Recovery at Work: reframing the conversation

Navigating discussions around functional capacity and time off work after injury can be challenging, even for experienced clinicians. Beyond considering a patient's clinical status, this process involves balancing diverse context-specific factors and psychosocial variables. Reintegrating into the workplace is an essential step in recovery, however, evidence suggests many injured patients are being signed off for too long, potentially compromising long-term outcomes. The following resource outlines the ACC Recovery at Work initiative from a general practice perspective, discussing how this system is best used to achieve optimal patient outcomes, and what resources are available for those requiring an additional layer of rehabilitation support.

KEY PRACTICE POINTS:

- Vocational rehabilitation outcomes have progressively deteriorated in New Zealand over recent years, with injured patients spending more time away from the workplace, and taking longer before they return to normal work hours or tasks.
- A prompt return to, and recovery at, work should be prioritised for most patients with non-complex injuries to improve physical rehabilitation, mental health and to maintain social/vocational connections.
- Clinicians have an important role within the Recovery at Work model by performing initial injury consultations, evaluating work capacity, setting shared expectations and making decisions around medical certification; this information in turn guides ACC claim decision-making and the provision of additional supports such as financial and rehabilitation assistance.
- There are three ACC medical certification categories for patients with accident-induced injuries: (**1**) Fully fit, (**2**) Fit for selected work and (**3**) Fully unfit. The definitions have changed over time; it is important to understand these distinct categories and the criteria that must be met.
  - Patients do not need to be "Fully unfit" to be eligible for ACC compensation. A fully unfit certification is usually only required where a return to work would significantly risk a patient's health or the safety of others. If this certification is used to support initial recovery in the immediate days post-injury, consider an appropriate timeframe until subsequent review, balancing any potential benefits against the increasing risk of the patient becoming disengaged in returning to work.
  - Being "Fit for selected work" allows patients to earn up to 100% of their pre-injury income through a combination of work income and ACC compensation. This does not mean patients must immediately return to previous levels of work engagement, and sometimes there will be no suitable alternative duties or arrangements available. In these situations, patients still receive 80% of their pre-injury income via ACC, and can access other ACC-mediated support(s), e.g. stay at work services, physical rehabilitation, social assistance.
- Clinicians are not expected to determine whether suitable work tasks are available for patients within their specific workplace when providing a medical certificate; that is for the employer and employee to decide based on the medical certification, with help from ACC and vocational rehabilitation service providers, if required. Instead, the focus should be on building a clinical picture of the patient's current physical and cognitive capabilities and restrictions.
- The framing of initial injury conversations can have a profound impact on how recovery progresses over time. Clinicians should focus on reinforcing positive recovery expectations, addressing fears around re-injury early and correcting misconceptions (particularly around medical certification definitions). Patients should be involved in decision-making about their care and goals.
- Regular follow up is important for patients who are certified as being "Fully unfit" and "Fit for selected work" to support recovery at work. This provides an opportunity to monitor physical recovery, reinforce positive recovery expectations, ensure workplace accommodations are being implemented and to adjust the treatment plan accordingly, if required.

Supporting a recovery at work following injury

The recovery trajectory for patients following injury can vary significantly. Context-specific factors need to be considered to establish a tailored management plan, rather than clinicians applying a standardised approach. Recognising the best plan for a patient, and adapting to evolving circumstances, is a nuanced skill that builds progressively with experience.

In New Zealand, the Accident Compensation Corporation (ACC) promotes a system where early return to work is emphasised as an important component of recovery for most patients.[1] This is based on the principle that patients experience improved health and wellbeing outcomes when they maintain employment and return promptly to their usual routine (see: "The advantages of facilitating recovery at work"). General practices have a crucial role within this process, ensuring their patients receive appropriate management and support based on their specific clinical and vocational circumstances.

ACC has progressively adapted the "Recovery at Work" initiative over time, including recent changes to referral frameworks, as well as revising definitions around medical certification. Understanding the key components of this initiative from a primary care perspective will enhance decision-making for clinicians and clarify the potential benefits and supports available for patients.

Vocational rehabilitation outcomes have worsened in recent years

ACC accepts around two million new injury-related claims each year in New Zealand; the most common injury types are falls, sports/recreation accidents, work-related injuries and injuries sustained when lifting/carrying objects (**Figure 1A**).[1] The profile of injury causation has not changed considerably over time, however, vocational rehabilitation outcomes have gradually worsened, particularly since the start of the COVID-19 pandemic (**Figure 1B**).

Between March, 2020, and March, 2024, the proportion of patients returning to work within ten weeks of an injury decreased by 5% (from 66.5% to 61.5%), and 3% fewer patients returned to work within nine months (from 91.9% to 88.7%).[1] During this four year period, the average days per medical certificate, proportion of days designating the patient as "Fully unfit" and average total duration of ACC compensation, increased.[1]

The parallel between prescribing medicines and "prescribing" time off work

In the same way that medicines are often prescribed for pain management after injury, "prescribing" time off work can be considered as a treatment. In some cases, short-term absences from work immediately post-injury can be important for recovery. However, as with any treatment, potential associated harms must be considered before initiation. The concept of rational medicine use outlines that patients should receive treatment "*appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community*".[4] This principle can similarly be applied to time off work; rather than following a standardised approach (e.g. routinely signing patients off for a set number of days), balance the type/severity of injury against the specific physical and cognitive restrictions it imposes when determining medical certification.

From this perspective, inappropriately designating a patient as "Fully unfit" rather than "Fit for selected work" could be considered akin to prescribing an opioid analgesic when paracetamol or a NSAID is sufficient, or prescribing a long course of pain relief when discomfort is expected to resolve within a short timeframe. In addition, as with medicine use, it is important to regularly review whether the benefits of continuing to prescribe time off work outweigh the potential risks, thereby limiting the risk of "misuse", i.e. extended durations disengaged from employment (see: "Follow-up for patients returning to work"). If concerns arise regarding the suitability of either intervention (i.e. medicine use or time off work), the approach should be adjusted accordingly.

Practice point: If required, "prescribe" time off work at an appropriate dose, frequency and duration. Just as prescribing too much medicine can lead to harm, prescribing too much time off work can detrimentally affect a patient's vocational outcomes, without providing any added benefit to their physical recovery.

