre, (Dunedin or Hamilton). This streaming process is undertaken electronically and separates those claims on which it is likely that ACC will only be required to pay medical fees from those claims that will require other support from ACC. Claims requiring other support (entitlements) from ACC, are then forwarded to the Contact Centre nearest to the claimant's place of residence.

Contact Centres are situated in Christchurch, Dunedin, Hamilton, and Wellington. The Contact Centre contacts each claimant, sets up essential entitlements, and undertakes a 'risk assessment'. Claimants assessed to be lower risk, in terms of the impact of their injury, will have a case co-ordinator allocated, and the claim will be managed from the Contact Centre. Where claimants are assessed as having more complex needs the claim will be forwarded to a Branch and allocated to a case

manager. From time to time claims will be transferred from a Contact Centre to a branch after a period of management when it has become evident that the rehabilitation needs of the claimant are more complex than first envisaged.

The role and responsibilities of the case manager

The role and responsibilities of case managers and case co-ordinators are documented in job descriptions which apply across all business units.

In summary, the role of the case manager/case co-ordinator is;

- to work with the claimant and relevant others, e.g. family members, employer, general practitioner etc. to determine the impact of the claimant's injury on their everyday life;
- to obtain appropriate clinical advice about any physical limitations resulting from the claimant's injury;
- to organise any assessments necessary to determine the extent of assistance that ACC should provide for the claimant;
- to agree with the claimant the steps to be taken by ACC and the claimant, respectively, to progress the claimant's rehabilitation;
- to authorise the purchase of any equipment, aids or appliances, or rehabilitation services agreed as necessary for the claimant;
- on appropriate clinical recommendation to authorise the payment of certain treatment services; and
- to monitor the claimants rehabilitation progress.

The background and training of case managers

Case managers are expected to be tertiary qualified and their qualifications are often, but not necessarily, in an allied health discipline. Case co-ordinators are working with less complex cases and do not require the same skill sets. Case co-ordinators only have contact with the claimants concerned by telephone and require excellent oral communication skills, and listening skills.

ACC provides extensive training for case managers and case co-ordinators, which is often developed specifically for ACC staff. This training covers ACC's legislation, policies and processes, technical information on the use of ACC's systems, content specific courses dealing, for example, with ACC's contracted services.

The circumstances in which case managers may encourage a claimant to use particular providers of services, or classes of providers (e.g. EPN physiotherapy providers rather than non-EPN physiotherapy providers).

Often ACC claimants will be referred to a physiotherapist by their general practitioner, or they may self-refer, and in either event the case manager is not involved in the choice of physiotherapist. In any situation where a claimant seeks

guidance from ACC staff in respect to the choice of a physiotherapist, the staff member is required to enable the claimant to make an informed decision. This involves providing the claimant with a list of ACC registered physiotherapists practising in their area. In facilitating an informed decision the claimant may be advised to enquire of the physiotherapist of their choice whether a co-payment is required.

ACC has had reports from the NZSP that case managers have moved claimants from one physiotherapist who was providing care to another providing an Activity-based Programme, before the acute treatment has been completed. ACC does not endorse this practice, has given instruction for this to stop, and is monitoring and dealing with incidents as they arise.

Question 11

When is further evaluation of the EPN referred to in paragraph 3.2.7 of the ACC initial submission expected to be available?

ACC's primary submission mistakenly indicates that further work evaluating the EPN has been undertaken, and that the results of the evaluation will be submitted to the review once they become available. The *Evaluation Report – Endorsed Provider Network Physiotherapy Services* dated 9 March 2007 was included with the primary submission as support document 11.

Question 12

Of the approximately 80,000 ACC32 forms lodged per year by physiotherapists requesting prior approval for additional treatment, what proportion are turned down by ACC and on what grounds?

Of the approximately 80,000 ACC32 forms lodged per year:

91% are approved.

4.5% are declined outright.

4.5% are partially approved - i.e. the full amount of treatments requested is not approved, but a reduced number of treatments is approved.

