



Australian Government

Department of Veterans' Affairs

**NOTES FOR
ALLIED HEALTH PROVIDERS
SECTION ONE: GENERAL**

These Notes are applicable to the following providers:

- Chiropractors
- Clinical Psychologists
- Dentists, Dental Specialists and Dental Prosthetists
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Neuropsychologists
- Occupational Therapists
- Occupational Therapists (Mental Health)
- Optometrists, Orthoptists and Optical Dispensers
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists (Registered and Clinical)
- Social Workers (General)
- Social Workers (Mental Health)
- Speech Pathologists

I, Simon Lewis PSM, President of the Repatriation Commission, Chair of the Military Rehabilitation and Compensation Commission (MRCC) and Secretary of the Department of Veterans' Affairs (DVA) hereby:

(a) revoke the Notes for Allied Health Providers May 2015; and

(b) approve these Notes.

.....
(S. Lewis PSM)

Dated this day of 2016

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The purpose of the Notes for Providers

1. DVA recognises that health care providers play a key role in providing treatment for entitled persons. These ‘Notes for Providers’ (Notes) have been developed to define the parameters for providing health care services entitled persons [see clause 10 for definition] and to describe the relationship between the Department, the patient and the provider.
2. These Notes provide information about the provision of services to entitled persons by the following health care providers:
 - chiropractors;
 - dentists, dental specialists and dental prosthetists;
 - diabetes educators;
 - dietitians;
 - exercise physiologists;
 - neuropsychologists;
 - occupational therapists;
 - occupational therapists (mental health);
 - optometrists, orthoptists and optical dispensers;
 - osteopaths;
 - physiotherapists;
 - podiatrists;
 - psychologists (registered and clinical);
 - social workers (general);
 - social workers (mental health); and
 - speech pathologists.
3. These Notes explain the procedures to be followed when health care providers render services to entitled persons under the following legislation:
 - (a) *Veterans’ Entitlements Act 1986* (VEA); or
 - (b) *Military Rehabilitation and Compensation Act 2004* (MRCA); or
 - (c) *Australian Participants in British Nuclear Tests (Treatment) Act 2006* (APBNT(T)A).These are collectively referred to as “the Acts”.

The Commissions and DVA

4. The Repatriation Commission and the MRCC, collectively referred to as “the Commissions”, administer the Acts. DVA undertakes the administration of the Acts on behalf of the Commissions.
5. Under the Acts, the Commissions are authorised to prepare legislative instruments called the Treatment Principles for each Act as documents legally binding on providers, entitled persons and the Commissions. The Treatment Principles set out the circumstances under which financial responsibility is accepted for the health care treatment of entitled persons.

Status of the Notes

6. In addition to the Treatment Principles, these Notes are a legally binding document setting out the conditions under which health care providers may provide treatment to entitled persons under DVA's health care arrangements.
7. Health care providers are required to deliver treatment and meet the accountability requirements as set out in these Notes. Any breach of these Notes may lead to action in accordance with the Treatment Principles, such as non-payment of claims or recovery of monies from claims previously paid, or where serious breaches are identified, the matter may be referred to the Commonwealth Director of Public Prosecutions. Relevant professional boards may also be advised in serious cases of inappropriate conduct of a health care provider.
8. Each provider should ensure they have a complete set of notes. A 'complete' set includes Section 1 – General information and Section 2 as follows:

Provider Type	Provider specific section
Chiropractors	Section 2(b) – Chiropractors
Clinical Psychologists	Section 2(a) – Allied Mental Health Care Providers
Dentists, Dental Specialists and Dental Prosthetists	Section 2(c) – Dentists, Dental Specialists and Dental Prosthetists
Diabetes Educators	Section 2(d) - Diabetes Educators
Dietitians	Section 2(e) – Dietitians
Exercise Physiologists	Section 2(f) – Exercise Physiologists
Neuropsychologists	Section 2(a) – Allied Mental Health Care Providers
Occupational Therapists	Section 2(g) – Occupational Therapists
Occupational Therapists – Mental Health	Section 2(a) – Allied Mental Health Care Providers
Optometrists, Orthoptists and Optical Dispensers	Section 2(h) - Optometrists, Orthoptists & Optical Dispensers
Osteopaths	Section 2(i) – Osteopaths
Physiotherapists	Section 2(j) – Physiotherapists
Podiatrists	Section 2(k) – Podiatrists
Psychologists	Section 2(a) – Allied Mental Health Care Providers
Social Workers (General)	Section 2(m) – Social Workers
Social Workers – Mental Health	Section 2(a) – Allied Mental Health Care Providers
Speech Pathologists	Section 2(l) – Speech Pathologists

Amendment of the Notes

9. These Notes may be amended from time to time by DVA, consistent with any legal obligations. Any amendments made to these Notes will be dated and DVA will undertake to ensure health care providers are made aware of the amendments to these Notes in advance of them taking effect. This will be undertaken through consultation with representatives from respective peak provider associations.

Treatment of entitled persons

Entitled persons

10. An “entitled person” means a person eligible for benefits or treatment from the Commonwealth as represented by the Commissions, in accordance with relevant legislation in the Veterans' Affairs portfolio. Entitled persons will hold a DVA Health Card issued by DVA, or have written authorisation on behalf of the Repatriation Commission or the MRCC. The cards entitling treatment are the Gold Card and the White Card. Please see clause 142 for details on Factsheets available for these health cards.



