



Australian Government

Military Rehabilitation and Compensation Act 2004

MRCA TREATMENT PRINCIPLES

Instrument 2013 No. MRCC 53

I, Michael Ronaldson, Minister for Veterans' Affairs, pursuant to section 286(3) of the *Military Rehabilitation and Compensation Act 2004*, approve this instrument made by the Military Rehabilitation and Compensation Commission.

Dated this 26th day of November 2013

Michael Ronaldson.....

MICHAEL RONALDSON

The Military Rehabilitation and Compensation Commission:

(a) pursuant to section 286(2) of the *Military Rehabilitation and Compensation Act 2004* (the Act) revokes the instrument made under section 286(1) of the Act known as the *MRCA Treatment Principles* (Instrument 2004 No. M21); and

(b) pursuant to section 286(1) of the Act hereby determines the places at which, the circumstances in which, and the conditions subject to which, a particular kind or class of treatment may be provided under Part 3 of Chapter 6 of the Act; and determines the matters in paragraphs 286(1)(d), (e) (f) and (g) of the Act.

Dated this 13th day of November 2013

The Seal of the
Military Rehabilitation
and Compensation Commission
was affixed hereto in the
presence of:)
)
)SEAL
)
)

Simon Lewis.....	Shane Carmody.....	Major General Mark Kelly.....
SIMON LEWIS	SHANE CARMODY	MAJOR GENERAL MARK KELLY
CHAIR	MEMBER	MEMBER
		AO DSC

Kylie Emery.....	Rear Admiral Robyn Walker AM, RAN
MS KYLIE EMERY	REAR ADMIRAL ROBYN WALKER AM, RAN
ACTING MEMBER	ACTING MEMBER

MRCA Treatment Principles

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PART 1 — INTRODUCTION



Australian Government

MILITARY REHABILITATION AND COMPENSATION COMMISSION

Military Rehabilitation and Compensation Act 2004

Section 286

MRCA Treatment Principles

Instrument 2013 No. MRCC 53

PART 1 — INTRODUCTION

1.1.1 This Instrument is known as the *MRCA Treatment Principles* and is prepared by the Military Rehabilitation and Compensation Commission (Commission) under section 286 of the *Act*.

1.1.2 The *MRCA Treatment Principles* set out the places at which, the circumstances in which, and the conditions subject to which, a particular kind or class of treatment may be provided for *entitled persons* under Part 3 of Chapter 6 of the *Act* and are to be read subject to the *Act*. *The MRCA Treatment Principles* also set out:

- (a) the places at which, the circumstances in which, and the conditions subject to which, a particular kind or class of treatment may be provided under Part 3 of Chapter 6 of the *Act*;
- (b) the kinds or classes of treatment that will not be provided under Part 3 of Chapter 6 of the *Act*;
- (c) the places at which, the circumstances in which, and the conditions subject to which, treatment will not be provided under Part 3 of Chapter 6 of the *Act*;
- (d) whether the *Commission's* prior approval of a particular kind or class of treatment is required under Part 3 of Chapter 6 of the *Act*;

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- (e) if the *Commission*'s prior approval is required:
- (i) the circumstances in which the *Commission* may exercise its power to give prior approval; and
 - (ii) the circumstances in which the *Commission* may exercise its power to give approval if the treatment was obtained without prior approval.

1.1.3 The *MRCA Treatment Principles* state the policies under which the Commission may accept financial responsibility for the cost of treatment for persons entitled to treatment under the *Act*.

Note: Consistent with the *Act*, treatment extends beyond medical treatment and encompasses social and domestic assistance.

1.1.4 The *MRCA Treatment Principles*, except the references to “SRCA disability” in paragraph 1.4.1, commences on the day after it is registered on the Federal Register of Legislative Instruments.

1.1.5 The references to “SRCA disability” in paragraph 1.4.1 commence on 10 December 2013.

Note: on 1 July 2013 the *Veterans' Affairs Legislation Amendment (Military Compensation Review and Other Measures) Act 2013* (amending Act) amended, among other Acts, the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) to enable certain employees (service personnel) with compensable conditions to obtain treatment for those conditions under the *Veterans' Entitlements Act 1986* or the *Military Rehabilitation and Compensation Act 2004*. The amendment made by Schedule 11 of the amending Act commences on 10 December 2013.