Data indicates that patients are spending longer periods of time disengaged from the workplace after injury and taking longer before they return to normal work hours or tasks. Multiple factors likely contribute to this trend, including inconsistent application of work certificate definitions, time/resource barriers during consultations, and patient/employer hesitancy to "recover at work" as they misunderstand what this means. There is no direct international comparator for these statistics given the uniqueness of ACC and its interplay with the New Zealand healthcare system. However, reports from countries such as the United Kingdom indicate there are increasing rates of people off work globally, and it is speculated that the impact of the COVID-19 pandemic has changed some peoples attitude towards illness, recovery and work.[2, 3]

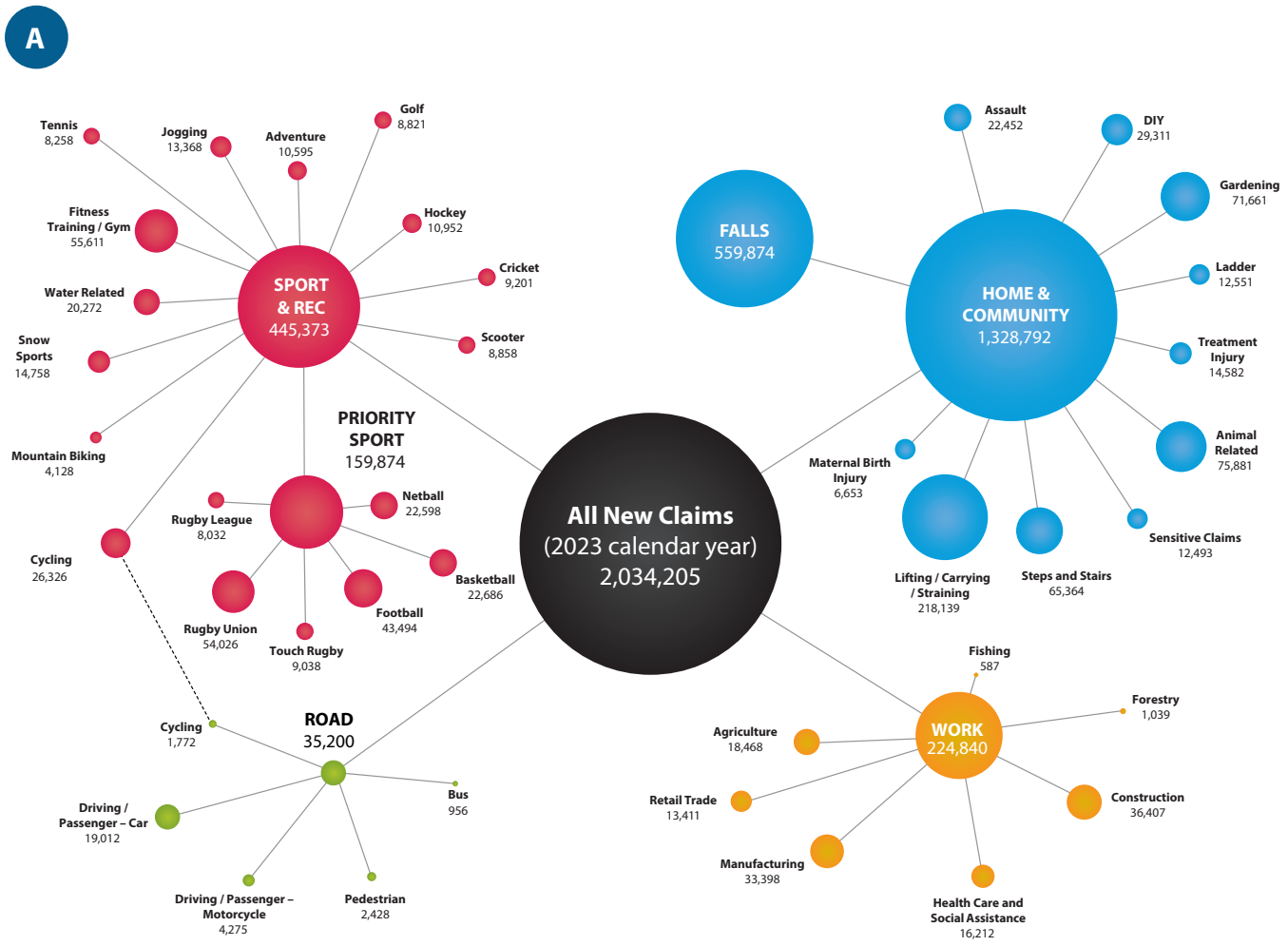


Figure 1. An overview of ACC injury claims data by A) type of injury and B) vocational rehabilitation outcomes. Data obtained directly from ACC.[1]

N.B. Comparator timepoints for part B were selected to minimise potential confounding associated with the acute response to the COVID-19 pandemic in New Zealand, e.g. lockdowns, temporary changes to the provision of healthcare and associated decision-making.

"Time off work" within the biopsychosocial model of care

Clinical guidelines often focus on the biopsychosocial model of care in the context of injury recovery (**Table 1**).[5, 6] This framework recognises that health is not only influenced by biological factors, but also by an interacting network of psychological and social variables, all of which can present barriers or enablers to recovery. As such, effective management following injury should combine multiple strategies to address each component; time off work is just one possible element to review in the wider clinical picture.

Table 1. The biopsychosocial model of care in the context of injury recovery.[5]

		Factors influencing return to work following injury	Corresponding recovery intervention	
Biopsychosocial model	**Biological** 	■ Physiological dysfunction (e.g. tissue damage/injury) ■ Pain neurophysiology ■ Job physical demands ■ Overall physical health ■ Medicine use	■ Provision of timely evidence-based healthcare ■ Progressively increasing activity and exercise levels, as appropriate ■ Modifying work activities to align with functional restrictions	Systematically address multiple factors to maximise the probability of successful and timely recovery
	Psychological 	■ Beliefs and expectations about the injury and recovery process ■ Coping strategies ■ Motivation to recover ■ Perceptions about the workplace ■ Mental health, including anxiety, depression and other mood disorders	■ Identifying and addressing beliefs/attitudes that are barriers to recovery ■ Developing coping strategies ■ Changing behaviour patterns, e.g. fear-avoidance behaviours ■ Identifying realistic and adaptable goals ■ Provision of appropriate psychological support	
	Social 	■ Family circumstances and relationships ■ Other social support(s) ■ Work-related factors ■ Socioeconomic status and living situation ■ Cultural and linguistic background	■ Involving the employer in the rehabilitation process. Ideally prompting them to review and change any detrimental organisational policies, processes and attitudes. ■ Ensuring the patient has sufficient and appropriate social support available, e.g. family involvement in rehabilitation plan	

Conducting an initial medical certification consultation

Injury assessment is a fundamental skill familiar to all primary care clinicians. A key focus throughout this assessment is what the patient can do despite their injury, not just what they cannot do. This process usually encompasses:[7]

- **History** – consider the mechanism and details of the injury, including the specific forces involved as this helps to refine the diagnosis. Identify the features of pain (as well as any other symptoms, e.g. paraesthesia, weakness) and how function(s) have been affected since the injury occurred. Consider possible complicating factors such as previous similar injuries, existing dysfunction or disability, relevant co-morbidities or current medicine use.
- **Physical examination** – dependent on patient history and injury type. Usually encompasses observation (including posture, gait and general demeanour as the patient enters the consultation room, sits down or removes clothing, and whether patterns of movement change during the consultation), palpation and assessment of active and passive movement. Verbal distraction can help distinguish between true functional restriction versus apprehension or fear of movement. Additional investigations may sometimes be required, e.g. neurological examination in patients exhibiting weakness, numbness or radicular pain.

Information obtained during this assessment is used to fill out the initial ACC45 form or subsequent ACC18 forms (see: "Issuing a medical certificate"). Other information such as psychosocial variables (e.g. previous fear avoidance or catastrophising behaviours, social support) should also be considered during the consultation and used to help develop an individualised recovery plan.