Reasons for decline or partial approval include:

- Non-compliance, e.g. form not signed by claimant.
- Treatment requested does not relate to the covered injury.
- The request is more than 12-24 months following the original injury, and it is not clear if the treatment is for a recurrence or a new injury.
- Insufficient/inadequate explanation on ACC32.
- Treatment significantly in excess of best practice treatment profile without adequate supporting information.

Clinical advisers often discuss the request with the provider prior to making decisions - leading, often, to agreed decisions - clinical adviser and provider agree an appropriate approach and number of treatments.

It is important to note that an ACC32 is technically a request on behalf of a claimant. All decisions made are reviewable by the claimant.

Question 13

What specific criteria are used to determine whether a physiotherapy provider is an outlier in the annual outlier analysis undertaken by the ACC Monitoring Team – and are the same criteria applied to EPN physiotherapists as regulation-funded physiotherapists?

In identifying outliers, ACC applies different criteria to physiotherapists funded under regulation to those funded under EPN. This is because for service evaluation and monitoring purposes it is necessary to treat the two distinct from each other and compare like with like i.e. EPN with EPN and Regulations with Regulations. Another example where ACC does this is between general practitioners funded under Regulations and those funded under contracts such as the Rural General Practitioners Contract or the Accident and Medical Clinic Contract.

For providers working under the Cost of Treatment Regulations, ACC compiles a high level report that identifies those providers who are two standard deviations from the 25th and 75th percentiles, i.e. it identifies outliers, measured across the following categories:

- Total costs for the period measured
- Number of visits per day
- Number of visits per claim
- Total costs per claim
- Costs per visit
- Number of claims per claimant.

For those providers working under the EPN contract, the following criteria are applied.

- Total number of claims per provider
- Total number of visits
- Average visits per claim (if provider treated more than 20 claims in period reviewed)
- Proportion of Level B services (if provider treated more than 20 claims in period reviewed).

Questions 14 and 15

How many EPN physiotherapists and how many regulation-funded physiotherapists were identified as outliers in each of the last 3 years – and what proportion of total EPN and regulation-funded physiotherapists did they constitute?

In each of the last three years, how many EPN physiotherapists and how many regulation-funded physiotherapists who were identified through outlier analysis were asked to provide additional information regarding business practice?

The table below summarises the information for 2005, there was no outlier analysis undertaken in 2004 and 2006. A further outlier analysis will be completed in 2007.

Type of funding	Number of outliers	% of total	How many were asked to provide additional information?
EPN	52	7.3%	49
Regulation-funded	47	3.6%	14

Question 16

After physiotherapists who are identified as outliers provide information requested that does not allay all concerns (or if they refuse to provide information) are they dealt with through the standard Provider Performance Management process along with those identified as having performance problems through other means, or are they dealt with separately and using a different process – and if the latter, by whom using what process?

The standard Provider Performance Management Process is used in all instances. See supporting document 17 with the primary submission.

Question 17

In the Operation Quest III programme referred to in section 4.4 of your initial submission:

- a) What were the criteria used to select the sample of physiotherapy providers from amongst those who claimed on 'per treatment visit' basis?*

ACC conducted a series of studies in order to determine the risk of fraud to ACC. These studies were named Quest I, II and III and focused on the claimant group (Quest I), general practitioners (Quest II), and physiotherapists and chiropractors (Quest III). The objective of these studies was to determine the level of fraud risk for ACC in order to determine the appropriate level and allocation of staff for the identification, investigation and prosecution of fraud.

The criteria were:

- Endorsed physiotherapists were excluded.
- The provider population only included those that were not claiming as a hospital.
- The population only included those physiotherapists and chiropractors that claimed under regulations.

From this population 384 providers were randomly selected.

b) *How many physiotherapists were in the sample?*

265 physiotherapists were in the sample.

c) *What methods were used to establish that “the level of fraud observed within the physiotherapist and chiropractor groups for individual transactions is 8.14%.”*

As stated above, the objective of the Quest studies was to determine the level of risk of fraud to ACC. The 8.14% identified relates to the level of risk rather than the level of fraud (this was incorrectly stated in ACC’s primary submission). This is where the individual transactions selected could not be validated as legitimate charges to ACC, but were not necessarily fraudulent.