1.2 Application of MRCA Private Patient Principles

1.2.1 The MRCA Private Patient Principles (the MPPPs), determined by the *Commission* under paragraph 286(1)(b) of the Act, apply in all States and Territories

1.2.2 A provision of the *MRCA Treatment Principles* does not apply if it is inconsistent with the MPPPs.

1.2.3 Nothing in these Principles is to be taken to require prior approval for admission at a public hospital in a State or Territory.

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1.3 Delegation

1.3.1 The *Commission* may delegate all or any of its powers under the *Principles* (except this power of delegation) in the same manner, and subject to the same conditions, that it may delegate all or any of its powers under the *Act*.

Note: section 384 of the *Act* sets out the circumstances in which the *Commission* may delegate its powers.

1.4 Interpretation

1.4.1 In these Principles, unless a contrary intention appears:

“**ABN (Australian Business Number)**” has the meaning given by the *A New Tax System (Australian Business Number) Act 1999*.

“**aboriginal health worker**” means a person who is qualified as an aboriginal health worker after undertaking a course in Aboriginal and Torres Strait Islander Health, provided by an institution recognised by the *Department of Prime Minister and Cabinet* as suitable for providing a course of that nature, and who obtained a Certificate Level III (or higher) under the course.

“**Aboriginal Health Worker Care Co-ordination treatment**” means treatment provided by an *aboriginal health worker* to an *entitled person* under the *Coordinated Veterans' Care Program*, comprised of:

- (a) implementing the *GPMP* for the person under the Program — in particular co-ordinating treatment services under the *GPMP*;
- (b) liaising, in relation to the *GPMP*, with the *LMO* who manages the *GPMP* for the person;
- (c) performing such other functions under the program that the *aboriginal health worker* has under the *Notes for Coordinated Veterans' Care Program Providers*.

“**ACPMH treatment**” means action taken with a view to maintaining an *entitled member* in mental health and includes:

- (a) training members of the Defence Force or staff made available under section 382 of the *Act*, or both, in the mental health care disciplines that could benefit the mental health of an *entitled member*; and

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- (b) conducting research into mental injuries or diseases suffered by members of the Defence Force or into the mental state generally of such members with the resulting knowledge being applied to the benefit of the health of an *entitled member*; and
- (c) improving communication on mental injury or disease health care matters between:
 - (i) members of the Defence Force who are staff-managers; and
 - (ii) staff made available under section 382 of the *Act*; and
 - (iii) an *entitled member*; and
- (d) conducting mental injury or disease health care policy research with the outcomes of that research being applied to the benefit of the health of an *entitled member*.

Note (1): under section 13 of the *Act* treatment can be action taken with a view to maintaining a person in physical or mental health.

Note (2): the term “member” is defined in these *Principles* so as to include “former member” and the term “Defence Force” is defined in s.5 of the *Act*.

“**Act**” means the *Military Rehabilitation and Compensation Act 2004*.

“**admission date**” means the date on which an *LMO* records in writing (including in electronic form) that the *LMO* has decided an *entitled person* may participate in the *Coordinated Veterans' Care Program*.

“**admitting LMO**”, in relation to an *entitled person* in the *Coordinated Veterans' Care Program*, means the *LMO* who decided an *entitled person* may participate in the *Coordinated Veterans' Care Program*.

“**allied health provider**” means a category of provider mentioned in the Table in 7.1A.1.

“**approved provider**” means a State, Territory or Local Government, or incorporated organisation, or person, that has entered into an arrangement with the *Commission* for the provision of:

- (a) a *Home Care service (category A)*; or
- (b) a *Home Care service (category B)*; or
- (c) a *Home Care service (category C)*; or
- (d) a *limited MHC-type service*;

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to an *entitled person*, whether by the *approved provider* or a *sub-contractor* engaged by it.

“Australian Government’s Better Access initiative” means the mental health initiative described in the document entitled “Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative” *in force on the date in Schedule 1*.