11. Entitled persons may be broadly described as:
- veterans;
 - members and former members of the Australian Defence Force;
 - members of Peacekeeping Forces;
 - war widows and war widowers;
 - Australian mariners;
 - children and other dependants of veterans; or
 - persons from overseas who are entitled to treatment under an arrangement with another country.
12. Gold Card holders are entitled to clinically necessary treatment covered by DVA's health care arrangements for all health conditions.
13. White Card holders are entitled to clinically necessary treatment for the following conditions:
- an 'accepted' disability, i.e. an injury or disease accepted by DVA as caused by war or service;
 - malignant cancer (neoplasia);
 - pulmonary tuberculosis;
 - posttraumatic stress disorder (PTSD);
 - anxiety and/or depression;

- (f) symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service);
- (g) alcohol use disorder; or
- (h) substance use disorder.

[Please note: see clause 17 for treatment of allied veterans.]

- 14. If a health care provider is unsure of an entitled person's eligibility for treatment or the extent of what is covered for a White Card holder, they should contact DVA for information [see clause 129 for contact details].
- 15. All DVA Health Cards must be current, as indicated by the expiry date, for the entitled person to be eligible for DVA funded treatment. Other cards issued by DVA, such as a Pensioner Concession Card or the Orange Card, do not entitle the person to health care services. Spouses and dependants of living entitled persons are not automatically eligible for treatment under DVA's health care arrangements.
- 16. Treatment can only be provided to the entitled person named on the DVA Health Card and must be provided in person unless otherwise allowed in the relevant fees schedule [see clause 99].

Allied veterans

- 17. DVA acts as an agent for certain other countries whose veterans reside in Australia. These allied veterans may hold a White Card with limited eligibility for treatment. Subject to decisions by the relevant governments of these countries, allied veterans may be treated for conditions accepted by their country as related to their war service.
- 18. Where allied veterans have authority to receive specified treatment, this will be provided for under DVA's health care schemes. Allied veterans are not automatically eligible for treatment for non war-caused malignant neoplasia, pulmonary tuberculosis, PTSD or anxiety and/or depression.

Treatment thresholds/limits

- 19. The health care provider determines the type, number and frequency of the treatments to be provided to the entitled person for all of the services that do not require prior financial authorisation from DVA. The determination must be based on the entitled person's assessed clinical needs and be part of a treatment plan agreed with the entitled person, which includes the anticipated type and frequency of treatments and the goals expected of the treatment. They must be recorded in the patient's treatment notes.
- 20. Treatment must be provided consistent with the fees and conditions as set out in the Schedule of Fees for the respective health care provider type [see clause 99].
- 21. The following conditions must be met for the treatment to be considered adequate and appropriate. When treating an entitled person:
 - (a) the entitled person will be the centre of the treatment process;
 - (b) the entitled person will be assessed and provided treatment, according to assessed clinical needs and best practice; and

(c) care will be delivered in consultation with the entitled person and their Medical Practitioner, where appropriate.

22. An entitled person may ask for services that are not reasonably and clinically necessary. The Commissions will not accept financial responsibility for such services.

Referrals for Allied Health Services

23. A referral is required for an entitled person to receive DVA funded allied health care services, except for optical and dental treatment. A referral is valid for twelve months unless it is an ongoing referral [see clause 27]. For each new condition requiring treatment, a referral must be obtained.

24. Should an entitled person require treatment from more than one provider of the same provider type at any point in time, the second provider should contact DVA prior to commencing treatment to check whether they can claim an initial consultation.

25. Referrals can come from:

- (a) medical practitioners;
- (b) medical specialists;
- (c) health care providers with a current referral transferring the entitled person to another health care provider of the same speciality; or
- (d) hospital discharge planners.

26. The referral must be written on either a 'DVA Request/Referral Form' (Form D904) or using the letterhead of the referring health care provider. All referrals must include the following information about an entitled person to ensure the provider understands the entitled person's medical history and to allow the provider to claim payment from DVA:

- (a) name and DVA file number of the entitled person (as shown on the DVA Health Card);
- (b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions, if known, for White Card);
- (c) if the entitled person is resident in a Residential Aged Care Facility (RACF), the level of care that they are funded to receive and the date the funding began;
- (d) provider name and number of the referring health care provider;
- (e) date of the referral;
- (f) entitled person's clinical details (including recent illnesses, injuries and current medication, if applicable); and
- (g) condition(s) to be treated.

27. Patients with chronic conditions which require ongoing treatment do not need a new referral every twelve months. These patients should discuss their treatment needs with their Medical Practitioner, with a view to obtaining an indefinite referral for the ongoing treatment of their chronic condition. Indefinite referrals must only be used where the entitled person's clinical condition is chronic and requires continuing care and management.

28. Should a Medical Practitioner wish to make an indefinite referral they should clearly state on the referral that it is an indefinite referral for a chronic condition. Only the Medical Practitioner can determine if an indefinite referral is appropriate for the patient.
29. Referrals are not required to be sent with your accounts to the Department of Human Services (DHS) however, **all** referrals must be kept with patient records and if required, made available for auditing purposes. The health care provider must be aware of the dates of referrals as they are not able to provide services once a referral has expired. If an indefinite referral was issued, the patient must be reviewed every 12 months to ensure the relevancy of the delivered clinical treatment to meet the patient's clinical needs.

