Australian Government
Department of Veterans' Affairs

Pain Programs
Prior Financial Authorisation

Please download and save this form to your computer and open it using Adobe Acrobat Reader 7 or above. This will enable all of the features of the form when you fill it in on screen.

This form is to be used by health providers when requesting prior financial authorisation to provide a multidisciplinary pain management program to eligible Department of Veterans' Affairs (DVA) health card holders. Please note there are other prior financial authorisation request forms that can be used for requesting individual services for the treatment of persisting pain. Please check the available forms to ensure you are using the most appropriate form.

DVA strongly encourages the use of contracted pain management programs available through contracted hospitals. Contracted pain management programs do not require prior financial authorisation.

Please ensure all information provided is complete and correct as missing or incorrect information including clinical justification for the request, may delay the processing of your request.

For further information and support to complete this form please contact the Provider Hotline on 1800 550 457 (Option 3, Option 1), Monday to Friday, 8.30 am to 5.00 pm (local time).

Returning this form – email to: HEALTH.APPROVAL@dva.gov.au

or post to: **Health Approvals & Home Care Team**
Department of Veterans' Affairs
GPO Box 9998
Brisbane QLD 4001

Privacy notice – DVA collects personal information under and for the purposes of performing its functions in portfolio legislation administered by DVA. These functions include claims, the delivery of payments, programs, services and treatments and for veteran and family wellbeing. We also use these for wider purposes in performing those functions including reporting, continual improvement and evaluation. We collect, use and disclose your personal information as set out in various program and claim form notices and as further set out in DVA's claim and program application forms, its Card and Card Carrier notices, specific program collection notices where applicable and as set out in the *DVA Privacy Policy* available at https://www.dva.gov.au/about/overview/legal-resources/dva-privacy-policy. More information about privacy rights and obligations is contained in the policy and at *How does the DVA protect my privacy* https://www.dva.gov.au/about/accessing-information/what-can-i-access/personal-information-access/how-does-dva-protect-my-privacy

Important – The provider by submitting this form is indicating that the client has given informed consent to provision of the claim and personal information to DVA for the purposes of assessing eligibility and providing treatment and services and benefits under DVA legislation. This includes participating in the program as well as for use in clinical review, audit, evaluation, reporting and management purposes and disclosure to the client's treating team of clinicians. The practitioner confirms that appropriate notices and consents have been given in that regard and is responsible for ensuring that the client is aware that their personal information is to be collected, used and disclosed in that way.

THIS FORM SHOULD BE COMPLETED BY A HEALTH PROVIDER

Decision timeframe

Please allow 28 days from the date this request is forwarded to DVA to allow adequate time for a funding decision. You must receive approval prior to proceeding with treatment. Retrospective funding cannot be guaranteed.

1 **What is the proposed commencement date of service?** (dd/mm/yyyy)

2 **Is this request urgent?** No ☐ Yes ☐ ▶ Please provide clinical reasons

Client details

3 Client's name **Surname**

Given name(s)

4 Date of birth (dd/mm/yyyy)

5 DVA file number

6 Client's email address

Considerations for Program Funding

7 DVA expects multidisciplinary pain programs to be delivered in line with best practice guidelines for the management of persistent pain. Pain programs are not to be used preventatively.

All of the criteria (points a – p) below should be met for DVA to consider funding a multidisciplinary pain program. Please tick No or Yes as appropriate to the items below:

a. Does the client currently experience persistent pain? No ☐ Yes ☐

Pain is an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Chronic pain, referred to as persisting pain throughout this document is pain that persists or recurs for longer than 3 months. Persisting pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome.

b. Are the client's needs multifactorial and require clinical input from a multidisciplinary team? For example, mood, sleep, limited physical function or activity avoidance, interpersonal relations, poor pain coping strategies. No ☐ Yes ☐

c. Does the client have a Gold Card, or a White Card with an accepted condition or Provisional Access to Medical Treatment (PAMT) that is reasonably related to persisting pain? No ☐ Yes ☐

