THE ACC32 AND ACC CLAIMS

A Practical Guide for Osteopaths

Based on a member education webinar presented to Osteopaths New Zealand

Presented by an osteopath with experience as an ACC Clinical Advisor

Osteopaths New Zealand | Nga Matanga Wheua o Aotearoa

Introduction

The ACC32 - ACC's further treatment request form - is one of the most commonly encountered, and frequently misunderstood, administrative processes in ACC-funded practice. For many osteopaths, it represents a source of uncertainty: when to use it, how to frame a request, why requests get declined, and what to do when they do.

This resource is based on a member education webinar presented to Osteopaths New Zealand. The presenter brought a unique perspective, having worked for two years as an ACC Clinical Advisor - reviewing and auditing ACC32 requests from the inside. The content reflects both the technical requirements of the form and the practical, human realities of how clinical advisor decisions are made.

A Note on Perspective

The presenter of this webinar is not a representative of ACC and does not speak on their behalf. The insights shared are drawn from personal experience as a former ACC Clinical Advisor and as a practising osteopath. This resource aims to give osteopaths a clearer picture of how the system works - so they can navigate it more effectively for the benefit of their patients.

Learning Objectives

After reviewing this resource, practitioners should be able to:

1. Understand the foundational principles underpinning ACC claim management
2. Know the claim timeline, diagnostic limitations, and what 'cover' means in practice
3. Write clinical notes that effectively support ACC32 requests and withstand review
4. Frame ACC32 requests accurately and persuasively
5. Understand how read codes work and when to add them
6. Navigate complex scenarios including re-aggravations, pre-existing conditions, and declined decisions
7. Understand the position of osteopaths with respect to sensitive claims and the concussion space

1. Foundations: What ACC Covers and Why It Matters

The Diagnostic Constraint

One of the most important - and frequently frustrating - realities of ACC practice is that osteopaths are limited in the diagnoses they can record on an ACC claim. In practice, we are largely restricted to sprains, strains, and contusions.

This constraint is not incidental - it is foundational to how ACC constructs and evaluates claims. Everything that follows in the ACC32 process flows from this starting point: what is the patient covered for, and can you demonstrate that what you are treating is still that covered injury?

The Core Question

At every stage of ACC claim management - from initial lodgement through to a further treatment request - the question that a clinical advisor will return to is: Am I still treating the covered injury? This question must be answerable through your clinical notes. If it is not, an ACC32 is unlikely to succeed.

The Claim Timeline

Understanding the ACC claim timeline is essential for managing treatment expectations and planning further treatment requests appropriately.

Timeline Point	What It Means
Date of injury (index event)	This is the anchor point for the claim. All subsequent treatment must relate back to the injury recorded at this date.
364 days from the index event	The deadline by which the ACC45 must be lodged.
364 days from the lodgement date	The period within which treatment must be completed - unless a further treatment request (ACC32) is approved.
Within 12 months of lodgement: up to 16 sessions	Within the first 12 months, up to 16 treatment sessions are treated as a high-trust, rubber-stamping exercise. No formal ACC32 is required.
Beyond 16 sessions or beyond 12 months	A formal ACC32 request must be submitted and approved before treatment can continue under ACC funding.
After 12 months	The bar for further treatment rises. The expectation of ACC is that sprains and strains should have resolved. You must now be able to evidence why treatment is still required and why it remains connected to the covered injury.

Important

Treatment must address the covered injury - not just the patient's pain. If a patient says 'I have 12 treatments left on this claim, can I come in for my knee?' but their claim is for a shoulder injury, you cannot treat the knee under that claim. The covered injury is what was recorded at the time of lodgement, and that is what you are funded to treat.

The High-Trust Model

ACC has chosen to operate a high-trust model for the first 16 sessions within 12 months of lodgement. This means the responsibility for clinical integrity sits with the practitioner. The rubber stamp is not a green light to treat whatever you like - it is an expression of trust that you are treating the covered injury.

As the presenter noted, this places a real ethical obligation on practitioners. The question 'Am I still treating the covered injury?' is one we should be asking ourselves with each session - not just when an ACC32 becomes necessary.