If it is suspected that a patient's physical injury has caused significant behavioural, cognitive or psychological dysfunction (i.e. these mental factors are not pre-existing), patients may be eligible for additional cover from ACC (see: "Support for mental injuries").

Practice point: If there is uncertainty regarding a diagnosis following this review, a provisional diagnosis entered on an ACC45 form can later be updated on a subsequent ACC18 form (see: "Getting the diagnosis right when submitting injury claims").[8]

Considerations that inform a work capacity assessment

Following clinical assessment, considering the information in the context of ability, tolerance and risk can be useful to inform work capacity decisions:[8]

Ability. This encompasses both the physical and cognitive capacity of the patient and how this affects the types of tasks they can perform. Provide a diagnosis, treatment or rehabilitation recommendations and prognosis (if possible or appropriate).

Tolerance. Consider any appropriate accommodations that could be made to enable the patient to continue working within their current ability level. This may include changes to hours, travel, tasks. Identify key dates for a staged return to work, as applicable.

Risk. Specify tasks that exceed the patient's tolerance level, and which must not be performed to keep both themselves and others safe; this may be due to the injury itself or adverse effects of medicines being taken, e.g. opioids. Determine what constitutes a risk, such as specific activities (e.g. lifting heavy objects, prolonged sitting) or situations (e.g. driving, climbing on a roof). Identify any specific actions that should be taken to decrease risk, e.g. changes to the environment, equipment, breaks. Remind patients that restrictions relating to vocational tasks should also be applied at home, e.g. if they cannot lift heavy loads at work, they should not be doing it at home.[6]

This process should focus on building a clinical picture of the patient's physical and cognitive capabilities and restrictions. Clinicians are not expected to decide whether suitable work tasks are available for the patient within their specific workplace; that is for the employer and employee to decide based on the medical certification, with the help of ACC and vocational rehabilitation service providers (if required).

N.B. Information and options for self-employed patients is available at: **www.acc.co.nz/for-business/understanding-your-cover-options/types-of-cover-for-self-employed**.

Understanding the medical certification definitions

ACC released revised definitions for medical certifications in February, 2023.[8] The aim is to encourage a system supporting patients to recover while returning to work at a level suitable for their injury. These definitions apply when lodging ACC45 and ACC18 forms; work incapacity can only be certified by a registered medical practitioner or nurse practitioner (see: "Issuing a medical certificate"). A key challenge is managing patient expectations and understanding around these terms; they should be considered based on their definition, not how the title is perceived, and any misconceptions should be addressed promptly (see: "Navigating recovery at work conversations and decision-making").

Practice point: Framing medical certification as a "fit note" rather than a "sick note" can shift patient perception and help establish positive recovery expectations, i.e. changing the "default setting" from considering what the patient cannot do to what they can do.

Fully fit

Assessing patients as being "Fully fit" means they are able to functionally perform their full pre-injury work duties and hours.[1] Even though they are not eligible for weekly income compensation from ACC, this certification is still important as it allows patients to receive appropriate ACC-funded rehabilitation support (see: "*What support is available from ACC?*").[8]

Examples of fully fit:

- An office worker rolls their ankle during a weekend walk. They present in primary care early the next week after resting and elevating the ankle, saying that while walking feels okay, rolling it sideways induces pain. You decide they may require physiotherapy to support rehabilitation, but their employment otherwise involves sedentary desk work that is not impacted by the injury.
- A call centre worker sprains their left wrist after it is bent backwards during a basketball game. They are initially assessed as being "Fit for selected work" (see next section) and gradually recovered at work. They can now complete their full pre-injury duties and hours so are reassessed as being "Fully fit", but can still receive ACC funded treatment/rehabilitation supports, if needed.

Fit for selected work

This type of certification should be the first consideration for most injured patients who are not "Fully fit", i.e. they have some functional restrictions but can complete certain activities safely. Patients assessed as being "Fit for selected work" are able to engage in physical rehabilitation and/or some level of work with support.[8] This may include:[8]

Amended duties – changing the type of duties undertaken based on the type of injury, e.g. administrative tasks rather than manual labour

Workplace adaptations – changing aspects of the workplace to facilitate the performance of specific tasks

Altering hours – changing the times or duration of work

A phased return to work – starts back with reduced hours or duties and progressively increases engagement over time

These requirements can be specified on ACC45 and ACC18 forms. Certifying a patient as "Fit for selected work" does not mean patients must immediately return to their previous level of work engagement and there may be instances where, after they have a discussion with their employer, there are no alternative duties or arrangements available. Instead, using this type of medical certification helps establish an expectation that recovery can occur in the workplace (thereby limiting the risk of a delayed return to work), and provides the flexibility for patients to:[8]

- Earn up to 100% of their pre-injury income through a combination of ACC compensation and work-related income for hours spent at work; if alternative duties or accommodations cannot be facilitated by the employer, patients still receive 80% of their pre-injury income via ACC compensation after the first week.
- Maintain a professional and social connection to their workplace, including retaining current skills or developing new ones. Patients who return to work early are much more likely to remain in employment long term.
- Make the most of their recovery and access the full range of ACC-mediated rehabilitation supports available (**Table 2**). Being certified as "Fully unfit" (see next section) can limit engagement with certain aspects of rehabilitation support, potentially delaying the overall recovery process.

Examples of fit for selected work:

- A warehouse worker sustains a lower back injury. They cannot do certain tasks relating to their usual work (e.g. lifting stock) but there are other tasks they could potentially help out with (e.g. stock-taking and other administrative tasks). If their employer agrees to these alternative duties, they could receive up to 100% of their pre-injury income as they recover at work. If there are no suitable tasks, then the worker will still receive 80% of their pre-injury income from ACC.
- A teacher sustains a broken ankle and is initially assessed as being "Fully unfit" due to immobility and the need for strong analgesia (see below). Following this brief period, they are reassessed as being "Fit for selected work" and, with ACC assistance, access funded transportation to get to work and obtain a knee scooter to help with mobility to reach the classroom. Their medical certificate specifies they cannot undertake prolonged standing or walking, so the school has agreed they can teach while remaining seated at their desk rather than moving around the class during lessons.

ACC has developed a patient handout to explain the "Fit for selected work" certification, available at: **www.acc.co.nz/assets/provider/understanding-your-medical-certificate_FFSW.pdf**

Fully unfit

Of the three ACC medical certification types, the definition of "Fully unfit" has undergone the most significant change. Patients assessed as "Fully unfit" are essentially those who are hospitalised or "house-bound", and should meet one of the following limited criteria:[8]

1. **Total inability to work** – the patient is either admitted to hospital or confined to bed. This is not the same as general "rest"; to meet this criterion the patient should be unable to effectively mobilise from their bed.

   Example: A person involved in a motor vehicle accident who sustained multiple leg injuries is restricted to bed rest.

2. **Contagion risk or quarantine need** – the patient is at risk of infection due to their injury and the environment they usually work in and is unable to work remotely.

