Australian Government
Department of Veterans' Affairs

transforming DVA

Community Nursing Program

Information for providers

July 2026

Version 1.4

Overview of the Community Nursing Program

- Aim - to enhance the independence and health outcomes of DVA clients by providing clinically necessary nursing and personal care services in their own home, avoiding early admission to hospital or residential aged care.
- Contracted providers deliver clinically required nursing and personal care services to eligible DVA clients. This includes:
  - Assessing client needs and developing a care plan
  - Providing care to meet assessed clinical needs (nursing and personal care)
  - Re-assessing needs over time and updating care plans
  - Liaising with other health care providers as required

Care environment

- Providers must deliver all services face to face in the client's home
- Providers CANNOT deliver services in any of the following locations:
    - o Acute care facility (e.g. hospital)
    - o Residential aged care home
    - o Multi-purpose centre or community centre
    - o Clinic of any type or location

Eligibility for community nursing services

- Veteran Card – All Conditions holders can receive community nursing services to meet their assessed clinical nursing and personal care needs
- Veteran Card – Specific Conditions holders with an accepted condition can access services that directly relate to their accepted condition/s – eligibility must be confirmed by DVA before commencement of services
- Veteran Card – Specific Conditions with current approval for Provisional Access to Medical Treatment (PAMT) and recipients of Non-Liability Health Care are also eligible
- Providers are responsible for confirming each client's eligibility prior to commencing services. DVA is not liable for services provided to ineligible clients
- If a client has a Veteran Card – Specific Conditions, contact DVA Provider Enquiries on 1800 550 457 to determine if a client is eligible to receive DVA funded Community Nursing services

Referrals

- Providers must receive a valid written referral from an authorised referral source:
  - GP
  - treating medical practitioner in a hospital
  - hospital discharge planner
  - nurse practitioner
- Referrals from GPs are valid for 12 months / hospital and nurse practitioner referrals are valid for 6 weeks
- Referrals must be renewed every 12 months or after each episode of care (i.e. if a client is out of care for over 28 days, a new referral is required)
- Referrals should outline the clinically required nursing and personal care services to meet an assessed nursing care need. Providers must confirm the requested services are in scope for the Community Nursing Program
- DVA does not refer clients to a provider - it is the provider's responsibility to promote their availability to eligible referrers

Scope of program services

- All services provided must be **within scope** of the program i.e. clinically required nursing and/or personal care services
- Services that are **out of scope** include:
  - X Hospital substitution services (e.g. HITH)
  - X Respite care and/or supervision
  - X Instrumental Activities of Daily Living (IADLs) e.g. laundry, cleaning, social assistance, companionship, shopping, meal preparation, driving
  - X Transport and accommodation
  - X Duplication of services

Delivery of services with multiple providers

- Clients **can** access DVA services as well as Department of Health, Disability and Ageing (DHDA) funded services e.g. Commonwealth Home Support Programme / Support at Home program

- Community Nursing providers should liaise with other service providers to ensure no duplication of services and that the client's clinical care needs are being met.

- Providers can support clients to maximise the services available

- Where a client is eligible for DVA Community Nursing services, they should never be billed directly for clinically required nursing care because they are entitled to access these services through DVA to meet their care needs (this includes where they are receiving DHDA services)

Program requirements – service delivery

- Services must be delivered in line with the Notes for Community Nursing Providers (the Notes). Providers are responsible for understanding and complying with the Notes – the Notes form part of the contract with DVA.

- Before services commence:
  - ✓ A comprehensive nursing assessment must be conducted by an RN
  - ✓ The RN must develop an individual nursing care plan with each client based on the comprehensive nursing assessment, and the nursing care plan must only include services within scope of the Community Nursing Program
  - ✓ Client (or authorised legal representative) must agree and sign the nursing care plan before services commence

- Any care needs outside of scope should be referred to the GP (or relevant service provider e.g. allied health, aged care assessment, Veterans' Home Care services)

- DVA expects the client's GP to have ongoing clinical oversight and management of the client's care. As such, the Community Nursing provider must communicate with a client's GP on a regular basis

Program requirements – service delivery

- All care must be overseen and delegated by an RN
- Clinical care services can only be delivered by an RN or EN (without notation) (e.g. wound care, medication administration)
- Personal care services can be delivered by personal care workers (PCWs) or RNs/ENs (e.g. showering/hygiene, assistance with eating, continence care)
- Care requirements must be assessed by an RN and care plans updated, as needed or at least every 3 months
- Care may be short term or long term, depending on the client's clinical needs (e.g. short term after an operation for wound care, or long term if assistance is required ongoing for showering/hygiene needs etc)