Transferring referrals

30. If a health care provider decides to cease treating entitled persons, move from an area, ceases practice, or if an entitled person is moving away, the health care provider should either:
 - (a) refer the entitled person to another health care provider within their speciality; or
 - (b) advise the entitled person to contact their Medical Practitioner for another referral.
31. Prior to transferring an entitled person, the health care provider must notify each of them by telephone, in person or in writing. A separate referral is necessary for each entitled person.
32. The transfer referral should be made valid for the remaining time period left on the entitled person's current referral. For example, if an entitled person has four months remaining on a twelve month referral, the transfer should be for a four month time period.
33. If the health care provider transfers to another practice location, they must ascertain whether the new practice continues to be the nearest suitable health care provider in that area for the entitled persons they are treating. If they are not, the health care provider and the entitled person will be eligible only for travelling allowances equivalent to those otherwise payable to the nearest suitable health care provider.

Patient Care Plans*

34. The health care provider must formulate a written Patient Care Plan (PCP) following the first consultation with each entitled person. The PCP should be revised with any changes in the entitled person's clinical circumstances. Consultation fees are not payable for the ongoing maintenance of patient care plans.
35. PCPs should be consistent with professional association guidelines but as a minimum, must include:
 - (a) presenting condition(s);
 - (b) objective assessment results based on the use of validated outcome measurement and diagnosis of the condition(s);

- (c) the planned treatment regimen, including the anticipated type, number and/or frequency of services;
- (d) details of any aids and appliances required;
- (e) the expected outcomes or results of the treatment regime for the entitled person plus proposed timelines; and
- (f) written informed consent of the entitled person.

36. The entitled person's Medical Practitioner, as the care coordinator, may request a copy of the PCP. DVA may also request a copy of the PCP. A copy must be given pursuant to any request within seven days from the date of that request.

NOTE: Where specific DVA Programs stipulate requirements for PCP, please adhere to the specific program requirements.

**Optical providers are not required to keep patient care plans but only those clinical notes as stipulated by law and/or by their association and are not required to provide this to the Local Medical Officer.*

Prior financial authorisation

37. Certain health care services require prior financial authorisation from DVA. These services are highlighted in the relevant Schedule of Fees with shading or in the case of dental treatment, listed as Schedule B [see clause 99]. Health care providers must contact DVA prior to administering these services to be able to claim for payment [see clause 129 for contact details].
38. A health care provider can request prior financial authorisation from DVA by phoning or by forwarding a written request by mail or facsimile on official letterhead [see clause 129 for contact details].
39. The written request for authorisation must include:
- (a) the name and DVA number of the entitled person;
 - (b) the treatment entitlement of the person, i.e. Gold Card or White Card;
 - (c) if the entitled person is resident in a RACF, the level of care that they are funded to receive at the date of the request;
 - (d) the provider number of the requesting health care provider;
 - (e) the provider number of the referrer;
 - (f) the date of the referral;
 - (g) the service requiring prior financial authorisation;
 - (h) the costs of the treatment where appropriate; and
 - (i) clinical justification for the requested service.
40. DVA will not automatically grant requests for prior financial authorisation. Each request is considered individually. Previous approval of an unrelated request for the same or another entitled person or for another health care provider does not exempt the health care provider from requesting prior approval in each circumstance.
41. Generally, DVA will not pay retrospectively for services where financial authorisation was required from DVA but not obtained unless the circumstances

are exceptional. DVA reserves the right to recover monies paid to providers for services where financial authorisation was required from DVA but not obtained.

42. DVA will advise the outcome of the request.

NOTE: Dental providers should refer to Section 2(c) Notes for Dentists, Dental Specialists and Dental Prosthetists, clauses 16 – 19 for further details on prior financial authorisation for dental services.

Prescription of items in the Rehabilitation Appliances Program (RAP)

43. Certain health care providers are recognised prescribers of selected appliances under the Department's *Rehabilitation Appliances Program (RAP)*. When using RAP, assessing health prescribers must forward the RAP item order form to the appropriate DVA-contracted RAP supplier.
44. Further information on RAP, including which providers are eligible to prescribe RAP items, is available on the DVA website or by contacting DVA [see clause 1333 for details]. The RAP schedule of items can be found at:

<http://www.dva.gov.au/providers/provider-programmes/rehabilitation-appliances-program-rap>

Travelling assistance for entitled persons

45. DVA provides support for entitled persons to travel to attend treatment through the Repatriation Transport Scheme (RTS). Entitled persons can seek reimbursement of their travelling expenses or subject to certain criteria, may be able to access the Booked Car Scheme (BCS). A Factsheet detailing the RTS is available on the DVA website [see clause 143].

