



Community Nursing Program CLAIMING QUICK REFERENCE GUIDE

This guide is designed to be a quick reference tool to assist providers with claiming for services provided to eligible clients under the DVA Community Nursing Program.

Helpful Definitions and Descriptions

CLAIM PERIOD	The claim period is 28 days and starts from the date the client enters the Program that is, the date of the first face-to-face visit where the comprehensive assessment is completed in the client's home. You submit your claim for payment for services delivered to Medicare at the end of the 28-day claim period.
MAJORITY OF CARE	Majority of care is generally based on visit count, although there are situations when the length of visit time may represent the majority of care. To work out the majority of care for each client by visit count, compare the number of visits for clinical care to the number of visits for personal care, excluding any visits for overnight care which do not count towards the majority of care principle. The type of care with the most visits is the majority of care and becomes the core item for claiming. If there is the same number of visits, the majority of care is clinical.
VISIT TYPE	 Clinical care – nursing care includes medication administration, wound care and palliative care Personal care – includes assistance with hygiene and medication assistance Other care – including palliative, overnight and bereavement follow-up.
VISIT LENGTH	In the Community Nursing Schedule of Fees, visits are categorised by the time spent at each visit: • Clinical care – Short (20 mins or less) and Long (21 mins or more) • Personal care – Short (30 mins or less), Medium (31–45 mins) and Long (46 mins or more) • Other care • Second Worker – choose item for the appropriate visit type (as listed in the Schedule of Fees). • Overnight Care – choose item relevant to the care provided (listed in the Schedule of Fees).

Key Contacts

For enquiries about Medicare claiming processes contact DVA Provider Enquiries 1800 550 457

For claims that have been rejected contact Medicare 1300 550 017 (option 2)

For all other claiming enquiries contact nursing@dva.gov.au

How do I determine the CORE ITEM?

To determine whether to use the clinical or personal care core schedule, add up how many clinical visits and how many personal care visits you did in the 28-day claim period excluding any visits for overnight care. If applicable, consider the length of visits.

example

10 clinical visits + 8 personal visits = clinical care is CORE ITEM; personal care is ADD-ON.

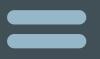


How do I determine the VISIT LENGTH?

Total <u>minu</u>tes



number of visits



average visit length

Add up the total minutes for clinical care and personal care services delivered over the 28-day claim period.

10 visits
450
MINUTES



CLINICAL 450 ÷ 10

Average
45
minutes per visit
= 10 long visits

PERSONAL 240 ÷ 8

Average
30
minutes per visit
= 8 S/M/L visits

Average length of visit and number of visits determines the item numbers you claim on the Schedule of Fees.

Most visits were clinical so we look at the Clinical core schedule (Item NL14).

Personal care will be in the Personal Add-On schedule (Item NT02).

What ITEM NUMBERS do I use for a claim?

Having identified the CORE and ADD-ON items and the average visit length for clinical and personal care, you can find the item numbers for other services you may have delivered or items you may have used in the tables in the Community Nursing Schedule of Fees. The process below is colour coded to the different tables in the Schedule of Fees.

CORE ITEM
Clinical Care
10 long visits
(Item No. NL14)



ADD-ONs*
Personal Care
8 S/M/L visits
(Item No. NT02)



OTHER ITEMS/
CONSUMABLES
(if applicable)



SUBMIT CLAIM TO MEDICARE

^{*} Note: You would also claim from the Second Worker and Overnight Care tables in the Schedule of Fees if services were provided in those areas.