Please state relevant accepted or PAMT condition if White Card holder.

d. Is the client's persistent pain and general health in a reasonably stable state? No ☐ Yes ☐

Clients with any of the following are likely to benefit from individual care or delaying commencement of a pain program:

- those who are recovering from or have planned surgeries / interventions e.g. knee replacement for severe knee osteoarthritis
- those who are not engaged in clinically necessary treatments e.g. severe depression with limited or no psychological care
- those who are receiving intensive treatment for an unstable non-pain condition e.g. severe depression.

e. Is the program delivered by an appropriately qualified, trained and experienced multidisciplinary clinical team? No ☐ Yes ☐

A multidisciplinary pain program should include clinicians from a variety of medical and allied health disciplines who have experience in pain management. Programs should be supervised by an appropriately trained clinical lead with expertise in pain management.

f. Is the program in line with current evidence informed clinical practice? No ☐ Yes ☐

Please review your program against research evidence, including resources as published by The Australian Pain Society, International Association for the Study of Pain (IASP) and Agency for Clinical Innovation.

g. Is the client ready for change? No ☐ Yes ☐

Clients in the precontemplation stage of readiness for change may benefit from individual treatment.

h. Has the client been assessed in the last 3 months as suitable to participate in a group program of the proposed intensity? No ☐ Yes ☐

Pain program effectiveness is dependent on careful participant selection based on individual characteristics and clinical need. Individual treatment can be more appropriate for some clients.

i. If an individual or low intensity program is requested, has the client been referred by a pain specialist and/or their usual treating GP? No ☐ Yes ☐ Not applicable ☐

j. If a moderate to high intensity program is requested, has the client had pain specialist involvement or been referred by and assessed as suitable by a pain specialist, and other relevant members of the programs multidisciplinary team? No ☐ Yes ☐ Not applicable ☐

It is the requesting providers responsibility to choose a suitable intervention based on assessment of the client, with consideration of the client's expectations of, and agreement to attending the program.

If you answer 'No' to this question DVA may fund a multidisciplinary assessment for eligible clients. Please complete a D1328 form. The date of assessment must have been within 6 weeks of this request.

k. Have all barriers that may impair the client's ability to participate effectively in the group, and not affect other participants, been excluded? No ☐ Yes ☐

Examples of barriers affecting participation: personality and personal attributes in group setting, severe mental health conditions including significant drug and alcohol use or problematic anger, poor physical health, recent or upcoming surgery, work commitments, carer responsibilities, travel.

l. Does the program utilise validated pre, post and follow-up measures for assessing individual clinical outcomes? No ☐ Yes ☐

The program must gather evidence of its effectiveness in treating persisting pain using validated outcome measures. This may include evaluating outcomes of healthcare use, pain severity and interference in daily activities, mood, pain catastrophising or pain self-efficacy.

m. Over the last 6 months has the pain program collected data that demonstrates clinically significant improvement across participants? No ☐ Yes ☐

n. Is the client's usual treating GP, and other members of the treatment team aware of this referral, and do you have a process in place for communicating with them? No ☐ Yes ☐

o. Does the program have an ongoing physical and mental health risk assessment and management system in place? No ☐ Yes ☐

p. Is there a follow-up process in place for clients who discontinue the program? No ☐ Yes ☐

As part of the **DVA assurance process**, DVA may request evidence of compliance with the above. Failure to comply will result in the request being declined.

Pain Management Program details

Please attach a brief outline of the program that covers Q8 – Q18 below **OR** complete this section.

☐ Please tick this box if an outline is attached

8 Clinic name

9 Pain program name

10 Does the program report to the electronic Persistent Pain Outcome Collaboration (ePPOC)?

No ☐ Yes ☐

11 Total number of days

12 Total number of hours per day

13 Cost per session

$

Please note: DVA will not fund sessions not attended by the client.