Home visits and kilometre allowance for health care providers

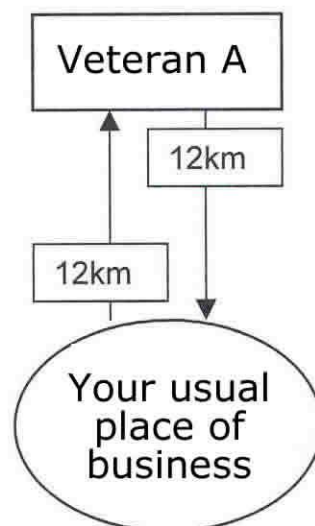
46. A health care provider may perform an assessment or a treatment in an entitled person's place of residence, either their home, a residential aged care facility or a hospital. There must be a genuine need to travel to see the entitled person. Examples of genuine need include where there is a requirement to conduct a home assessment or if the entitled person is physically unable to travel. If there is no evidence of a genuine need to travel, the kilometre allowance will not be paid..
47. The kilometre allowance will not be paid if;
- (a) there is no evidence of a genuine need to travel;
 - (b) you are a mobile allied health provider, without a registered street address representing your registered place of business, also referred to as your 'usual place of business'. A postal address is not accepted as a registered place of business; and
 - (c) there is a suitable health care provider who is located closer to the entitled person.
48. A kilometre allowance may be paid for travel from the nearest consulting rooms to visit an entitled person and return. The kilometre allowance is not payable for the first ten kilometres of each journey. The kilometre allowance may be paid if:
- (a) the travel exceeds ten kilometres; and

- (b) there is no suitable health care provider who is located closer to the entitled person.
49. The kilometre allowance is claimed by writing the entire distance travelled to visit the entitled person under the heading 'kilometres travelled' on the service voucher used to claim for the service.
50. Different arrangements apply to Occupational Therapists providing treatment in rural and remote areas. Refer to Section 2(g) for more information
51. The following are examples of how to claim:

Note: when calculating the distance travelled from your 'usual place of business', you must use the distance from your closest practice address to the entitled person's place of residence. The 'usual place of business' refers to a registered place of business, with a street address. A postal address is not accepted as a registered place of business.

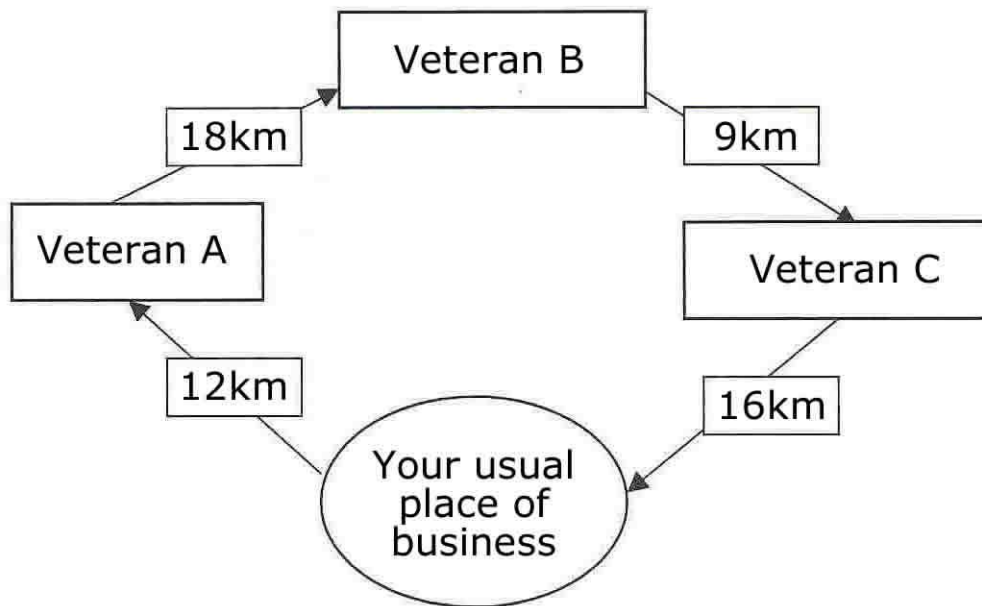
Note: For the purpose of these examples, veteran refers to entitled persons.

Example 1:



- The trip from your usual place of business to Veteran A is 12 kilometres. You return to your place of business after treating this veteran.
- Write the entire amount of the trip (24km) under 'kilometres travelled' on the claim voucher for Veteran A.
- You will be paid the kilometre allowance for 14km of this visit (the distance travelled, less the first 10km).

Example 2:



If you travel from one veteran patient to another during the day, kilometres should be claimed in components against each patient:

- The distance travelled from your usual place of business to Veteran A is 12km. Write this entire amount on the claim voucher for Veteran A. You will be paid the kilometre allowance for 2km of this trip.
- From Veteran A, you travel directly on to visit Veteran B which is a distance of 18 kilometres. Write this amount on the claim form for Veteran B. You will be paid the kilometre allowance for 8km for Veteran B.
- You then travel to Veteran C, a distance of 9km. After treating Veteran C, you return to your office, a distance of a further 16km. You should claim 25 kilometres (9 + 16) against Veteran C on the claim voucher. You will be paid the kilometre allowance for 15km of this journey.
- Do not claim the total trip against only one patient.
- For trips which include non-DVA patients:
 - Do not claim kilometres travelled to your non-DVA patients.
 - Kilometres are only paid for the most direct route between veteran clients.

Residential Aged Care Facilities (RACFs)

Note: This section does not apply to optical dispensers or dentists as they do not have access to items for RACF services.

52. The level of care an entitled person is receiving in a RACF refers to the health status and classification of the entitled person as determined under the Classification Principles 2014.