Audit Awareness

Clinical notes are rarely audited - but when they are, they must demonstrate that what you are treating aligns with the covered injury and your treatment plan. ACC is also aware of patterns such as 'tailgating' - where one claim concludes around 11 months and another claim for a nearby body site begins shortly after - and 'dovetailing', where two concurrent claims overlap in a way that suggests treatment is being perpetuated rather than genuinely required. These patterns are visible to clinical advisors and may attract scrutiny.

Sprains, Strains, and the Expectation of Resolution

ACC's clinical position is that sprains and strains will, in most cases, resolve within a reasonable timeframe - roughly six to twelve weeks for a straightforward injury. This is not unreasonable from a pathological standpoint.

The difficulty arises when pain or dysfunction persists beyond this window. The persistence of pain alone does not, in ACC's view, evidence the persistence of the original covered injury. After a certain point - and that point is generally around twelve months - ACC's default assumption is that if a patient is still in pain, they are likely being treated for an underlying condition (such as degenerative change) rather than for the original injury.

This is where the quality of your clinical notes becomes the most powerful tool you have.

2. The Initial ACC45: Getting It Right From the Start

Why the Initial Claim Matters So Much

Many ACC32 difficulties can be traced back to the initial claim. A vague or generic ACC45 creates a thin foundation for any subsequent treatment request. Conversely, a well-constructed initial claim - with a clear mechanism of injury, accurate diagnosis, and rich clinical findings - creates a narrative that will support you months or years down the track.

The presenter was emphatic on this point: for the complex patient - the one who walks in and you already sense is not going to be a straightforward case - the first consultation notes are your most important clinical document.

What to Include in Your Initial Claim

- Mechanism of injury: described with as much precision as the presentation warrants. A rich mechanism description links the injury event to the clinical findings. If the mechanism is complex, document it in full.
- Diagnosis: you are limited to sprains, strains, and contusions - but within those constraints, be as specific and structured as you can. A 'lumbar sprain' is a starting point; a 'lumbar strain with evidence of acute segmental dysfunction at L4/5, consistent with the recorded mechanism' is far more useful.
- Acuity and severity: document the severity of pain (use a validated pain scale such as the VAS), the degree of functional limitation, the patient's reported disability, and any significant clinical findings. Do not understate.

- Timeliness of presentation: whether the patient presented immediately or delayed. Early presentation adds to the evidence of acuity. If they delayed, document why.
- Findings on the asymptomatic side: one of the most commonly missed elements. If you examine and record the contralateral or asymptomatic side, you create a baseline against which future asymmetry - particularly degenerative change - can be contextualised. If there is no record of the asymptomatic side, it is very difficult to argue that degeneration is consequential to the injury rather than pre-existing.
- Any pre-existing conditions: if degenerative change is present, note it - and note how it relates (or does not relate) to the current presentation. You can have cover for a sprain in the context of pre-existing degeneration, but you need to document this relationship clearly from the outset.

The Triangulation Principle

The most persuasive clinical narratives are those where the mechanism of injury, the clinical findings, and the imaging (if obtained) all tell a consistent story. A clinical advisor reviewing your notes should be able to read them and say: 'Yes, this makes sense.' If any element of the triangle is missing or inconsistent, the argument weakens. Build the triangle from the very first consultation.

Mechanism of Injury: More Than Just 'Fell Over'

The mechanism of injury recorded on the ACC45 has a long reach. When imaging is later obtained - and findings such as labral tears, disc herniations, or other structural changes are identified - the clinical advisor will ask: is this consistent with the mechanism of injury recorded?

A mechanism recorded as 'fell over' provides very little to work with when imaging returns a labral tear. However, if the mechanism was documented as 'fell and was wrenched into abduction and external rotation with significant force,' the triangulation becomes possible.

This is not about embellishing. It is about documenting accurately and completely. If the mechanism was genuinely complex, that complexity must be recorded.