   Example: An apprentice plumber sustains a significant burn to their face. There is an increased risk of infection during the initial recovery phase, and the nature of their job does not allow them to work safely in their usual working environment.

3. **Health and safety risk** – the patient being in the workplace, even with assistance or modifications, poses a specific health and safety hazard to themselves, their co-workers or the general public (e.g. due to the impact of the injury or the effects of medicines being taken). This criterion does not apply when there are alternative tasks that could potentially be done, even if these do not align with the patient's usual role in the workplace.

   Example: A person who sustained a severe traumatic brain injury (TBI) or who requires strong analgesia as a result of an injury. Regardless of the environment or work performed, these factors will significantly impact a person's cognitive ability, e.g. ability to make sound, safe, timely and effective decisions. As a result, they could be considered a risk to the public if they drive or operate heavy machinery, or a risk to their co-workers if they cannot respond quickly to high-risk work environments.

   In contrast, this criterion, for example, would not apply to a roofer who sustains an arm injury; while they cannot safely be on a roof until their arm has fully recovered, the injury does not prevent safe, productive work if they were to perform other tasks without using the injured limb (therefore they can be "Fit for selected work" regardless of whether the alternative tasks are actually available within their workplace).

Patients who are "Fully unfit" are eligible for ACC-funded general treatment and rehabilitation support to assist in their recovery.[8] However, while they remain certified as being "Fully unfit": [8]

- There may be some aspects of ACC-mediated rehabilitation support that the patient cannot engage with
- The patient's income is capped at 80% of pre-injury earnings (via ACC compensation)
- Their likelihood of a timely and successful rehabilitation progressively decreases

Given these consequences, this certification must be used appropriately. If it is required to support initial recovery in the immediate days post-injury, consider an appropriate timeframe until subsequent review, balancing any potential benefits of time off work against the progressively increased risk of patients becoming disengaged in the return to work process (see: "Determining the duration of medical certification").

Issuing a medical certificate

Figure 2A provides an overview of the medical certification decision-making process and how the different endorsements can be applied to ACC45 (initial injury claim) and ACC18 (medical certificate) forms. **Figure 2B** outlines information relating to employee payments if ACC compensation is applicable.[8]

Medical certification is first issued as part of the initial ACC45 injury claim and, after obtaining patient consent, can be submitted through the PMS or the ACC online system.[8] Ensure clear and sufficient information is provided to enable faster approval; if there is inadequate information to establish a causal link between an accident and the injury, ACC will need to follow up with the clinician or patient to clarify, thereby prolonging the acceptance process.

Most treatment providers can lodge ACC45 injury claims assuming the type of injury is within their scope of practice, e.g. registered medical practitioners, nurse practitioners, nurses, physiotherapists. However, only registered medical practitioners or nurse practitioners can certify incapacity for work, i.e. medical certification.

For further information on lodging an ACC45 form and the information required, see: **www.acc.co.nz/for-providers/lodging-claims/lodging-a-claim-for-a-patient**

Addressing patient expectations around medical certification

Clinicians and patients may sometimes have differing opinions on whether a specific type of medical certificate or extension of an existing one is appropriate. When discussing work capacity, consider how the patient feels they would manage in their current role and factor this into decision-making. However, the Medical Council of New Zealand outlines that medical certificates should be provided according to clinical judgement based on history and examination findings, not based on patient request alone.[9] If there are differences in perspective around medical certification, clinicians should explain their rationale to the patient, how this aligns with ACC definitions around work capacity, and explore an alternative management plan.[9] In many cases, "Fit for selected work" will be the most appropriate option, but patients may sometimes become insistent or even aggressive regarding the proposed certification, which can be confronting for clinicians.

Early intervention strategies to de-escalate patient aggression:[10]

- **Communicate in a calm, confident and respectful manner, emphasising that you want the best care for them**, e.g. "*I understand that you still don't feel 100%, but I am prioritising what I think is best for your recovery, and that involves seeing if we can get you back in the workplace. We'll put restrictions in place so you don't push things too hard. Let's see whether your employer thinks this might work after you talk to them; if not, that's okay, but we need to try first.*"
- **Use clear, direct language and simple explanations**, e.g. "*Marking you as fit for selected work just means that even though you're injured, there are still some things you can do. You won't be made to do anything at work that will affect your recovery– I'm going to put those details on the medical certificate.*"
- **Use reflective questioning** – repeat back what the patient has told you and frame it as a question to demonstrate you are listening, e.g. "*you have injured your back and don't think you will be able to manage all of your usual work, is that right?*"
- **Be conscious of your body language** – turn towards the patient when speaking to them, keep your arms at your sides or in a neutral position (not crossed), maintain regular eye contact without staring.
- **Prioritise questions likely to elicit a "yes" response** – answering multiple questions in a row with an affirmative response can help patients perceive you as being sympathetic to their situation or "on their side", e.g. "*this back pain makes it hard to do your normal tasks, is that right?*"
- **Involve the patient in finding solutions,** e.g. "*you say you are too sore to drive to work safely. Can you think of other ways you could get to work? If not, ACC may be able to assist with travel to work.*"

For more comprehensive advice, see the RACGP guide for preventing and managing patient aggression, available at: **www.racgp.org.au/patientaggression**.

If the patient cannot immediately continue pre-injury levels of work engagement, ACC45 forms can include one period of "Fully unfit" and/or one period of "Fit for selected work", up to a combined maximum period of 14 days.[8] An ACC45 may be all that is required for many patients with non-complex or less severe injuries. For those with complex or more severe injuries, follow-up assessment will be needed and an ACC18 form completed for work capacity. In some cases, an ACC18 form can be completed at the initial consultation after completing the ACC45 form, e.g. in patients with more serious injuries where a return to work within 14 days is clearly not appropriate.

Getting the diagnosis right when submitting injury claims

Read Codes are used by ACC to provide a standardised way of grouping injury diagnoses. Most practice management systems have Read Codes embedded within them, or they can be searched at **readcode.tubo.nz**.[8] Use a Read Code that represents the physical injury (not the symptoms or cause) where possible and avoid using non-specific Read Codes.[8] More than one Read Code can be provided per claim (e.g. when there are multiple injuries from the same accident), and the comments field used to clarify the clinical situation, if required.

Best practice tip: If there is uncertainty regarding the Read Code for a diagnosis, select the closest match or use the code "Z", and clarify the injury further in the comments field or by using the dropdown boxes available. ACC can then determine the most appropriate coding. For example, if it is unknown whether an ankle injury is a sprain or fracture, use the Read Code for ankle sprain (S550), with a comment "Suspected fracture, awaiting imaging". Qualifiers such as "Suspected (S)" or "Probable (P)" can also be selected/applied to Read Codes using the dropdown box.

N.B. SNOMED Clinical Terms (CT) will likely replace Read Codes in the future; work is currently being undertaken to co-ordinate this transition. SNOMED CT can be used by certain providers if they have SNOMED enabled software, however, they will be translated into Read Codes by ACC. For further information, see: **www.acc.co.nz/for-providers/lodging-claims/using-snomed-clinical-terms/**.

What support is available from ACC?