“Australian Centre for Posttraumatic Mental Health” and **“ACPMH”** mean the Australian Centre for Posttraumatic Mental Health Incorporated.

“authorised nurse practitioner” has the meaning it has in subsection 84(1) of the *National Health Act 1953*.

“Authorised Representative”, in relation to a medical practice in which a *participating LMO* is employed, means the person whose name is given as the Authorised Representative for the Practice in the form: “Application for Practice and Provider registration to In-Home Telemonitoring for Veterans Initiative” lodged with the Department of Human Services.

“acute care certificate” means a certificate given by a medical practitioner in similar form to the acute care certificate provided for in section 3B of the *Health Insurance Act 1973* to the extent that the provisions of that section are applicable.

“approved provider”, in relation to *transition care*, has the meaning it has in the *Aged Care Act 1997*.

Note: the *Aged Care Act 1997* can be found on COMLAW: <http://www.comlaw.gov.au>

“carer” means a person who provides ongoing care, attention and support for a severely incapacitated or frail person to enable that person to continue to reside in his or her home, and is not limited to a person who is receiving a carer service pension.

“Centre for Military and Veterans’ Health” means the entity in the University of Queensland, Herston Campus, operated by the *Board of Management*.

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“Chief Executive Medicare” has the meaning it has in the *Human Services (Medicare) Act 1973*.

“clinical psychologist” means a *psychologist*:

- (a) who has been given a *provider number* in respect of being a psychologist; and
- (b) who, in the opinion of an employee of, or consultant to, the *Department* or the *Department of Human Services*, has appropriate qualifications in clinical psychology and practises as a clinical psychologist.

“CMVH treatment” means action taken with a view to maintaining a member in physical or mental health and includes:

- (a) training members of the Defence Force in the health care disciplines that could benefit the health of a member;
- (b) conducting research into injuries or diseases suffered by members of the Defence Force or into the state of health generally of such members with the resulting knowledge being applied to the benefit of the health of a member;
- (c) improving communication on health care matters between members of the Defence Force who are staff-managers and a member; and
- (d) conducting health-care policy research with the outcomes of that research being applied to the benefit of the health of a member.

Note: under section 13 of the *Act* treatment can be action taken with a view to maintaining a person in physical or mental health.

“Commission” means the Military Rehabilitation and Compensation Commission.

“Commission-funded treatment” means treatment for which the Commission may accept financial responsibility.

Note: although the Commission may accept financial responsibility for treatment, actual payment for that treatment is made by the Commonwealth. See paragraph 423(c) of the *Act*.

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“community nurse” means a *registered nurse* or *enrolled nurse* who works in a community nursing setting and who is employed or engaged by a *DVA-contracted community nursing provider*.

“Community Nurse Care Co-ordination treatment” means treatment provided by a *community nurse* to an *entitled person* under the *Coordinated Veterans' Care Program*, comprised of:

- (a) implementing the *GPMP* for the person under the Program — in particular co-ordinating treatment services under the *GPMP*; and
- (b) liaising, in relation to the *GPMP*, with the *LMO* who manages the *GPMP* for the person.

“community nursing services” means the community nursing services provided to an *entitled person*, in respect of which the *Commission* will accept financial responsibility for under Part 7 of the *Principles*.

“community services” means services provided by Commonwealth, State, Territory or local government authorities or agencies (other than the Department of Veterans' Affairs or the Repatriation Commission) and other community agencies (whether or not funded in whole or in part by a government).

“consumable rehabilitation appliance” means an appliance with a short term function and includes appliances such as continence products.

“Contracted Day Procedure Centre” means premises:

- (a) at which any patient is admitted and discharged on the same day for medical, surgical or other treatment; and
- (b) operated by a person contracted to the *Commission*, the *Repatriation Commission* or the *Department* in respect of treatment provided at the premises to *entitled persons*;

but does not include any of the following premises:

- (c) premises conducted by or on behalf of the State;
 - (d) a public hospital or health service under the control of a public health organisation;
 - (e) a *private hospital*;
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- (f) a nursing home;
 - (g) a residential rehabilitation establishment.