The Labral Tear Example

Labral tears present a particular challenge because they are relatively common as a natural variant in the asymptomatic population. A 35-40 year old presenting with a hip that has not resolved following a minor mechanism of injury, who is subsequently imaged and found to have a labral tear, faces a significant challenge in attributing that finding to the injury. The mechanism must be consistent with the finding. The richer and more accurate the mechanism description, the stronger the argument.

3. Clinical Notes: Your Most Powerful Tool

Why Clinical Notes Are Central to ACC32 Success

The single most consistent message from the presenter - drawn from two years of reviewing ACC32 requests as a clinical advisor - is that clinical notes are the most powerful vehicle practitioners have for supporting their patients through the ACC system.

A clinical advisor cannot approve funding they cannot justify. If your notes do not tell the story, the answer will be no - regardless of how confident you are in your clinical reasoning. The notes must do the work.

From the Clinical Advisor Perspective

When reviewing an ACC32 request, a clinical advisor is looking for a cogent argument that connects the covered index event with the need for further treatment. If that argument is not present in the notes, they will decline. The decision is not personal, and there is no favouritism between professional groups - it comes down to the information provided.

What Good Clinical Notes Look Like

For complex patients, notes should build a narrative across time. Each entry should contribute to a coherent picture that a reviewer - reading the notes months later, without any prior context - can follow and understand.

Initial Consultation

- Full mechanism of injury (rich, accurate, specific)
- Severity indicators: VAS or equivalent pain scale, functional limitation, patient-reported disability
- Objective clinical findings: range of motion, neurological assessment, orthopaedic tests, palpatory findings
- Findings on the asymptomatic side
- Any imaging ordered or referenced
- Your initial clinical impression - including any indication that this is likely to be a more complex presentation

Ongoing Notes

- Progress (or lack of progress) - and the reasons for it
- Evolution of the clinical picture - how findings are changing over time
- References to imaging reports, specialist letters, or input from other practitioners
- Reflection on the case: your clinical reasoning as the case develops
- Any changes in diagnosis or approach, with justification
- Prognosis: what you expect to happen, and in what timeframe
- Contingency planning: if treatment is not delivering expected results, what is the next step? Referral for imaging? Specialist review? Co-management?

Demonstrating Progress

You must be able to show that treatment is having a positive effect. If a patient has had 16 sessions and there is no documented evidence of change, a clinical advisor cannot justify approving further treatment. However, lack of symptomatic progress is not necessarily a barrier - if you can demonstrate functional improvement and explain why symptomatic resolution is delayed, that narrative can be compelling.

In complex cases, osteopathy often involves a period of facilitating systemic change before symptomatic improvement becomes evident. If this is your clinical rationale, document it explicitly. Do not leave the clinical advisor to infer it.

Show Your Thinking

Reflection notes - brief entries that articulate your reasoning about a complex case - are a genuinely useful addition. They demonstrate clinical engagement, thoughtfulness, and an understanding of why the case is behaving as it is. They also protect you: if a decision is later reviewed, your documented reasoning is evidence of good practice.

Noting Degenerative Change

Degenerative change is one of the most common grounds on which ACC declines further treatment requests. Their reasoning: if imaging shows degeneration, and the patient is not responding to treatment after a reasonable time, the assumption is that the underlying condition (the degeneration) is what is being treated - not the covered injury.

To counter this, your notes must:

8. Document findings on the asymptomatic side from the initial consultation, so any asymmetry in degeneration can be contextualised
9. Note the presence of degenerative change and reflect on its relationship to the injury - was it pre-existing? Is the injury superimposed on it? Is the degeneration consequential to the injury?
10. Create an argument for why treatment is still addressing the covered injury, not just the underlying condition

You can have cover for a sprain in the presence of pre-existing degenerative change - but after a certain period without resolution, ACC will conclude that the degeneration has become the primary driver of symptoms. The timeline for this is approximately twelve months, though this is not a fixed rule.

4. The ACC32: What It Is and How to Use It

When Is an ACC32 Required?