Program requirements – documentation

- DVA undertakes routine compliance monitoring of community nursing services. As part of this, documentation will be requested from providers as part of the review, including:
  - Valid community nursing referrals
  - Comprehensive nursing assessment
  - Nursing care plan/s
  - Progress notes
- Other documentation may be requested where applicable, including relating to medication, wound management, and to support overnight care
- Providers are expected to maintain all relevant documentation in line with requirements in the Notes for Community Nursing Providers

Reviews

- Providers must conduct a review of the care needs at set times, or at any time if the care needs change
  - Seven day review
    - All Exceptional Cases (RN)
    - When classified under Personal Care schedule and medication assistance services delivered by a PCW (RN or EN without notation)
  - 28 day review
    - When classified under Clinical Care schedule (RN)
    - When classified under Personal Care schedule (with no CC add on or CC overnight) (RN or EN)
  - Three monthly review
    - RN (regardless of service type)
    - Includes comprehensive review of assessment and nursing care plan

Claiming for services – 28 day period of care

- Claiming for the DVA Community Nursing Program is based on an episode of care model where providers claim retrospectively at the end of each 28 day claim period
- Each claim period is 28 days and is unique to each client based on their date of admission
- The date of admission is the first face-to-face contact visit between a Community Nursing provider's personnel and the client
  - *The first face-to-face contact must include a comprehensive assessment undertaken by an RN, in the client's home. This is the start of the first 28 day claim period*
- Providers must continue claiming based on the initial claim period start date for all future claiming periods during the episode of care
  - *A new claim period cannot commence prior to the end of the previous claim period. If a claim with an earlier start date is submitted this will be rejected by Medicare*
  - *Episode of care will end if client is absent from services for more than 28 days*
- Providers claim for services **after** the completion of each 28 day period
- Ready reckoners assist providers in determining the 28 day claim period cycles

Claiming for services – Schedule of Fees

- The Community Nursing Schedule of Fees is the non-negotiable fee schedule that compensates providers for the costs associated with the delivery of services for each client during a 28-day claim period
- Providers claim for all services provided within the 28 day claim period using the relevant item number/s from the Schedule of Fees
- Each claim period, providers determine whether to claim a **Clinical Care core item** OR **Personal Care core item**, under the majority of care principle
  - Providers determine the majority of care provided to each client by comparing the number of clinical services delivered to the number of personal care services delivered in each 28-day claim period
  - Majority of care is generally based on visit count, although in some cases the length of visit time may represent the majority of care. The majority of care determines the **core** item for claiming
  - Where time and the number of visits have been equally spent on clinical and personal care, the client should be classified under the Clinical Care core

Claiming for services – Schedule of Fees

- Providers can claim additional items from the Schedule of Fees where applicable
  - Add-ons – Clinical Care or Personal Care e.g. where a Clinical Care core item is claimed, a Personal Care add-on may also be claimed if personal care services were provided in the same 28 day claim period
  - Other Items – assessment, bereavement, palliative care, additional travel
  - Second Worker
  - Overnight Care
- Where providers have **obtained and used** eligible nursing consumable items to provide care for clients, these can be claimed using the relevant Nursing Consumables item number from the Schedule of Fees. Providers cannot claim for items in the 'nurses toolbox' or items available through RAP and/or the PBS.
- Community Nursing quick reference guide assists providers in determining the relevant item number to use when claiming

Medicare claiming

- Two options are available for claiming DVA Community Nursing services through Medicare (Services Australia):
  - Medicare Online claiming
    - Community Nursing providers can lodge claims for payment through Medicare Online claiming. This is the preferred method for claiming and allows for the automatic submission of the Minimum Data Set (MDS)
    - Providers can only submit online claims using Medicare compliant software (refer to Software developers for Medicare Online)
  - Manual claiming
    - Providers must complete hard copy forms and vouchers that are submitted via post to Medicare for processing
    - Community Nursing providers who claim for services manually must submit MDS each claim period by using the MDS Collection Tool. The MDS Collection Tool is an Excel spreadsheet that is used to collect MDS data manually