The risk of fraud was identified if a physiotherapist or chiropractor had deliberately taken an action that had caused an incorrect decision to be made by ACC. Such actions may be identified by:

- Forged or incorrect documentation to support a claim for service;
- Documents or other evidence that identify that the health provider has wilfully misled, or failed or omitted to advise the ACC of the true circumstances surrounding the claim; and
- Treatment claimed for that has not been applied as indicated.

Some examples of matters that were not considered to constitute a risk of fraud were:

- Error on the part of ACC in the management of health provider claims;
- Disputed clinical diagnosis and treatment (as long as the matter in dispute does not relate to deceit on the part of the provider); and
- The degree and frequency of treatment.

Each claimant was personally contacted and asked questions relating to their treatment to validate transactions. The results indicated that there was a risk of fraud in 8.14% of the transactions reviewed.

Question 18

Of the 12 open physiotherapy fraud investigations being undertaken, and the 37 physiotherapist investigations reported on between 1 September and 1 December 2006 (refer page 28 of ACC main submission):

a) *How many were first identified as part of the Quest III programme?*

One physiotherapist was identified as part of the Quest III programme.

b) *How many were identified by other means – please specify the distribution by source (e.g. how many through outlier analysis by ACC Monitoring Team, how many through claimant complaint etc).*

The table below sets out the distribution of fraud investigations currently.

Source of referral to investigate	Number of investigations
Monitoring team	10
Medical fees	1
Data analysis by Fraud Unit	17
Quest III	1
Clinical advisors	4
Branch and other ACC staff	5
Information received	11
Total	49

Question 19

In the last 3 years, of those physiotherapists whose risk was assessed by the ACC Monitoring Team using Template B (Provider Risk Indicator Tool), regardless of the source of the referral:

- a) How many EPN physiotherapists and how many Regulations-funded physiotherapists were assessed as being a Level 1 risk (knowledge deficit) and were referred for relationship management, education and provider development – and of those:*

The following table sets out how many regulations funded and EPN physiotherapists were assessed as being a Level 1 risk (knowledge deficit) and were referred for education and provider development.

Year	Regulation funded	EPN
2004	0	0
2005	4	14
2006	7	71

- 1. How many subsequently changed their behaviour, resolving the issue?*

ACC is unable to assess how many providers changed their behaviour following ACC's initial intervention. ACC considers that a level 1 risk is not sufficient to require follow up to ensure behaviour is changed.

- 2. How many didn't change their behaviour and were identified by the Review Panel as requiring further action?*

See answer to previous question.

b) For those physiotherapists assessed as being of risk Levels 2 – 6 (as defined in Note 2 to the Provider Performance Management flowchart, Item 17b in the supplementary material provided with the ACC submission to the review):

1. What criteria were applied to determine which type of further action to take?

The Standard Operating Process and Policy Framework (SOPPOF) - Investigate and Manage Provider Performance was used to determine which further type of action to undertake. This process document is attached to this appendix.

2. How many EPN physiotherapists and how many non-regulation funded physiotherapists had each form of further action taken?

- i. Practice visits
- ii. Audit by risk and assurance
- iii. Formal investigation for fraud
- iv. Removal of bulk billing privileges.
- v. Report to the Physiotherapy Board
- vi. Prosecution

The table below summarises the further actions ACC has taken for EPN and other non-regulation funded physiotherapists:

Type of response	EPN	Non-regulation funded (Contracted)
Practice Visits	0	0
Audit by risk and assurance	7	4
Formal investigation for fraud	6	0
Removal of bulk billing privileges	0	0
Report to Physiotherapy Board	0	0
Prosecution	0	0

vii. Other form of action (please specify what)

One EPN and 3 Regulation physiotherapists have been considered by the ACC internal Competence Review Panel.

