Guidelines for taking good clinical notes:

These are requirements of both Acupuncture NZ and ACC

1. All notes **must** be written in English.
2. All notes **must** be legible / readable
3. Notes should be made for each consultation, at the time of the consultation.
4. Notes should be recorded in such a way that another practitioner would be able to easily understand the treatment provided and rationale behind it.
5. **All notes must contain:**
    a. Patients full name
    b. Date
    c. Patient contact details eg address, telephone numbers
    d. Patient date of birth (DOB)
    e. Name of referring doctor, specialist or health provider
    f. ACC details: ACC45 / claim number, date of injury
    g. Date of the treatment
    h. Subjective findings. This should include:
        i. The chief complaint
            1. If injury related include:
                a. how and when the incident occurred
                b. the date the injury occurred
        ii. Current medications and/or supplements
        iii. Presenting symptoms including:
            1. onset and progression
            2. aggravated by and relived
        iv. a pain scale (1-10)
        v. Past medical history
        vi. How does this condition / injury affect them and their daily lives? (include at least 2 examples)

i. Objective findings:

Record measurable, quantifiable and observable data. This is the physical examination section and should include:

i. any external information such as reports or imaging reports.

ii. Describe any physical assessments you have done including:

1. Range of movement (ROM)
2. Physical assessments
3. Tongue diagnosis
4. Pulse diagnosis
5. If this is an ACC client see appendix with ACC specific note taking requirements.

j. Assessment:

i. Describe your assessment of the presenting condition.

ii. What is your diagnosis? This must be clearly stated. It can either be a TCM or western diagnosis.

k. Plan:

i. What is your treatment principle?

ii. What are the treatment objectives? including biomedical and functional details.

iii. What advice have you given the patient?

l. Consent:

i. Consent is an on-going process, and the patient needs to be consulted throughout the session.

ii. A consent form should be completed prior to treatment commencing explaining what to expect and the patient's agreement to this.

iii. Specialists consent form/s to be used for the use of procedures such as Gua Sha, wet cupping, dermal hammering, scarring moxa, bleeding, thread embedding and exposure to sensitive areas.

iv. Consent given by parent/caregiver, Power of Attorney or Enduring Power of Attorney.

m. Treatment:

i. Write clearly what your treatment included.

ii. ALL acupoints used must be stated (either point numbers eg ST36 or name ZuSanLi).

1. If using Ahshi points, then the anatomical location must be clearly stated.

iii. If using non-standard TCM eg Dong / Jiyi style acupuncture state the style being used so it is clear exactly what the treatment was.

iv. Include any, and all, adjunctive therapies used.

v. Include how long the patient was receiving Direct Treatment.

Additional information:

1. If you have been communicating with other health providers or ACC about the patient this must be recorded in the notes. Include:
    a. the date and time of the communication,
    b. whether it was via telephone or email, and
    c. a brief summary of the content of the communications.
    d. Attach any email or written report/s to the notes.
2. Record any other information that may be relevant to the case. For example, a patient with a low back sprain due to bending over and lifting a heavy brick may have been exposed to strong cold winds for some hours before the sprain. You may feel that this was a weakening factor and predisposed him to getting the injury. This should be documented as it is going to be relevant in your treatment and prognosis. That is, treatment will require some dispersing of the wind and cold as well as treating the sprain.

Follow-up Notes:

1. For all subsequent treatments complete the Acupuncture Treatment Record with:
    a. Date and signature of Practitioner
    b. Treatment Number
    c. Subjective findings:
        i. Results and Progress since last treatment. In all subsequent visits the progress made since the last visit must be included.
        ii. Keep the information clear and succinct. Put patient's words. "The patient said that they felt better". This was seen in the fact the patient was now able to lift their arm level with their shoulder.
    d. Objective findings
        i. Functional and TCM or WM examination findings.
    e. Re-assessment of the treatment principle and plan.
    f. Consent (remember this is an on-going process):
        i. Informal consent obtained throughout treatment (eg moving of clothing to access acupoint)

ii. Specialists consent form/s used for the use of procedures such as gua Sha, wet cupping, dermal hammering, scarring moxa, bleeding, thread embedding and exposure to sensitive areas.

g. Treatment

i. include all points used (as outlined above)

ii. list all adjunctive services used

Appendix 1: ACC Requirements

ACC provides for services to be delivered to their clients and fund acupuncturists to provide acupuncture services to these clients. This is a relationship between ACC and the acupuncturist.

By accepting to treat an ACC client you have agreed to the expectations as laid out by ACC. It is your responsibility to be aware of these 2 documents and their contents.