Rejected claims

- If claims are rejected by Medicare, providers should contact Medicare in the first instance on 1300 550 017 (select Option 2)
- Where Medicare advises that the provider needs to contact DVA regarding rejected claims, please email nursing@dva.gov.au with rejected claim details and the Medicare response
- Providers must ensure they use the current and correct provider number for each claiming period – claims will be rejected by Medicare if the incorrect provider number is used and will need to be resubmitted

Exceptional Cases

- Where the care required for a client falls significantly outside the Schedule of Fees, a provider may submit an Exceptional Case (EC) application to the Community Nursing Program for consideration of funding
  - *Only DVA contracted Community Nursing providers can submit an EC application and receive approval – these cannot be submitted by clients/family members or other health care providers*
- DVA will review EC applications for completeness and will advise in writing if additional information is required. We endeavour to provide an outcome within 10 business days upon receipt of a complete application
- EC care requires **prior approval in writing** before the commencement of care
  - *The provider receives approval for the funding of services to the client – the client does not receive the approval or the funding*
- The approval letter will detail the services approved and include the amount claimable per 28-day claim period
  - ***DVA will only fund care that is clinically required*** *and as such, approval may differ to what was requested - details should be carefully reviewed before services commence*

Exceptional Cases

- Where **urgent circumstances** apply regarding the commencement of care, the provider can contact DVA via secure email to outline these special circumstances and request urgent approval. At DVA's discretion, one off approval can be granted for a short period of time to provide EC care without a comprehensive application
  - *DVA will provide urgent approval in writing*
  - *Where urgent approval is granted, the provider is required to submit the completed EC application within five business days for assessment and processing*

- EC requirements are at Attachment A of the Notes
- EC application forms are on the DVA Website
- EC funding approval includes all required care for the claim period. Providers cannot claim care through Schedule of Fees items while there is an EC approval in place
  - *Any care delivered within the claim period before the EC approval will be incorporated into the EC approval amount*
  - *Exception to this is claiming for Nursing Assessment, Additional Travel, Nursing Consumables and Bereavement visit*

Palliative care

- Providers can deliver palliative and/or end of life care services to eligible clients
- Palliative care should generally be provided under the supervision of the relevant palliative care specialist or team, where clinically required
- Providers DO NOT require prior approval to deliver services that can be claimed for under the Schedule of Fees
- The DVA office is closed outside of business hours, over the weekend and on public holidays. During this time, Community Nursing providers should continue to deliver clinically required nursing services for eligible DVA clients under standard arrangements, in line with the Notes for Community Nursing Providers and the Schedule of Fees.
  - If an eligible client requires urgent care to commence outside of DVA usual business hours, and the clinically required care exceeds what can be provided under the Schedule of Fees, providers should deliver necessary care that is within scope of the Community Nursing Program. The provider must immediately advise DVA in writing by email to exceptional.cases@dva.gov.au **prior to the care commencing**. DVA will respond the next business day.

Strengthened Aged Care and Quality Standards

- The Community Nursing Program aligns with the strengthened Aged Care Quality Standards
- The Standards place a holistic focus on the individual and provide clarity for providers about service standards and expectations
- Each of the five quality standards has a set of outcomes against which providers can self-assess their performance
  - Standard 1: The Person
  - Standard 2: The Organisation
  - Standard 3: The Care and Services
  - Standard 4: The Environment
  - Standard 5: Clinical Care

Resources for providers

- Community Nursing Newsletters
  - It is important that all providers and their staff read the Newsletters as these contain important information and updates
  - Ensure contact details are kept up to date

- Community Nursing services - A guide for veterans, family members and carers

- Client Charter
  - DVA Community Nursing clients' rights and responsibilities
  - Promoted via the Newsletter and on the DVA website, providers should comply with and promote with clients so they understand their rights and responsibilities under the program

Resources for providers

- DVA website
  - Community Nursing Program information for providers
  - Notes for Community Nursing Providers
  - Community Nursing Schedule of Fees
  - Training and resources for Community Nursing providers

Enquiries and contact details

- Community Nursing Program enquiries

  nursing@dva.gov.au

- Exceptional Case applications and enquiries

  Exceptional.cases@dva.gov.au

- Claiming
  - Provider software, general and rejected claims - contact Medicare in the first instance on 1300 550 017 (select Option 2)
- Contract enquiries and updating provider details

  community.nursing.contracts@dva.gov.au