- When a patient requires more than 16 treatment sessions within 12 months of lodgement
- When treatment continues beyond 12 months from the lodgement date
- In both cases, the request must be approved before treatment can proceed under ACC funding

Completing the ACC32 Online

The ACC32 is now completed online, which is generally simpler than the previous paper process. Key fields include:

- Patient details and claim number
- Current diagnosis and read codes
- Clinical findings: current presentation, objective measures, functional status
- Progress to date: what has changed, and what has not
- Treatment proposed: what you intend to do, for how long
- Prognosis: what you expect the outcome to be
- Contingency: if further treatment does not produce the expected result, what is the next step?

Make It Make Sense

The ACC32 is not a tick-box exercise. The clinical advisor reviewing your request will read your submission and ask: does this make sense? Can I see why this person still needs treatment, and why that treatment is related to their covered injury? The more clearly and logically you construct your argument, the more likely it is to succeed.

The Test: Necessary and Appropriate

The standard against which every further treatment request is measured is whether treatment is necessary and appropriate for the covered injury. This two-part test should be the lens through which you frame every ACC32 submission:

Necessary	Appropriate
Is there still a clinical need for treatment? Is the patient's presentation consistent with an ongoing consequence of the covered injury?	Is the treatment you are proposing the right treatment for this presentation? Is it evidence-based and proportionate to the clinical picture?

Both limbs of the test must be satisfied. Treatment that is necessary but not appropriate (or vice versa) will not meet the threshold for funding.

After 12 Months: The Higher Bar

Once a claim is more than twelve months old, the bar for further treatment rises. ACC's default position at this point is that a sprain or strain should have resolved. To overcome this, you must be able to demonstrate one of the following:

- The injury was more complex than a simple sprain or strain, and there is evidence of structural damage or ongoing dysfunction that justifies the extended timeframe
- There was a significant re-aggravation that reset the recovery timeline
- There are objective findings - ideally supported by imaging - that confirm ongoing injury-related pathology

- The case has unusual features (biomechanical, anatomical, or otherwise) that explain the prolonged recovery

A patient still being in pain twelve months after injury, without other supporting evidence, is not sufficient. Pain alone is not cover. You need to be able to demonstrate that what you are treating is still the covered injury.

5. Read Codes: Adding, Timing, and Justification

What Are Read Codes?

Read codes are the diagnostic codes used within the ACC system to identify the covered injury. On a standard ACC claim, osteopaths are restricted to codes corresponding to sprains, strains, and contusions. Read codes define the scope of what can be treated under a given claim.

Adding Read Codes

It is possible to add additional read codes to an existing claim - for example, if a secondary injury area becomes apparent after the initial lodgement. The process is:

- Complete the addition online through the ACC portal - it is relatively straightforward
- Include clinical justification for the additional code
- Add read codes at the earliest possible opportunity - do not wait

Timing Matters

Adding a read code after six months does not extend the claim by a further twelve months from the date of the new code - the original claim timeline continues to apply. However, a read code that is not present cannot be treated, so adding it promptly is important. If treatment is recorded against a body area or region that is not covered by the claim's read codes, you will need to be able to justify why.

When to Add a Read Code

Common scenarios where an additional read code is appropriate:

- A patient presents with an ankle sprain but, over time, develops back pain as a consequence of an altered gait pattern. The back pain is a secondary consequence of the original injury - add a read code for the back at the earliest opportunity and document the causal reasoning in your notes.
- A patient sustains multiple injuries in one event (for example, a fall that results in a broken tooth and a low back injury). Both should be coded on the original claim. This can be done online and is generally straightforward within the first twelve months.
- Imaging returns findings that are relevant to the covered injury but were not apparent at initial presentation.

After twelve months, adding a read code becomes more complex. A clinical advisor will look for evidence in the notes that treatment for that body area was occurring during the period in

question - simply adding a code after the fact, with no supporting treatment history, is unlikely to be accepted.