14 Program type (please tick)

This table has been developed as a guide. Detailed guidance can be found at *NSW Agency for Clinical Innovation – Which patient for which program*, (2023) at https://aci.health.nsw.gov.au/networks/pain-management/resources/which-patient-program

☐ **Individual**	☐ **Low**	☐ **Medium**	☐ **High**
1–12 sessions 30–60 minutes each	Total time: 3–20 hours 1–10 sessions 1–8 hours each 1–4 weeks	Total time: 24–36 hours e.g. 3–6 hours/wk over 4–6 weeks	Total time: 50 – 100 hours e.g. 24 hours/wk over 4 weeks

15 Please attach a course outline that includes a brief description of each session and facilitator name for each session. Programs should be in line with current evidence informed clinical practice.

☐ Please tick this box once attached

16 Mode of delivery

☐ In person ☐ Telehealth

17 Maximum number of group participants per session

18 Provide details of all staff involved in the pain program delivery including their qualifications in the table below or please attach staff information

☐ Please tick this box if staff information is attached

Treatment program staff	Name	Provider number	Relevant Qualifications / experience in treating pain
Overseeing Pain Specialist (essential for medium or high intensity programs)			
Physiotherapist or other physical therapy provider			
Psychologist or other mental health provider			
Others			

Clinical information

19 Please outline a history of the client's pain presentation including date of assessment (dd/mm/yyyy).
You may attach a copy of the client's clinical correspondence.

☐ Please tick this box if attached

20 If a moderate or high intensity program is requested, please attach a copy of the pain specialists referral or summary from their assessment

☐ Please tick this box if attached

Pain Specialist's name

Provider number

21 If a moderate or high intensity program is requested and the client's psychological distress is severe, is the client's attendance of the pain program supported by a registered mental health provider treating the client?

No ☐ Yes ☐ ▶ Please attach a letter of support from the treating mental health provider.

Not applicable ☐

22 The choice of program is based on individual assessment which includes consideration of individual circumstances, needs and presenting problems in consultation with the client

Please tick the most appropriate response representing the impact of the following on your client:	Low	Medium	High
Catastrophising	☐	☐	☐
Pain interference	☐	☐	☐
Self-efficacy	☐	☐	☐
Medication reliance	☐	☐	☐
Mood interference	☐	☐	☐
Interpersonal relations	☐	☐	☐
Sleep interference	☐	☐	☐
Functional limitations	☐	☐	☐

23 What are the client's goals?
Tick all that apply

- ☐ Improved functional capacity
- ☐ Increase community and social engagement
- ☐ Improved sleep
- ☐ Improved mood and interpersonal relations
- ☐ Reduced reliance on pain medications (in particular opioid analgesics)
- ☐ Reduce healthcare utilisation
- ☐ Other – please specify

24 Please explain why a contracted hospital pain management program is not being used for this individual

Travel

25 Is the client obtaining treatment from the closest practical provider?

No ☐ ▶ If No, you may need to provide supporting information to your client for DVA to fund travel. Funding of travel for treatment is not assessed as part of this request. Details on DVA travel arrangements can be found at https://www.dva.gov.au/get-support/providers/travel-bookings-providers

Yes ☐

Declaration and acknowledgements

26 I declare and acknowledge the following:

- ☐ The client has given consent for disclosure of their medical information to DVA for the purpose of processing this application.
- ☐ The information contained in this form is accurate to the best of my knowledge.
- ☐ I agree to be contacted about this application should DVA need to clarify any of the responses provided in this form.
- ☐ DVA may ask for evidence that the assessment of the client and proposed treatment meet minimum clinical best practice.
- ☐ If approved, I understand payment will only be made for sessions attended.

Details of the health provider completing the form

Name	
Provider number	
Profession / Title	
Contact number	
Email address	
Date (dd/mm/yyyy)	

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