Support provided in primary care will often be sufficient to enable successful recovery and return to work. Following an injury, many patients require stretching, strengthening and functional exercise to regain normal function, and this can be co-ordinated via referral for physiotherapist treatment. However, ACC can provide a range of additional support(s) for patients following injury if they do not have straightforward vocational or physical circumstances. Types of assistance include more comprehensive return to work support, compensation for lost earnings, travel costs, childcare, personal care, equipment provision and home modifications and additional treatments, e.g. surgery (**Table 2**).

Making a referral for recovery support. Clinicians can indicate the need for further assistance initially by selecting "Rehabilitation assistance required" when filling out the ACC45 form. However, this need may not be known until later in the recovery process. Instead, the requirement for rehabilitation or return to work assistance is usually specified on subsequent ACC18 forms, or by filling out the dedicated referral form for a specific service.

Clinicians can specify the type of treatment or support that would meet the patient's needs on the ACC18 form, or request that ACC contacts the clinician directly. The ACC Recovery Support team can liaise with the patient, employer or clinician at any point to make a referral for rehabilitation services.

Patients can request support independently at any stage following ACC45 approval by using MyACC (see: "MyACC"), by completing an **ACC1** form or by contacting a Recovery Team member.

Clinicians can receive direct ACC assistance by calling the Provider Helpline at 0800 222 070 or by emailing: **providerhelp@acc.co.nz**.

MyACC

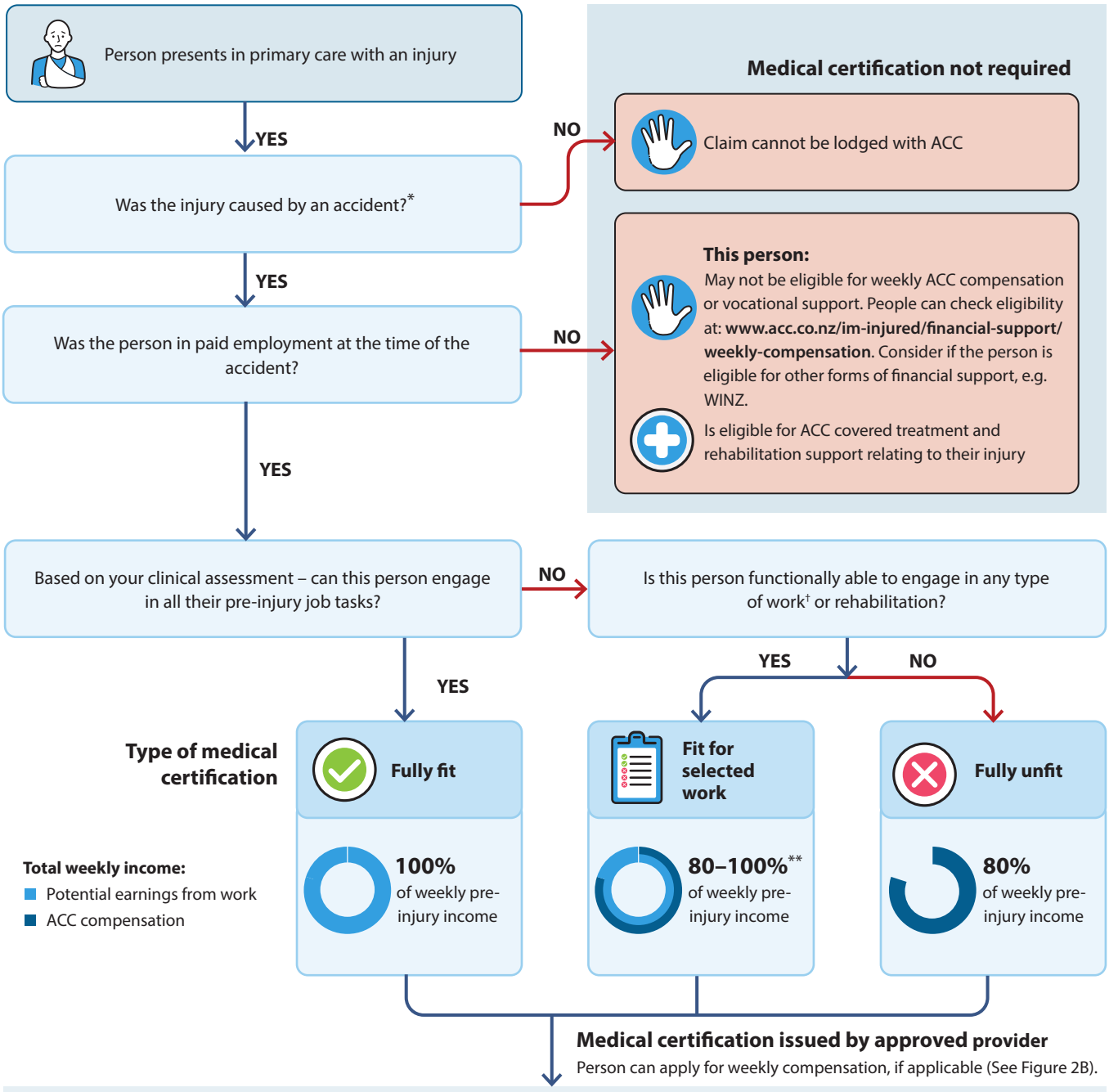
Following claim approval, ACC will email or text the patient to confirm the outcome, and provide information on registration details for **MyACC**.[16]

This online service allows patients to:[16]

- Update contact details
- Access claim information (from 2007 onwards)
- Apply for weekly compensation (if applicable based on medical certification)
- Enter hours worked (if gradually returning to work)
- View upcoming payments
- Upload new medical certificates
- Apply for other forms of ACC support, e.g. prescription and travel reimbursement, assistance at home
- Access additional support via a live chat feature

For further information on MyACC, see: **www.acc.co.nz/im-injured/myacc**

A The medical certification decision-making process



Injury claim forms

ACC45

Day 0
Claim lodged

Primary form used at first visit to lodge and identify injury claim – acts as first medical certificate

Up to Day 14
(review can be earlier – see below)

ACC18
(if required)

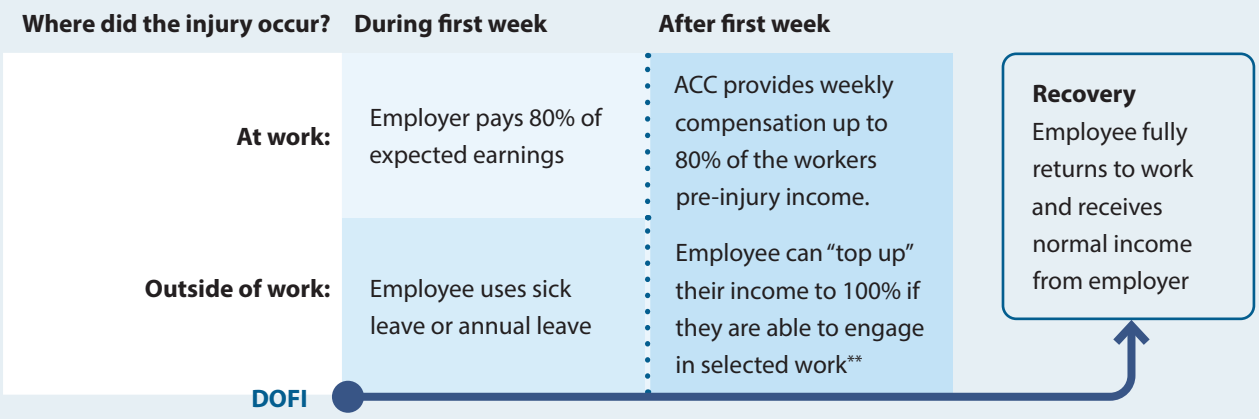
Used during subsequent visits to certify work capacity and verify eligibility for ACC compensation. Can be used to change or add to diagnosis.