From 1 September 2006, ACC has investigated payments to two EPN physiotherapists who were found to be practising without a current practising certificate. In one case the physiotherapist received a warning and no money was recovered, in the other matter a warning was issued and money was recovered for the period where no practising certificate existed.

A review of audit reports formally issued to date notes that practice reviews have been completed for six physiotherapist practices, but only for services provided as part of the Activity-based Programme contracts.

- c) *For each form of further action taken, what was the distribution of outcomes? (E.g. for audit and assurance, in how many cases was no evidence of fraud found, and in how many cases was evidence of fraud found. E.g. for those prosecuted, how many cases had a guilty verdict and how many a not guilty verdict).*

Audit by risk and assurance

Practice audits which are conducted in terms of the protocol between ACC and the New Zealand Medical Association (NZMA) have the objective of evaluating the level of compliance with the regulations and provider contracts.

The audit results are reported to the provider in draft format and the final report includes input from the provider.

The main outcome of provider audits is the identification of generic and specific issues relating to contract or regulation compliance, and the appropriateness of billing. The audit results are used by ACC to assist in the compilation of educational programmes for providers as well as to ensure the proper application of the contract billing requirements.

Formal Investigations

In respect of the formal investigations for fraud of the six EPN physiotherapists investigated to date, three are still ongoing and therefore no outcomes are available. The three investigations finalised had the following outcomes:

- Warning letter issued for practising without a certificate;
- Warning letter issued and debt raised for practising without a certificate; and
- Debt raised for claiming treatment while overseas.

Question 20

In respect of other treatment providers (e.g. GPs, radiologists, chiropractors, osteopaths), what comparative information is available in regard to questions 13-19?

In respect to monitoring, fraud, and audit, ACC applies the same standard to all treatment providers. A full break down comparing ACC's experience with

physiotherapists against other treatment providers is being prepared and will be available by 14 May 2007.

Additional questions

Question 1

What was in place before the Audit Protocol, which was published in 2005? Please provide a copy of the prior document.

There was no formal audit protocol prior to 2005. Very few audits were undertaken and these related to fraud investigations. The protocol was established when it was planned to commence routine practice audits. No practice audits were undertaken until the protocol was in place.

Prior to the planning of practice audits an annual screening of the entire provider group was undertaken. This involved an analyst running a report on the provider group and identifying outliers according to predetermined variables – as is the case now. ACC's programme managers, and later provider performance managers, worked with the providers identified as outliers to determine the reason for their different claiming patterns. Most provider issues were dealt with by further explanation of ACC processes. A few providers were referred to ACC's Fraud Unit if there were significant indicators of fraud such as unexplained claims.

Question 2

On page 4 of the Audit Protocol it states that it will be reviewed in 6 months. Has there been a review, and if so, what if any decisions were made as a result?

In 2006 ACC started a process to review the Audit Protocol. Once the process had started it became evident that as the protocol had not been used much to that date, it would be difficult to review. At that point, ACC decided to delay the review until there was sufficient experience to make the review worthwhile. ACC is committed to initiating a review of the Audit Protocol in 2007. ACC will work with NZMA and other professional groups to complete this review.

Question 3

Have ACC put in place systems for ensuring and monitoring compliance with the protocol, and reporting to relevant senior managers in respect to the achievement or otherwise of any targets? (For example whether the provider being audited has the opportunity to see a draft report of an audit as soon as practicable after the audit and not later than four weeks from the audit – as referred to on page 14 of the Audit Protocol).

ACC performs its duties in terms of the standards for professional practice of internal auditing as promulgated by the International Institute of Internal Auditors. In terms of

the standards all audits are planned, scheduled and reviewed before final audit reports are issued. In relation to the audits conducted in terms of the protocol between ACC and the NZMA these standards require that the requirements are built into the execution of every individual audit.

This means that each practice review team has a tracking system in place for their scheduled clinical reviews. Each provider is contacted in advance of a visit in accordance with the protocol, is provided with information regarding the review, and has the opportunity to receive and comment on the draft report. Timeframes are tracked by each audit team, and providers are notified if there are any delays. Providers are also given the opportunity to comment on the performance of the audit team.