Note (1): a person in a RACF requiring a greater level of care is described in paragraph 7(6)(a) of the *Quality of Care Principles 2014* as a care recipient

whose classification level as determined under the Classification Principles 2014 includes any of the following:

- (i) high ADL domain category;
- (ii) high CHC domain category;
- (iii) high behaviour domain category;
- (iv) a medium domain category in at least 2 domains; or
- (v) a care recipient whose classification level is high level residential respite care.

53. Prior financial authorisation from DVA is required for all treatments provided to an entitled person in a RACF classified as requiring a greater level of care as described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*.
54. If you are in doubt about the classification of an entitled person in an RACF who has been referred to you, contact the facility. It is the health provider's responsibility to ascertain the assessed classification of an entitled person with the facility before treatment is provided.
55. For an entitled person residing in a RACF classified as requiring a greater level of care, as described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*, the Commissions will consider payment for short term intensive health care services required following an acute episode, such as serious illness or injury, surgery or trauma, based upon an assessed clinical need.
56. Financial authorisation is required prior to commencement of treatment and will only be approved in exceptional circumstances. Circumstances where approval may be considered include treatment to a limb following a fall and fracture or for chest physiotherapy following illness.
57. The Commissions will not accept financial responsibility for non-post acute health care services provided to an entitled person in a RACF classified as requiring a greater level of care as referred to in paragraph 7(6)(a) of the *Quality of Care Principles 2014*.
58. In some circumstances, Commissions may pay for an initial consultation to allow assessment of an entitled person's condition in circumstances where it is unclear whether the entitled person meets the above criteria.
59. For an entitled person residing in a RACF classified as requiring a lower level of care, and not described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*, the Commissions will accept financial responsibility for clinically necessary health care services.

DVA management requirements

Eligibility to provide DVA funded treatment

60. DVA allows health care providers who are eligible to claim for treatment services under DHS to provide health care services to entitled persons under DVA's statutory registration provisions without having to enter into a contract with DVA.

To apply for a DHS provider number, register as a DVA provider or to amend DHS registration details, please contact DHS [see clause 138 for contact details].

61. To be eligible to provide treatment under the DVA health care arrangements, a health care provider must be a registered provider with DVA at the time the service is provided.
62. Health care providers must meet the professional and ethical standards set by the relevant professional regulatory and/or representative body. DVA expects health care providers to meet continuing education requirements set by the relevant professional regulatory and/or representative body.

Insurance & indemnity

63. State or territory laws or national provider registration bodies may require, as a condition of registration, health care providers carry a certain level of insurance and indemnity. This may vary across provider type and jurisdiction. For health care providers covered under DVA's statutory registration scheme (i.e. registered with DHS), DVA does not stipulate insurance requirements or level of coverage but expects providers to hold adequate levels of insurance.
64. DVA requires that providers shall at all times indemnify and hold harmless the Commonwealth, the Repatriation Commission and MRCC, their officers, employees and agents (in this paragraph referred to as "those indemnified") from and against any loss (including legal costs and expenses on a solicitor/own client basis), or liability, incurred or suffered by any of those indemnified arising from any claim suit, demand, action, or proceeding by any person against any of those indemnified where such loss or liability was caused by any wilful unlawful or negligent act or omission by yourself, your officers, employees or agents in connection with DVA's statutory registration scheme or in the course of, or incidental to, performing the health services.

Privacy

65. As a minimum requirement, health care providers must comply with the *Privacy Act 1988* in relation to the collection, storage, security, use and disclosure of the personal information of entitled persons.

Record keeping requirements and provision of information

66. The health care provider must create and maintain adequate and appropriate records relating to all administrative and clinical aspects of the provision of treatment to an entitled person. The care plan and/or clinical notes must be updated in a timely manner in relation to health care services provided on a specific date of service. [For further information regarding record management see clauses 101-104 for online claiming and clauses 106-116 for paper claims.]
67. All clinical records, including assessments, care plans, progress notes and clinical pathways, belong to the health care provider and must be retained and securely stored for the appropriate time period required under relevant State/Territory or National legislation.

68. Health care providers will comply with any reasonable request from DVA to supply information in relation to any entitled person. Sufficient information must be provided within seven days of receiving an information request from DVA.
69. In relation to inappropriate or non-compliant claiming, the health care provider must cooperate fully with DVA in investigating the matter, and must provide sufficient information within 14 days of receiving an information request from DVA.

Electronic Communication

70. For the purpose of these Notes, and unless the contrary intention appears, DVA and a health care provider may communicate about any matter by electronic transmission e.g. secure e-mail, facsimile message.
71. For clause 70, communication includes the making of a request or the provision of a notice or document.

Advertising

72. The provisions of the *Health Practitioner Regulation National Law Act 2009* must be adhered to by all DVA providers, but in addition, health care providers must not refer to DVA in any promotional material unless they observe the following conditions:
 - (a) the only permissible words providers can use to indicate the availability of allied health services to the veteran community are 'DVA Health Cards (Gold and White) are accepted as payment upon a GP referral', noting these services should not be advertised as free to DVA clients. .
 - (b) the Australian Government logo must not be used in the advertisements;
 - (c) the advertisement or websites must not imply endorsement as DVA's preferred health care provider, or that the health care provider is an employee or agent of DVA. The advertisement may only advise that the health care provider will treat DVA entitled persons;
 - (d) no false or misleading information is to be included in the advertisement;
 - (e) advertisements or websites referring to DVA will not be permitted if State/Territory regulations governing health practitioners prohibit advertising; and
 - (f) no inducements or other offers are to be made to DVA clients or their spouses.
73. If the advertisement or website is only brought to DVA's attention after publication, the health care provider will be contacted and advised of these guidelines. If the advertisement or website does not conform to these guidelines it can no longer be used and must be removed from the public space.
74. If a health care provider has been informed of these guidelines and breaches them, DVA can take appropriate and necessary action which could include action under the *Competition and Consumer Act 2010*.