“contracted private hospital” means a private hospital with which the Commission has entered into arrangements for the care and welfare of entitled persons.

“convalescent admission” means a short period of medically prescribed convalescence for a entitled person who is recovering from an acute illness or an operation.

“Coordinated Veterans' Care Program” means the treatment program of that name set out in Part 6A of these *Principles* and in the *Notes for Coordinated Veterans' Care Program Providers* that aims to reduce the need for hospitalisation among *Gold Card* members of the veteran and defence force community and improve their social well-being. In particular the program has the following main features:

- assessment - a Local Medical Officer (LMO) will assess a person with complex care needs due to chronic disease to see if the person would benefit from the clinical care services under the program and ascertain if the person meets the program’s eligibility criteria;
- consent – a person needs to consent in writing to participation in the program and the LMO needs to record that consent. As treatment is being provided it is the LMO’s responsibility to ensure a potential participant in the program understands the nature of the program and that the person’s personal details that are relevant to the person’s treatment under the program may be provided to bodies and individuals such as the *Department*, the *Department of Human Services* and health care providers, who have a need for the information in connection with the person’s treatment under the program.
- care plan – the LMO will prepare a comprehensive care plan (GPMP) for a person the LMO admits to the program;
- consultation - the person will be consulted in the preparation of the care plan and its review;
- implementation and co-ordination - the LMO’s practice nurse (or a community nurse via a DVA-contracted community nursing provider, or an aboriginal health worker, if more appropriate) will implement the care plan and, in particular, co-ordinate services under the plan.

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“Coordinated Veterans' Care Program treatment” means:

- (a) *LMO Care Leadership treatment*; or
- (b) *Practice Nurse Care Co-ordination treatment*; or
- (c) *Community Nurse Care Co-ordination treatment*; or
- (d) *Aboriginal Health Worker Care Co-ordination treatment*.

“co payment”, in relation to the *MRCA Home Care Program*, means an amount of money an *approved provider* or a *sub-contractor* is permitted to charge an *entitled person*, pursuant to an arrangement between the *approved provider* and the *Commission*, in respect of a *Home Care service (category A)*.

“country area” means that part of the State outside the metropolitan area of the capital city of that State, determined by the Repatriation Commission to be a country area under paragraph 80(2)(b) of the *Veterans' Entitlements Act 1986*.

“data repository” means a repository of *telemonitoring initiative data* controlled by the *data repository controller* for the purposes of monitoring a *telemonitoring initiative participant's* physiological and behavioural data according to the *telemonitoring care plan* for that participant.

“data repository controller” means a person engaged by the *Department* to establish and maintain the *data repository* for the purposes of the *In-Home Telemonitoring for Veterans Initiative*.

“Day Procedure Centre” means premises that would be *Contracted Day Procedure Centre* premises if the operator of the premises was contracted to the *Commission*, the *Repatriation Commission* or the *Department*.

“DVA-contracted community nursing provider” means a community nursing provider who has entered into a Deed of Standing Offer with the *Commission* to provide *community nursing services to entitled persons*.

“DVA document” means a document prepared in the *Department* and available on the Internet at:

<http://www.dva.gov.au/Pages/home.aspx>

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“DVA Telemonitoring Practice Incentive” means the payment of that name referred to in the “Department of Veterans’ Affairs Fee Schedules for Medical Services” and which is payable once only to the *Authorised Representative* for a medical practice — where, in the *Commission’s* opinion, all necessary steps have been taken to enable a *participating LMO* (and any Practice Nurse of the LMO) employed in the Practice to effectively participate in the *In-Home Telemonitoring for Veterans Initiative*

“dental hygienist” means a person registered under the *National Law* that provides for the registration of dental practitioners but does not include a person:

- (a) whose registration to practise as a *dental hygienist* has been suspended, or cancelled, following an inquiry relating to his or her conduct; and
- (b) who has not, after that suspension or cancellation, again been authorised to practise as a *dental hygienist*.

“dental therapist” means a person registered under the *National Law* that provides for the registration of dental practitioners but does not include a person:

- (a) whose registration to practise as a *dental therapist* has been suspended, or cancelled, following an inquiry relating to his or her conduct; and
- (b) who has not, after that suspension or cancellation, again been authorised to practise as a *dental therapist*.