Next consultation
(usually ≤ 2 weeks, however, ACC18 forms can be issued for up to 13 weeks)‡

ACC18
(if required)

N.B. One period of "Fit for selected work" and/or one period of "Fully unfit" may be certified on an ACC45 form for a maximum combined period of 14 days. An ACC18 form can be completed at any point after ACC45 submission (including on the same day).

B **Employee payments if ACC compensation is applicable** (i.e. they are not "Fully fit" within first week)



Date of First Incapacity (DOFI) is the first date someone is certified unable to work because of their injury, or the first date they had time off work to seek treatment (the earlier of these two dates).

Figure 2. An overview of information relating to (A) the medical certification process in primary care and (B) employee payments if ACC compensation is applicable.[1]

* Further information on the types of injuries covered by ACC is available at: **www.acc.co.nz/im-injured/what-we-cover/injuries-we-cover**. ACC usually only covers injuries caused by a specific identifiable event, not long-term gradual processes. However, ACC can cover injuries and conditions caused by long-term work-related harmful exposures or processes.

† Clinicians are not expected to know whether there are alternative duties or arrangements available in the patient's workplace; this assessment involves determining whether there are any types of physical or cognitive tasks the patient could potentially undertake without compromising recovery.

** ACC can provide injured employees compensation up to 80% of pre-injury weekly income. If the employee can complete some work, they can top up their weekly income to a maximum of 100% of pre-injury earnings (depending on the hours completed); ACC does not reduce (abate) the first 20% of earnings paid by the employer. ACC will abate weekly compensation payments based on additional income received from the employer beyond the first 20%, i.e. if the employer pays 40% pre-injury income, ACC will pay the remaining 60%.

‡ In rare cases, longer durations between reviews may be appropriate (e.g. 6- or 12-monthly intervals) for patients with stable serious injuries. However, this is subject to strict criteria and usually only applicable much later in the recovery timeline. For further information, see: **www.acc.co.nz/for-providers/treatment-recovery/issuing-medical-certificates**

Table 2. An overview of selected rehabilitation programmes offered by ACC (as of October, 2024).[1]

Rehabilitation programme	Overview
Vocational rehabilitation services	Vocational rehabilitation services help patients maintain employment, obtain new employment or acquire vocational independence after injury. Patients can be referred via ACC recovery support or the ACC18 form, or clinicians can directly contact a local vocational rehabilitation service provider who subsequently organises the referral.* A **standalone workplace assessment** may be all that is needed for patients with simple equipment requirements that would enable recovery at work, and usually involves a single on-site workplace visit by an occupational therapist. **Stay at work services** are a more comprehensive option to support recovery at work. This usually involves an occupational therapist going to the patient's workplace to perform an assessment and to discuss return to work options with the employer. The service co-ordinates a graduated return to work plan to help the patient engage in their pre-injury role, carry out a temporarily modified job or learn/develop new skills that are safe to do in the context of their injury. **Back to Work services** are for patients who are no longer in employment and need assistance regaining capacity for their type of pre-injury work, obtaining new employment, becoming vocationally independent or increasing their employment participation. If a patient is unable to retain their pre-injury employment, they will continue receiving weekly compensation from ACC until they are fit for their previous role or are identified as having the skills/ability to do another job. A **functional rehabilitation programme** may be arranged as part of vocational rehabilitation services. This involves exercise programmes addressing work-specific functional barriers preventing a sustainable return to work (typically delivered by a physiotherapist). **Vocational rehabilitation review** (VRR) may sometimes be required, and can be requested either by the clinician on the ACC18 form, the vocational rehabilitation service provider* or an ACC recovery support member. A VRR can occur at any point (i.e. early following injury, or later if rehabilitation progress stalls) and involves brief clinical assessment by an occupational medical practitioner who can: ■ Determine restrictions and fitness for work relating to the covered injury and/or other conditions ■ Explain to the patient their current condition, injury recovery process and fitness for work ■ Provide advice on subsequent rehabilitation steps ■ Identify any other factors affecting recovery ■ Clarify the diagnosis *Other vocational rehabilitation services also exist, e.g. pathways to employment services, job search services*
Social support services	A range of social supports can be co-ordinated to assist patients, including those relating to home support (including equipment, physical assistance), childcare, education and travel costs, e.g. taxis.
Psychological services	Counselling and therapy sessions can be co-ordinated for patients with psychological barriers to recovery. This may be particularly beneficial for those exhibiting pain catastrophising or fear avoidance.
Pain management services	Appropriate for patients with: ■ Persistent pain lasting at least three months as a result of the covered injury which is not resolving within normal clinical expectations; or ■ Complex Regional Pain Syndrome – confirmed or suspected diagnosis Provides triage and assessment by a specialist pain medicine physician. Tailored multidisciplinary treatment can then be provided depending on the patient's specific needs, in addition to support via group programmes. Patients can be referred using the pain management triage assessment **ACC6273** form.
Integrated care pathways	For patients with complex injuries requiring multiple rehabilitation services. Utilises a multidisciplinary approach to care co-ordinated via ACC case management. *An example is **Integrated Care Pathways Musculoskeletal** (ICPMSK) which is intended for patients who meet the following criteria:* ■ *Have suffered a musculoskeletal injury to the lower back, shoulder or knee regions that may require surgery* ■ *Had the injury within the last 12 months at time of referral* ■ *Patient's recovery requires interdisciplinary treatment* ■ *Accepted cover for an injury to a body site within the scope of ICPMSK* ■ *Intends to reside in Aotearoa New Zealand for the duration of the pathway*

* For a list of vocational rehabilitation service providers by region, see: **www.acc.co.nz/for-providers/treatment-recovery/referring-to-rehabilitation/vocational-rehabilitation-service-provider**

Support for mental injuries

Most ACC cover relates to physical injuries, however, in some cases additional support can be provided for patients with "mental injuries" (i.e. mental health condition or difficulty, mental illness). Mental injury involves persistent **clinically significant behavioural, cognitive or psychological dysfunction** that is causally linked to a specific accident or event. There are three main instances involving mental harm that ACC may cover, including when it is caused by:[8]

- **An ACC-covered physical injury.** The physical injury already covered under an ACC claim is a contributing factor to the mental injury; a mental injury will not be covered if it is solely caused by the experience of being in an accident. Cover is not available for mental injuries resulting from witnessing physical injury suffered by other people unless it occurs at work (see below).
- **Sudden traumatic events at work.** The mental injury must involve a single, sudden, traumatic event at work, likely to cause shock, horror or extreme distress to most people. The person does not need to be physically injured, but it must have happened during their work.
- **A criminal act** listed in **Schedule 3 of the Crimes Act 1961**, e.g. depression, anxiety, post-traumatic stress disorder caused by rape or sexual abuse. Patients do not need to have suffered physical injury to be covered under this category.