Use of locums, students and/or assistants

75. DVA will accept financial responsibility for the services of a locum if the locum health care provider is eligible to provide services under statutory registration and is willing to treat entitled persons under the DVA health care scheme.
76. DVA will not accept financial responsibility for health care services provided fully or in part to an entitled person by a fieldwork student or an assistant. An assistant or student undertaking practical experience can only provide treatment under direct supervision of the health care provider, subject to seeking the appropriate consent from the client. The supervising provider must be present at all times during the DVA funded consultation.

Benchmarking and monitoring and the audit process

77. DVA has systems in place to monitor the servicing and claiming patterns of health care providers. DVA uses this information, in addition to best practice guidelines from professional regulatory and/or representative bodies, to establish internal benchmarks for the future delivery of services and to identify possible instances of overpayment resulting from administrative error, inappropriate-servicing or non-compliance.
78. DVA conducts audits of health care providers. The audits will examine whether a health care provider is complying with:
 - (a) DVA's administrative arrangements; and
 - (b) DVA's treatment guidelines.
79. The key objectives of the audit process are to:
 - (a) ensure compliance with DVA's management requirements;
 - (b) provide an opportunity for DVA to inform health care providers about their responsibilities when treating entitled persons;
 - (c) monitor the quality of health care being provided;
 - (d) monitor the achievement of health care outcomes for entitled persons;
 - (e) minimise the risk of overpayment as a result of administrative error, inappropriate-servicing and non-compliance; and
 - (f) address cases of individual non-compliance, in a manner consistent with the range of remedies contained in the DHS Community Compliance Model Framework.
80. The compliance audits will be conducted at the provider location, or at a DVA Office at DVA's discretion. The health care provider will be given at least 14 days advance written notification of the audit.

Inappropriate claiming

81. The Commissions reserve the right to broadly determine the level and type of servicing for entitled persons for which it will accept financial responsibility.
82. Should it appear a health care provider may be supplying inappropriate levels or types of health care services, or has been submitting incorrect claims, DVA may contact the health care provider by telephone or in writing to discuss and clarify

the Department's concerns. This may include requesting copies of patient treatment notes and other relevant documentation.

83. A reasonable period of time (not exceeding 14 days) will be given to the health care provider either to:
- (a) demonstrate the health care services supplied were appropriate to meet the entitled person's treatment needs; and/or
 - (b) implement an agreed remedial action plan with DVA.
84. DVA retains the right to recover payments made for incorrect claims or servicing not appropriately provided. Overpaid monies may be sought by DHS on DVA's behalf in the first instance.

Right of the Australian Government to recover money

85. Without limiting the Australian Government's rights under any provision of these Notes, the Treatment Principles, any other legislation or under the Common Law, any payment or debt owed by the health care provider to the Australian Government under these Notes may be recovered by the Australian Government. The Australian Government can recover the amount of payment from any claim or from any other monies payable to the health care provider for any debt owed.
86. Recovery of monies paid to health care providers by DVA can also be pursued via the civil recovery process through the Australian Government Solicitor.
87. If agreement cannot be reached on a remedial action plan, or if inappropriate servicing or claiming practices continue at variance with the said plan, the Commission may:
- terminate your DVA provider registration and/or optical dispensers agreement (whichever is applicable);
 - withdraw entitlement for payment for any services performed by you after the effective date of termination;
 - recover any relevant payments made to you;
 - disclose any relevant information to the State/Territory or national registration board and national professional association that is not restricted by any Privacy Act provisions; or
 - notify your DVA patients of the change in your provider status, and make alternative arrangements for treatment.

GST and ABNs

88. It is the health care provider's responsibility to notify DHS of all changes to GST registration status. DHS must have this information to ensure correct GST processing of claims for payment. Failure to notify DHS could result in failure to comply with GST law.
89. DVA requires health care providers treating entitled persons to enter into a Recipient Created Tax Invoice (RCTI) Agreement with DVA if they are registered for GST, and will be providing services to DVA (for example, reports). [See clause 135 for contact details on where to send the Agreement.]

90. The RCTI Agreement permits DHS to automatically add GST to claimed taxable items. It also allows DHS to issue the health care provider with a RCTI to comply with GST law.
91. If a health care provider does not complete DVA's RCTI Agreement, DHS will reject claims for payment. The RCTI Agreement is available on the DVA website [see clause 135 for details].
92. All health care providers who receive DVA payments under DVA's health care scheme are required to have an Australian Business Number (ABN). Having an ABN does not automatically mean a business is registered for GST.