“dental prosthetist” means a person, however described, authorised under a law of a State or a Territory, to carry out the work of dental prosthetics without a written work order from a dentist or other person who may lawfully give a written work order for that purpose.

“dental specialist” means a qualified dental practitioner who:

- (a) is registered with a Dental Board of the State or Territory in which he or she practises; and
- (b) has obtained an appropriate higher qualification; and
- (c) has been recognised as a specialist in the particular field by:

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- (i) a Dental Board of the State or Territory in which he or she practises, where the Dental Board of the State or Territory has available a mechanism for such recognition; or
- (ii) another appropriate body mutually agreed in advance with the Australian Dental Association Incorporated.

“dentist” means a person registered or licensed as a dentist under a law of a State or Territory that provides for the registration or licensing of dentists but does not include a person so registered or licensed:

- (a) whose registration, or licence to practise, as a dentist in any State or Territory has been suspended, or cancelled, following an inquiry relating to his or her conduct; and
- (b) who has not, after that suspension or cancellation, again been authorised to register or practise as a dentist in that State or Territory.

“enrolled nurse” means a person who is registered under a law of a State or Territory or of the Commonwealth to practise as an enrolled nurse.

“enrolment day”, in relation to a person, means the date given for a decision by a *participating LMO* to enrol the person as a participant in the *In-Home Telemonitoring for Veterans Initiative*.

Note: see 6B.2.4 - 6B.2.6.

“Department” means the Commonwealth as represented by the Department of Veterans’ Affairs.

“Department of Health” means the Commonwealth Department of State, however named, that from time to time is responsible for the administration of the *National Health Act 1953*.

“Department of Human Services” means the Department administered by the Minister administering the *Human Services (Medicare) Act 1973*.

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“Department of Prime Minister and Cabinet” means the Commonwealth Department of State responsible for Commonwealth Aboriginal and Torres Strait Islander policy, programmes and service delivery.

“Department of Social Services” means the Commonwealth Department of State, however named, that from time to time is responsible for the administration of the *Aged Care Act 1997*.

"dependent eligible young person" has the same meaning as "dependent child" in the *Social Security Act 1991*.

“diabetes educator” means a person who:

- (a) is credentialled as a *diabetes educator* by the Australian Diabetes Educators Association (ADEA); and
- (b) is a member of, or eligible for membership of, the ADEA.

“diabetes educator services” means a program of education about diabetes with an emphasis on self-care, provided by a *diabetes educator* to a person with diabetes.

"Domestic Assistance" means the service under the *MRCA Home Care Program* consisting of:

- (a) assistance with domestic chores, including assistance with cleaning, dishwashing, clothes washing and ironing, shopping and bill paying; and
- (b) help with meal preparation where this is not the primary focus of the occasion of the service; and
- (c) in remote areas, activities such as collecting firewood.

“elective surgery” means any non-urgent surgical procedure performed for diagnostic or therapeutic purposes.

"eligible young person" has the meaning it has in section 5 of the *Act*.

“emergency” means a situation where a person requires immediate treatment in circumstances where there is serious threat to the person’s life or health.

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"emergency short term home relief" means care provided to an *entitled person* in his or her *home* on the following conditions:

- (a) the person or the person's carer is unable to provide care due to sudden and unforeseen circumstances; and
- (b) the period for which the care is provided does not exceed 72 hours (episode) per emergency except that, if the *entitled person* requires further care within 24 hours after the end of the previous episode in an emergency, and obtains prior approval, a further episode of care (up to 72 hours) may be provided in that emergency; and
- (c) the cumulative period of the care provided to the *entitled person* did not exceed 216 hours in a Financial year.

Note (1): *emergency short term home relief* is not relevant to the calculation of residential care amounts for *residential care* or *residential care (respite)*.

"entitled member" means a member or former member as defined in section 5 of the *Act* who is or was entitled to treatment under Part 3 of Chapter 6 of the *Act* and means a person with a *SRCA disability*.