ACC and the Musculoskeletal Whole

ACC's approach to claims is structurally quite orthopedic - it tends to think in isolated body parts. Osteopaths, by contrast, work with the body as an integrated system. The presenter acknowledged ACC is somewhat more forgiving of osteopaths than physiotherapists in this regard - they understand that treating an ankle injury may involve mobilising the thoracic spine. However, you should still ensure that your read codes and treatment notes are aligned, and that any treatment outside the primary injury area is clinically justified and documented.

6. Complex Scenarios

Re-Aggravations

When a patient re-injures themselves during the course of treatment, there are two options: continue on the existing claim or lodge a new claim. There is no single correct answer - it is a clinical judgment call.

Continue on Existing Claim	Lodge a New Claim
If the re-aggravation is to the same covered injury and body site	If the re-aggravation is a genuinely new and distinct injury
If the re-aggravation is a direct consequence of the original injury (e.g. compensatory overload on a related area)	If the new injury is to a different body site with a different mechanism
Document the re-aggravation clearly in your notes	Lodge an ACC45 for the new event and treat accordingly
Note that a re-aggravation may extend the expected recovery time - document your reasoning	

The greyness of re-aggravation cases reflects the complexity of real clinical presentations. When in doubt, document your reasoning explicitly - the decision trail in your notes is your protection.

Pre-Existing Conditions and Degenerative Change

A patient does not need to be injury-free to have a valid ACC claim. You can sustain a covered injury in the context of pre-existing pathology. The key question is whether the injury is a genuine superimposition on the underlying condition, or whether treatment is primarily addressing the underlying condition rather than the injury.

To support a claim with pre-existing degenerative change:

- Document the asymptomatic side from the initial consultation
- Note the pre-existing changes and contextualise them relative to the injury
- Track the patient's functional progress over time - even if symptomatic progress is slow
- When imaging returns degenerative findings, reflect on them in your notes: do they explain the presentation, or are they incidental?

The Twelve-Month Point

After twelve months of treatment for a sprain or strain with pre-existing degeneration, ACC's assumption will be that the degeneration - not the injury - is now driving the presentation. To counter this, you need something more than your clinical findings alone: ideally imaging that demonstrates ongoing injury-related pathology, and a clinical narrative that distinguishes between the injury and the underlying condition.

Taking Over a Long-Running Claim

A patient may present to you having been treated by another practitioner - or several - for a claim that is already months or years old. This creates specific challenges:

- You do not have access to the previous practitioner's notes, so you cannot fully know what was documented or how the claim was framed
- If the claim is more than twelve months old, you will need to construct your own clinical argument for why further treatment is warranted
- If there is evidence of something more complex than a simple sprain (for example, through imaging), you can build a new narrative around that finding
- If the claim only has cover for a sprain and you cannot evidence something beyond that, you will face the same challenges as any other practitioner in that position - regardless of the quality of your own work

The presenter was candid: taking over a poorly-managed long-running claim is genuinely difficult. You are not in a worse position because of someone else's deficiencies - but you also cannot create cover where none exists. What you can do is build the strongest possible clinical argument from the information available to you.

When Treatment Has Occurred at a Specialist Level

A patient may present having been seen by an orthopaedic surgeon or other specialist who has continued to treat them under their ACC claim. This is worth understanding:

- Orthopaedic surgeons operate within a different scope within the ACC system - they are not bound by the same diagnostic and treatment constraints as allied health practitioners
- The fact that an orthopaedic surgeon has continued to treat under a claim does not automatically extend your ability to treat under the same claim
- However, if there is now documented evidence of structural damage (surgery, confirmed structural findings on imaging, etc.), the claim has moved beyond 'sprain or strain' in a meaningful way, and this opens up a stronger argument for ongoing allied health treatment
- Document the connection between the structural finding, the original injury, and your treatment explicitly

Declined Decisions and the Review Process

When an ACC32 is declined, it is not necessarily the end. ACC has a review and appeals process, and the balance of probability in a review situation shifts in favour of the patient.