Characterising mental injury can be challenging as multiple factors often contribute to mental distress. To be eligible for ACC cover, mental injuries cannot be caused by gradual processes (e.g. bullying or stress) or involve pre-existing mental health conditions which were exacerbated by an injury.[8] If mental injury is suspected, clinicians can lodge a claim with ACC who assess whether it meets the criteria for cover. Patients with an accepted mental injury claim will receive support tailored to their specific needs, e.g. one-on-one talk therapy, body-based therapy, group therapy, Rongoā Māori, social work support. Counselling or psychological support can be accessed while patients await a cover decision (for options, see: **www.findsupport.co.nz/**).

For further information, see: **www.acc.co.nz/for-providers/lodging-claims/understanding-complex-cover**.

How does recovering at work aid physical rehabilitation?

A proposed explanation is that early return to work lessens the impact of physical inactivity and deconditioning otherwise likely to occur when someone remains out of work or is inactive, including muscle atrophy, loss of flexibility and reduced cardiovascular function.[21] In addition, physical activity associated with work or re-engagement in a normal daily routine likely supports localised recovery in other ways; stimulating blood flow, promoting the delivery of oxygen, nutrients and immune cells, as well as the removal of cellular debris which contribute to local inflammation.[29] In the context of concussion management, progressive activity re-engagement (following an initial 24 – 48 hour rest period) increases the production of brain-derived neurotrophic factor, a protein essential for supporting the survival of existing neurons and encouraging the growth and differentiation of new ones.[30]

These potential benefits are, however, influenced by the patient's type of work, e.g. patients with musculoskeletal injuries who perform manual labour can risk further aggravation or re-injury if re-engagement occurs too intensely initially. For this reason, amended work activities or workplace modifications may be required to facilitate a safe return to work while still mitigating risk. One meta-analysis (N = 1,897) found that workplace interventions (e.g. changes to the equipment, tasks, hours) improved the time before first return to work by at least 55% compared to usual standard of care, and were associated with a decreased cumulative duration of sickness absence.[31] Among patients with musculoskeletal injuries, workplace interventions were also linked to improved pain scores and functional status.[31]

Navigating recovery at work conversations and decision-making

The issue of "legitimacy". A concern among some injured patients is whether healthcare professionals will regard their condition as being legitimate.[11] In certain cases, physical injury will be obvious (e.g. a burn or laceration), whereas in others there will be no obvious signs, and review will rely on history, examination and movement assessments. Healthcare professionals have an **obligation to provide objective and impartial opinions to ACC**,[8] but should always maintain a positive, optimistic and non-judgemental attitude towards the patient, regardless of the expected diagnosis or claim outcome.

Reinforce positive recovery expectations and address fears around re-injury. Concern about re-injury is a major predictor of a delayed return to work.[12] A key message to deliver is that patients do not have to be "completely fit" or "100%" to return to work, and that recovery can still occur in a vocational setting.[12] Most patients can be reassured that symptoms experienced during recovery (e.g. pain) do not necessarily mean physical harm or further damage is occurring;[12] risks have been considered when developing their recovery plan, can be appropriately managed (e.g. with corresponding modified hours/duties, analgesia) and are likely outweighed by the harms of remaining out of work.

A 2023 New Zealand study involving patients with concussion presenting to outpatient services (N = 175) found that two-thirds of those exhibiting persistent high **fear-avoidance behaviour** (or increasing avoidance with time) did not return to usual work hours until six to nine months after injury.[13] In comparison, only one-third of patients with persistent low fear avoidance, and 17% with decreasing fear avoidance with time, had not returned to usual work hours.[13] Pain is a subjective experience; the manner with which initial conversations are framed can impact on how perceptions progress over time, which in turn affects recovery.[11]

Correct misinformation or misunderstandings that impede recovery. For example:

- "*I need to be fully unfit to get ACC compensation*"

  Correction: Patients certified as "Fit for selected work" still receive up to 80% of their pre-injury income via ACC compensation, and can earn up to 100% if they engage in selected work (i.e. topping up earnings via work-related income)

- "*I'll be made to work my pre-injury tasks if I'm not signed off as fully unfit*"

  Correction: Physical/cognitive restrictions can be included on "Fit for selected work" medical certificates. If no suitable alternative work can be agreed within the limits of these restrictions after the patient talks to their employer (see below), they do not have to work, and will still receive ACC compensation. They do not need to return for a consultation to obtain a "Fully unfit" certificate.

- "*I shouldn't be working more than 20% of my hours because that's my employer's share when I'm fit for selected work*"

  Correction: ACC can provide compensation up to a maximum of 80% of pre-injury weekly income for patients who are "Fit for selected work". If the patient can complete some work, they can top up their weekly income to a maximum of 100% of pre-injury earnings (depending on the hours completed); ACC does not reduce (abate) the first 20% of earnings paid by the employer. ACC abates weekly compensation based on additional income received from the employer beyond the first 20%, i.e. if the patient works enough to receive 40% of their pre-injury income, ACC pays the remaining 60%. Decisions around the number of hours a patient can work should be based on their clinical status and what this means in the context of their recovery plan (irrespective of how this affects the employer's contribution percentage).

- "*Returning to work before I'm completely better is bad for my recovery*"

  Correction: Recovery processes differ depending on the patient and their specific injury, but in many cases an early return to work lessens the impact of physical inactivity and deconditioning that may occur if the patient remains out of work or is inactive (see: "*How does recovering at work aid physical rehabilitation?*"). In addition, there are other advantages, such as improving mental health and maintaining social/vocational connections (see: "The advantages of facilitating recovery at work").

The role of the employer in the recovery process. Most employers accommodate the recovery at work process when provided with evidence around work capacity. ACC has developed a comprehensive guide to help patients initiate recovery at work conversations with their employer, available at: **www.acc.co.nz/im-injured/getting-back-to-work/recovery-at-work-guide/** (educational material for employers is also available at: **www.acc.co.nz/for-business/supporting-your-injured-employee-to-recover-at-work**). ACC's Recovery Team can provide support and liaise with patients and their employer to negotiate a successful return to work plan (this can be specified on injury forms or requested later). If clinicians engage directly with employers on the patient's behalf for any reason, first gain consent regarding the information they are comfortable with being disclosed.