Financial matters

Financial responsibilities

93. The Commissions will accept financial responsibility for the provision of health care services to meet the clinically assessed needs of entitled persons. The health care services must be delivered in accordance with these Notes.
94. The Commissions will not accept financial responsibility for the cost of a service provided to an entitled person by a health care provider if, at the time the service was provided, a DVA health care benefit would not have been payable.
95. Subject to clause 93, by accepting an entitled person's Gold or White Card the health care provider agrees to accept the DVA fee as full payment for health care services without imposing any additional charges on the entitled person, unless advised to the contrary in the Schedule of Fees [see clause 98], by legislation, or as described in these Notes. The Commissions financial responsibility for health care services provided to entitled persons is limited to the actual fees set out in the Schedule of Fees.
96. The Commissions do not accept financial responsibility for the payment of health services appointments missed by entitled persons. If it is standard practice to charge a fee for missed appointments, the entitled person must pay that fee.
97. DHS undertakes the processing of DVA claims for most allied health providers. DHS operates a computerised claims processing system to pay health care providers who treat entitled persons. Payment can be delayed or rejected if health care providers submit claims containing incomplete, inaccurate or illegible information.

Schedule of fees

98. Payment for health care services is based on DVA's Schedule of Fees relevant to the profession and the date treatment was provided. An entitled person must first be assessed as requiring treatment and be issued a referral before seeing an allied health provider.
99. The Schedule of Fees for each health care provider type is an integral part of these Notes.

Each Schedule of Fees is available on the DVA website at:

<http://www.dva.gov.au/providers/fee-schedules>

Indexation of fees

100. Subject to Government policy, DVA indexes the fees for most health care providers annually.

Billing procedures – online claiming

101. Online claiming allows health care providers to submit electronic claims for processing without the need to send any paperwork to DHS [see clause 139].

102. Paper copies of forms do not need to be retained if claiming online. However a copy of the voucher should be provided to the entitled person. Health care providers should be sure that they can, from other means of record keeping, satisfy any request from DHS or DVA for evidence of service and details of treatment.

103. The entitled person should be provided with a record of the treatment provided.

104. When using online claiming, the health care provider must adhere to the following principles, as is required when filling out Form D1217:

- (a) the services were rendered by the health care provider or on the health care provider's behalf and, to the best of the health care provider's knowledge and belief, all information in the claim is true;
- (b) none of the amounts claimed are for a service which is not payable by DVA; and
- (c) no charge was or will be levied against an entitled person for the service, i.e. no co-payment will be requested except where allowed by DVA.

Billing procedures – DVA Webclaim

105. DVA Webclaim is a real-time web based electronic claiming channel that allows health care providers to submit electronic claims via the internet, without the need to send any paperwork. The following should be noted when using DVA Webclaim;

- (a) access to DVA Webclaim is available via the Department of Human Services (DHS) Health Professional Online Services (HPOS) portal;
- (b) Health professionals need a Medicare provider number and an individual Public Key Infrastructure (PKI) certificate to access DVA Webclaim;
- (c) If you have a current Medicare provider number you can apply for your individual PKI Key through DHS; and
- (d) For more information on DVA Webclaim, see the DVA Website provider information.

Billing procedures – manual claiming

Providers of dental services should refer to Section 2(p) Notes for Dentists, Dental Specialists and Dental Prosthetists, clauses 59 – 68 of your Notes for manual dental claims information

106. An accounts claim is made up of a 'Health Practitioner Service Voucher' (Form D1221) and a 'Claim for Treatment Services Voucher' (Form D1217). To claim for time based fees, the 'Allied Health Time Based Voucher' (Form D695) should be used.
107. For providers of optical services, an accounts claim is made up of a 'Optometric / Optical Service Voucher' (Form D1223), 'Spectacles Prescription' (Form D931) and a 'Claim for Treatment Services Voucher' (Form D1217).
108. The health care provider can send the claim forms to DHS for processing. Please see clause 137 for details on where to send these claims.
109. The information below is required in the following circumstances for a claim to be considered as correctly submitted:
- where the patient is the holder of a DVA White Card, the name of the condition being treated (e.g. osteoarthritis), **not** the description of the treatment that was provided;
 - for the first consultation in the referral period, the referring health care provider's name, provider number and the date of the referral; and
 - if treatment was provided in a hospital or aged care facility, the name of that institution.
110. The process when making a paper-based claim for payment is as follows:
- All fields on the claim form should be completed in permanent pen before an entitled person is asked to sign
 - submit the original copies of D1221 and D1217 to DHS;
 - give the entitled person the patient copy of the claim voucher; and
 - keep the claimant copies of D1221 and D1217 on record.
111. For providers of optical services, the process when making a paper-based claim for payment is as follows:
- All fields on the claim form should be completed in permanent pen before an entitled person is asked to sign
 - submit the original copies of D1223, D931 and D1217 to DHS;
 - give the entitled person the patient copy of D1223; and
 - keep the claimant copies of D1223, D931 and D1217 on record.
112. Recording the patient's entitlement number exactly as it appears on their card when filling out DVA stationery minimises errors when processing accounts.
113. All health care services in an account submitted by an individual health care provider must have been rendered by the same health care provider. All health care services in an account submitted by an incorporated business entity or

Government body health care provider must have been rendered at the same practice location.

114. The claim may contain service vouchers of various clients, so long as the total number is no more than 50 and contains no more than 99 services.
115. All claims for payment should be forwarded to DHS by two years from the date of service delivery.
116. For health care services that require prior financial authorisation from DVA, please ensure the prior financial authorisation is granted by DVA at least one week before any associated claims are lodged with DHS.