Once a decision is taken to a formal review:

- ACC must demonstrate that the decline was correct - the burden shifts toward them
- If you can present a cogent, well-evidenced clinical argument, the pendulum is already moving in the patient's favour
- The review process can be supported by the treating practitioner providing a written clinical summary

The Reality of Reviews

Reviews are a legitimate pathway - but they take time. If your patient needs treatment now, the review process (which can take months) is a poor substitute for getting the ACC32 right the first time. The best investment is in the quality of the original submission.

7. Concussion and Sensitive Claims

Concussion: A Particularly Complex Area

Concussion occupies an especially difficult space within the ACC system. It is a covered injury, but one that ACC has traditionally managed as a purely medical diagnosis - meaning it must be diagnosed by a GP, even though osteopaths and physiotherapists are frequently the first or most consistent clinical contact for these patients.

This creates a structural problem: the most effective window for concussion intervention is the first week post-injury, but the pathway to formal diagnosis through a GP can take weeks. By the time a diagnosis is formally recorded, the optimal intervention window has often passed.

The Current Position

ACC is developing an allied health concussion diagnostic protocol, which would allow allied health practitioners - including osteopaths - to formally identify concussion without requiring a GP referral. This has been advocated for within ONZ for several years. We do not yet have that protocol, but conversations with ACC are ongoing. Watch for updates on the ONZ member portal.

What Osteopaths Can Do Right Now

While the formal diagnostic pathway remains restricted to medical practitioners, there are practical steps osteopaths can take:

- Ensure patients with suspected concussion are directed to their GP promptly - the sooner the diagnosis is recorded, the sooner the claim can be properly established
- Document any cervical or upper thoracic findings associated with a concussive event - these are legitimately within our scope, and it is well established that significant head trauma is commonly associated with cervical injury. Treat the cervical injury under the claim.
- Develop relationships with your local concussion contract holders (TBI Health, Habit Health, Careway, Active Plus, Proactive, and others depending on your region). If you have a relationship with a contracted concussion provider, they may be able to take a referral from you, fund the patient's treatment through their contract, and allow you to manage the physical treatment component.
- Patient choice is a right ACC is required to respect. If a patient requests to see you specifically as part of their concussion management, a contracted provider can, in principle, direct a tranche of funding to your practice for that patient's treatment.

Get to Know Your Local Providers

The most practical immediate step is to make contact with concussion contract holders in your region. Find out who they are (ACC can provide details of local contract holders for concussion, ICP MSK, and pain programmes), introduce yourself, and start building a relationship. Some providers will be receptive; others less so. But the relationship-building is where access begins. As the presenter put it: get to know your local providers, find out how friendly they are, and position yourself as someone they can work with.

Sensitive Claims

Sensitive claims - those arising from sexual abuse, family violence, or trauma - are a distinct category within the ACC system, with their own processes, checks, and provider requirements.

The current position for osteopaths with respect to sensitive claims:

- Osteopaths are not currently on the formal list of endorsed sensitive claim providers - but ACC has confirmed they are no longer actively excluding osteopaths from providing treatment in this space
- A new sensitive claims contract was being developed at the time of this webinar, with a rollout anticipated later in 2025/2026
- Patients do have some rights to request particular treatment approaches for sensitive claims, including manual therapy
- Psychological support is an important component of sensitive claim management, and ACC expects that any manual intervention in this space will occur within a collaborative, team-based care model
- Osteopaths who encounter sensitive claim patients with physical injuries (for example, bruising or musculoskeletal injury from physical assault) should not hold back from adding appropriate read codes to the claim for those physical injuries - these are covered injuries in their own right

Practical Approach

If you are seeing a patient with a sensitive claim who has associated physical injuries, add the relevant read codes for those injuries and treat them. This is within scope and should be processed as a covered physical injury. The sensitive claim context adds complexity but does not remove cover for genuine physical injuries. If in doubt, contact ACC directly.

8. Ethics and Integrity in ACC Practice

The High-Trust Model Requires Ethical Practitioners

ACC's decision to operate a high-trust model for the first 16 sessions is a significant expression of confidence in the professionalism of allied health practitioners. This trust comes with responsibility.