Cultural safety. Patients should be involved in decision-making about their care in a way that is relevant to their culture and identity.[14] This requires clinicians to recognise differences between groups (e.g. needs, priorities, what work means within the context of their culture) and address any biases that can potentially impact patient outcomes.[14] Consider culturally appropriate treatments or rehabilitation strategies alongside mainstream treatment, where possible; in some cases, this can be enabled through ACC support. For example, ACC funds **Rongoā Māori** under the social rehabilitation category, which encompasses a range of techniques related to the traditional Māori approach to care and healing, e.g. mirimiri (traditional massage/bodywork), rākau rongoā (native flora herbal preparations) and karakia (spirituality and prayer). As of 2023, there were over 150 ACC-registered Rongoā Māori practitioners in New Zealand.[15]

ACC has set out expectations for providing culturally safe care within Te Kawa Whakaruruhau, available at: **www.acc.co.nz/assets/provider/cultural-safety-policy.pdf**

For further information on cultural safety and competency, including the ACC "Te whānau Māori me ō mahi: Guidance on Māori cultural competencies for providers", see: **www.acc.co.nz/for-providers/provide-services/cultural-safety-and-competencies**

Follow-up for patients returning to work

Regular follow up is essential to facilitate a successful return to work.[7] This presents an opportunity to monitor physical progress, reinforce positive recovery expectations, enquire if workplace accommodations are being implemented and to adjust the treatment plan accordingly. In general, more regular consultations are often necessary initially, with the frequency gradually reduced as improvements become apparent.[7]

The primary setting for follow up can vary depending on the injury, but ongoing physical rehabilitation needs and progress are often supported by input from a physiotherapist, e.g. for patients with musculoskeletal injuries. General practice review then often occurs to align with the duration of each medical certificate (e.g. re-considering physical and vocational capacity, pain management) unless an event occurs triggering the need for earlier assessment (e.g. aggravation of the injury, insufficient analgesia). Some patients require more regular general practice review, e.g. those with burns or open wounds who require regular appointments for dressings, analgesic review or for consideration of antibiotics.

The role of telehealth. ACC generally encourages in person assessment in the context of injury follow up and medical certification, particularly if the patient's condition or circumstances change, or if recovery progress was expected but has not occurred. For further information on ACC expectations around telehealth use, see: **www.acc.co.nz/for-providers/provide-services/providing-services-via-telehealth/telehealth-criteria**.

Determining the duration of medical certification

A return to work "template" will not meet the needs of every injured patient, therefore definitive guidance around the ideal duration of medical certification is not possible. Clinical judgement is key, and decisions may also be guided by physiotherapy or return to work service input.

If time off work is required to support initial recovery, a pragmatic approach is that most patients with non-complex musculoskeletal injuries should not be signed off work for more than a few days to one-week post-injury before attempting a transition to "Fit for selected work" or "Fully fit". In patients with concussion, an early return to some form of vocational engagement following the required 24 – 48 hour rest period is recommended, assuming the work environment or duties do not put them or others at risk of injury.[17]

Ideally, any period of "Fit for selected work" should be sufficiently long enough to enable rehabilitation while gradually reintegrating the patient into their usual work, but not so long that they experience deconditioning, dependency on restricted tasks and delays in returning to full productivity. This can be a delicate balance. In non-complex cases, patients may work through a defined period of "Fit for selected work" and then return to full duties without the need for a follow-up consultation. However, patients should preferably be reassessed to obtain "Fully fit" certification before returning to their previous tasks; this may sometimes be requested by the employer and is particularly important if they were unable to perform high-risk tasks safely due to their injury, e.g. operate heavy machinery.

Practice point: Consider predictors of a prolonged return to work when tailoring the duration of medical certification and follow-up review. These should be identified early and addressed, where possible. Factors increasing the risk of extended work absences include patients with:[5, 18, 19]

- More severe or complex injuries (particularly those involving higher pain scores), or who do not receive a clear diagnosis
- Negative recovery expectations
- Multiple pre-existing co-morbidities
- Adverse pre-injury work conditions e.g. poor workplace culture, pre-existing relationship difficulties with an employer/manager/co-worker, job dissatisfaction, long workday schedules

Additional resources:

- ACC information hubs for:
  - Health providers – **www.acc.co.nz/for-providers**
  - Injured patients – **www.acc.co.nz/im-injured**
  - Employers/businesses – **www.acc.co.nz/for-business** (also see: **www.acc.co.nz/for-business/supporting-your-injured-employee-to-recover-at-work/resources-recovery-at-work**)
- ACC Q/A document for health providers – **www.acc.co.nz/for-providers/treatment-recovery/how-we-support-clients-throughout-their-recovery**
- ACC "Quick guides" on a range of topics: **www.acc.co.nz/for-providers/getting-started/quick-guides**
- Information on MyACC – **www.acc.co.nz/im-injured/myacc/**
- Medical Council of New Zealand standards for medical certification: **www.mcnz.org.nz/our-standards/current-standards/medical-certification/**

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The advantages of facilitating recovery at work

Encouraging and enabling a safe and timely return to work is usually important for improving physical rehabilitation and mental health outcomes. A seminal review on this topic is the 2008 "**Working for a healthier tomorrow**" report by Dame Carol Black from the United Kingdom.[20] This review outlined that remaining in work, or returning to work with minimal delay following injury, illness or disability, is essential for protecting health and wellbeing.[20]

In the context of an injury, reported benefits of recovering at work include:[5, 8]

- A shorter time to complete recovery (see: "*How does recovering at work aid physical rehabilitation?*")
- Reduced perception of disability
- Maintaining or learning new vocational skills, meaning patients are more likely to remain in employment and achieve long-term financial security
- A continued or renewed sense of purpose and self-esteem through routine/structure
- Opportunities for social interaction

These advantages cannot readily be tested and quantified through randomised controlled trials (for both practical and ethical reasons), however, evidence can be drawn from observational data. For example, in a study (N = 557) investigating patients with acute low back pain, a return to work within seven days post-injury was associated with significantly improved pain perception and functioning at three months versus a delayed return (more than seven days).[21] This effect was still observed after adjusting for 11 potential confounders including demographic (e.g. age, education, income), medical history and workplace variables.[21]

Avoiding the progression towards worklessness

Another reason to support patients in returning to work early is to avoid the progression to "worklessness". Definitions for worklessness vary in the literature, but it usually describes a state of long-term unemployment, with increasing health needs and a decreasing ability or desire to return to work. The risk of worklessness progressively increases with longer durations away from the workplace.[22]

An extended duration of unemployment more than doubles the risk of anxiety and depression,[23, 24] and has other impacts on mental health, including reduced levels of self-esteem and life satisfaction.[25] Patients out of work often develop a progressively weakened belief in their ability to return, which compounds these issues.[25] Negative effects can span generations, with children of chronically unemployed parents being more likely to experience distress, poor mental health and to be unemployed.[26]

Unemployment is also associated with poor physical health, however, this relationship is difficult to assess as it is both a consequence and cause of illness.[24] Evidence suggests that involuntary job loss may increase the risk of cardiovascular events (e.g. heart attack, stroke) both acutely and later in life, even after adjusting for CVD risk factors.[24] Overall, the mortality risk in the unemployed population is at least 75% higher compared with people who are employed.[27, 28] This health-damaging effect has been described as being equivalent to an extra ten years of age,[27] and is most significant for people during the early-to-middle stage of their careers.[28]

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