> "Working together A handbook for providers working under the Cost of Treatment Regulations" (https://www.acc.co.nz/assets/provider/acc7909-working-together-cotr-providers.pdf) and
>
> "ACC Understanding your Responsibilities" (https://www.acc.co.nz/forproviders/provide-services/understanding-your-responsibilities/).

Should ACC ask you to provide notes it is important that anyone reading your notes would easily see and understand the rationale of the treatment you provided. Please be aware that when a practitioner gives a full hourly treatment for all 12 treatments this shows up in the ACC data collection and this triggers a review.

For all ACC client notes you must also include:

1. all the information as outlined above (especially: Subjective, Objective, Assessment, Plan)
2. date of the injury
3. ACC claim number
4. detail the accident and covered injury/injuries
5. describe the injury impact on the client's ability to work or complete activities of everyday life
6. have a treatment plan that clearly links to the covered injury/injuries
7. when time-based billing, accurately record the time taken to provide the treatment directly related to the covered claim. Remember you can't bill any time spent on non-injury related care to ACC.

It is important that notes show that the treatment given is:

1. Necessary:
    a. Is TCM / acupuncture the appropriate treatment for the presenting condition? It is not appropriate to treat underlying conditions beyond the resolution of the presenting condition that ACC has agreed to fund. Ie. you cannot continue to treat the underlying Ki deficiency after the back pain has been returned to the pre-accident state.
    b. Should the patient be referred on for other services? Eg. Should the patient be referred for imaging if you suspect a fracture? They can then return for treatment for pain relief.
    c. Would someone from ACC understand why you used those distal points?
2. Appropriate:
    a. Do your notes reflect that the treatment provided was appropriate? Can ACC easily understand exactly what the treatment was?

3. Quantity:
    a. ACC has set the trigger number of 12 treatments for acupuncture treatments to be provided within 12 weeks from the first treatment provided (by an acupuncturist).
    b. As a treatment provider you are expected to use your clinical judgment and only perform the correct and appropriate number treatments as required to return the client to their pre-accident state.
    c. It is important that you provide only the number of treatments as required to solve the presenting condition that ACC has agreed to fund. It is not appropriate to continue to treat beyond this number.

Invoicing ACC

Only appointments actually attended can be invoiced to ACC. ACC will **not** cover "no-shows".

There are two ways that a provider can invoice ACC. This is generally established at the time you register with AcNZ and ACC.

See Specified Treatment Providers Costs for the rates paid https://www.acc.co.nz/assets/provider/spec-treat-provider-costs-may2021-acc1523.pdf

1. **Per-Patient basis**

    This is a set rate for each patient treated regardless of how long the patient is in the clinic.

2. **Time-Based Billing**

    This is invoiced on a 5 minute incremental basis. It is important that when invoicing ACC that you invoice to the nearest 5 minute unit (rounding up or down as appropriate).

    When using time-based billing it is expected that not all treatments given are one hour long. It is acceptable for the first treatment, with taking of a full history, may be acceptable to be one hour. It is expected that follow-up treatments would be between 30 to 50 minutes.

    Although ACC allow a maximum number of 12 treatments it is expected that most ACC clients will require fewer than this to achieve the desired outcome. Use your judgement to decide the number that are appropriate and necessary. This is not a goal.

    It is permissible to treat more than one person at the same time however you can only invoice for a maximum of 60 minutes in any given hour.

Here are 2 examples to try to explain this:

1. You have a patient booked to come for a 45 minute appointment starting at 10am. They arrive at 10.10am. There are now 2 possible scenarios that could play out:
    a. You see them for 35 minutes as you have someone coming in at 10.45am. or
    b. You decide that as you do not have someone coming in directly after them that you will still see them for 45 minutes and conclude your appointment at 10.55am.

In scenario a. You may invoice 35 minutes and

In scenario b. you may invoice 45 minutes.

2. 10am Patient 1 arrives. You talk with them and apply treatment.

   10.20 You leave them to rest with their needles in.

   10.20 Patient 2 arrives. You talk with them, apply treatment

   10.40 You leave them to rest with their needles in.

   10.40 You return to Patient 1 to remove needles, apply tuina etc and discuss the next steps etc.

   10.50 Patient 1 departs.

   10.50 You return to Patient 2 to remove needles, apply tuina etc and discuss the next steps etc.

   10.55 Patient 2 depart.

   You can invoice for 30 minutes for Patient 1 and 25 minutes for Patient 2. This is the length of time you were applying “direct treatment” to each patient