The presenter was direct: there are practitioners who misuse the ACC system - creating new claims as old ones expire, or treating outside the covered injury without justification. This is visible to clinical advisors through patterns in claims data. It reflects badly on the entire

profession, and it creates a harder environment for every honest practitioner trying to get appropriate care for their patients.

The Ethical Standard

The standard is clear: treat the covered injury, document your reasoning, and ask yourself honestly whether treatment is still necessary and appropriate. If the answer is no, the right thing to do is to discharge the patient from ACC-funded treatment - or to have an honest conversation about what their options are going forward. This is what good practice looks like, and it is what the ACC system relies on.

ACC Is Not the Enemy

A theme running through the webinar was the importance of approaching ACC as a system to be understood and worked with - not one to be gamed or resisted. Clinical advisors, in the presenter's experience, are generally good practitioners who genuinely want patients to receive the care they deserve. When they decline requests, it is almost always because the information provided does not support the approval.

The ACC website now contains significantly better resources for practitioners than it did even a few years ago. If you have not visited the provider section of the ACC website recently, it is worth doing so. The information available there - particularly around the ACC32 process - is a useful complement to the knowledge shared in this resource.

9. Quick Reference Summary

The Core Principle

At every stage - from initial lodgement through to a further treatment request - the question is: Am I still treating the covered injury? If you can answer yes, and your notes demonstrate it, you are in a strong position. If you cannot, no amount of clinical confidence will produce a different answer from a clinical advisor.

Initial Claim Checklist (ACC45)

- Rich, accurate mechanism of injury - document complexity where it exists
- Specific diagnosis within sprain/strain/contusion framework
- Pain severity recorded (VAS or equivalent)
- Functional limitation and patient-reported disability documented
- Objective clinical findings recorded in detail
- Asymptomatic side examined and documented
- Any pre-existing conditions noted and contextualised
- Clinical impression flags if this is likely to be a complex case

Ongoing Notes Checklist

- Progress documented at each session - symptomatic and functional
- Lack of progress explained, not just recorded
- Clinical reasoning and reflection included for complex cases
- Imaging reports referenced and reflected upon
- Prognosis and contingency planning documented
- Read codes cover every area being treated

ACC32 Submission Checklist

- Current diagnosis and read codes accurate and up to date
- Clear, logical argument linking covered injury to ongoing treatment need
- Progress to date documented - what has changed, what has not, and why
- Proposed treatment plan with expected outcomes and timeframe
- Contingency: what happens if further treatment does not produce results?
- Does the request pass the 'necessary and appropriate' test?

Common Reasons for ACC32 Decline

Reason for Decline	How to Address It
No evidence of clinical progress	Document functional changes even where symptomatic progress is slow. Explain why progress is delayed.

Pain alone presented as the basis for further treatment	Pain is not cover. Connect the ongoing presentation to the covered injury through objective findings.
Inconsistency between mechanism and findings	Ensure mechanism is documented richly and accurately from the outset. Imaging findings must be consistent with the mechanism.
Degeneration assumed to be the primary driver	Document the asymptomatic side from day one. Contextualise degenerative findings relative to the injury. Build a counter-narrative early.
Prognosis and contingency absent	Always include what you expect to happen and what you will do if it does not.
Treating outside the covered injury	Ensure read codes cover all areas being treated. Add codes promptly when secondary injury areas emerge.

Key Contacts and Resources

- ACC provider resources: acc.co.nz/providers - ACC32 information, forms, and guidance
- ACC claims queries: contact ACC directly via the provider line
- Local concussion contract holders: ACC can provide details of contract holders by region
- Osteopaths New Zealand: info@osteopathsnz.co.nz - for member support and escalation
- ONZ member portal: osteopathsnz.co.nz - for resources, updates, and further reading

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This resource was compiled by Osteopaths New Zealand based on a member education webinar. The presenter spoke from personal experience as a former ACC Clinical Advisor and practising osteopath, and did not represent ACC in any official capacity. ACC policies, processes, and diagnostic codes are subject to change - practitioners should verify current requirements directly with ACC. This document does not constitute legal or clinical advice.

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