Payment to different names and addresses

117. Provider numbers are location specific. The provider number used for claiming purposes must correspond to the provider number of the location at which the treatment was provided.
118. DHS has a group link facility, which allows payments to a name or address different from the name or address of the treating provider. When a group link is established, the payment name and address is linked to the health care provider number in the DHS system to ensure correct payment. To establish a group link, contact DHS [see clause 138 for contact details].

Non-payment of claims and resubmitting claims

Online Claims:

119. DHS will process online claims within two business days. It may take up to an additional two business days (if paid by Electronic Funds Transfer (EFT)) or an additional five business days (if paid by cheque) for payable benefits to be received by the provider. If your claim has not been paid within this time you should request an electronic remittance report.
120. Remittance reports detail claims paid and rejected. Where a claim has been rejected the report will indicate the reasons for the rejection.
121. If you wish to query an online claim, contact DHS [see clause 136]. DVA Webclaim allows providers to download the last two years of their DVA claims history. If you wish to query about DVA Webclaim, contact DHS (see clause 141)

Manual Claims:

122. DHS will process manual claims within 20 business days of receiving a complete and correct claim. Do not contact DHS with queries relating to unpaid claims until at least 25 business days after posting a manual claim. It may take up to an additional two business days (if paid by EFT) or an additional five business days (if paid by cheque) for payable benefits to be received by the provider.
123. If a claim is not paid by DHS because of errors on the form, the entire claim or a number of service vouchers will be returned to the health care provider with an explanation of non-acceptance.

124. If an entire claim is returned, please resubmit it to DHS with a new Form D1217. If a single voucher or number of vouchers is declined and returned, the information needs amending. The voucher(s) can be resubmitted with the next claim.

125. If you wish to query a manual claim, contact DHS [see clause 136].

Adjustments

126. An adjustment may be required if an incorrect payment has been made. Requests for adjustments should be made in writing to DHS, and the following information must be supplied:

- (a) the reason for the adjustment;
- (b) the health care provider number;
- (c) the claim number of the original claim; and
- (d) details of the entitled person on the claim.

127. The health care provider should not submit a Form D1221 or a Form D1217 to make an adjustment.

Services DVA will not accept

128. DVA will not pay for any of the following services:

- (a) services that have been paid for, wholly or partly, by Medicare or a health insurance fund;
- (b) services where the cost is otherwise recoverable, wholly or partly, by way of a legal claim;
- (c) examination for employment purposes;
- (d) examination for a medical certificate for membership of a friendly society;
- (e) All alternative therapies including herbalist services, homeopathy, naturopathy and iridology; and
- (f) massage that is not performed as part of physiotherapy, chiropractic or osteopathic services claimable through DVA and performed by a physiotherapist, chiropractor or osteopath.

Contact list

129. Health care providers can contact DVA for advice, including requests for prior financial authorisation, on the following numbers.

Metro: 1300 550 457
 Non-metro: 1800 550 457
 Fax: (08) 8290 0422

Postal address: GPO Box 9998
 In your capital city

130. Entitled persons can contact DVA for general information on the following.

General enquiries: 133 254
 Country callers: 1800 555 254
 Interstate Dial-in: 1300 13 1945
 Email: generalenquiries@dva.gov.au

131. Advice about prescriptions accessible under the Repatriation Pharmaceutical Benefits Schedule and approval for Authority prescriptions is available through the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC).

Phone: 1800 552 580
 Fax: (07) 3223 8651

132. To make a transport booking for an entitled person or for information about transport from the Repatriation Transport Unit, use the following numbers:

Metro: 1300 550 455
 Non-metro: 1800 550 455

133. Information about the *Rehabilitation Appliances Program* (RAP) is available at:

<http://www.dva.gov.au/providers/provider-programmes/rehabilitation-appliances-program-rap>

134. Information about DVA's community nursing program is available at:

<http://www.dva.gov.au/providers/community-nursing>

Phone 1300 550 466

135. Recipient Created Tax Invoice (RCTI) Agreement:

Form available at:

<http://www.dva.gov.au/providers/becoming-dva-service-provider#rcti>

Enquiries: 1800 653 629
 Fax form to: 1800 069 288
 Email (scanned copy): sa.gst.teamleader@medicareaustralia.gov.au

Mail form to:
GST Program
GPO Box 2956
ADELAIDE SA 5001

136. Claims enquiries should be directed to DHS:

Phone 1300 550 017.

137. Written queries and completed claims for payment should be sent to:

Veterans' Affairs Processing
Department of Human Services
GPO Box 964
ADELAIDE SA 5001

138. Applications for provider registration, changes to address or health care provider details should be directed to DHS as follows:

Application forms are available at:

<http://www.medicareaustralia.gov.au/provider/incentives/allied-health.jsp>

Changes to details and/or address:

Phone 1300 550 017

139. Online claiming

Phone 1800 700 199

Email onlineclaiming@dva.gov.au

141. Enquiries about DVA Webclaim

Phone: 1800 700 199

Email: eBusiness@humanservices.gov.au

142. Reporting Fraud

To report allegations of fraud to the Department's Business Compliance Section:

Phone (03) 9284 6402

Email fraudallegation@dva.gov.au

DVA Fact Sheets

143. DVA produces a range of fact sheets with information for health care providers and entitled persons. To access the fact sheets, go to <http://factsheets.dva.gov.au/factsheets/> and search by Keyword or use the Numeric Index.