"entitled person" means a person who is entitled to treatment under Part 3 of Chapter 6 of the *Act*.

Note: this includes a person with a *SRCA disability*.

"wholly dependent partner" or "wholly dependent partnerer" means a wholly dependent partner as defined in section 5 of the *Act*.

"episode of care" means services provided to a patient by a health provider that:

- (a) have been detailed in a patient care plan;
- (b) are characterised by continuity of treatment or provision of service; and an episode of care arises:
- (c) every time a service provider sees a new patient; or

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- (d) where a service provider has not seen a patient for some time and therefore no continuity of service can be provided, and the original patient care plan is no longer applicable or appropriate.

“exceptional case process” means the process whereby the *Commission* may accept financial liability for *community nursing services* provided to an *entitled person* who, due to dependency or complex needs, requires *community nursing services* which, in the opinion of the *Commission*, fall significantly outside those referred to in any arrangement between the *Commission* and a *DVA-contracted community nursing provider*.

Note: paragraph 3.5.1 (after paragraph (f)) enables the *Commission*, in exceptional circumstances to, among other things, accept financial liability for fees higher than those set out in an arrangement.

"excluded service" means a service within the scope of the Home and Community Care Program established under the *Home and Community Care Act 1985*, as amended from time to time, that is commonly known as:

- (a) domestic assistance or personal care; or
- (b) home maintenance; or
- (c) respite care;

Note (1): for the purposes of this definition, "respite care" does not include centre-based day care (also called "day centre respite" or adult day activity centres").

Note (2): the intention is that a Home Care service (category A), Home Care service (category B) and Home Care service (category C) are mutually exclusive.

"exempt amount" means an amount of money not payable by an *entitled person* in respect of any *Home Care service (category A)* or *Home Care service (category C)* provided to the *entitled person* by an *approved provider*, because the *entitled person* is an *exempt entitled person*.

"exempt entitled person" means, in relation to the provision of any *Home Care service (category A)* or *Home Care service (category C)* to an *entitled person*, an *entitled person* who:

- (a) has a *dependent eligible young person*; or

Note: under the *Acts Interpretation Act 1901* the singular includes the plural meaning a person can have more than one dependent eligible young person.

- (b) is a person who, in the opinion of the *Commission*, is experiencing severe financial hardship or who could experience severe financial

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hardship if the person was to make a payment in respect of the service; or

- (c) is in receipt of an *income support payment* at the maximum rate and does not earn, derive or receive *ordinary income* exceeding \$40 per fortnight.

Note: the *Commission* may allow exemption from payment for a period or until the occurrence of an event.

“Fee Schedule” means a *DVA document* approved by the *Repatriation Commission*, the *Commission*, or a member of the *Repatriation Commission* or of the *Commission*, or by the Secretary to the *Department*, with the words “Fees” and “Schedule”, in relation to a category of *health care provider*, in the title to the document, that sets out the terms on which, and the conditions subject to which, the *Commission* will accept financial responsibility for treatment provided to an *entitled person* by the *health care provider* the subject of the document.

Note: the DVA documents called Fee Schedules set out amounts the *Department* will pay for health care services and can designate whether a service required the prior approval of the *Commission* before it could be provided.

“flexible care” has the meaning it has in section 49-3 of the *Aged Care Act 1997*.

“General information about VVCS – Veterans and Veterans Families Counselling Service” means the *DVA document* of that name *in force on the date in Schedule 1* that, among other things, sets out the criteria for eligibility for *VVCS*.

“Gold Card” means the identification card described as the Repatriation Health Card - For All Conditions and provided to a person who is entitled under the *Act* to treatment, subject to these Principles, for all injuries or diseases.

“GPMP” means the care plan prepared by an *LMO*, in accordance with the *Notes for Coordinated Veterans' Care Program Providers*, for an *entitled person* participating in the *Coordinated Veterans' Care Program*.

Note: “GPMP” is used in the Department of Veterans’ Affairs Fee Schedules for Medical Services (see: paragraph 3.5.1).

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“health care provider” means a person who provides treatment to an *entitled person* in accordance with these *Principles*.

“high level of residential care” has the same meaning it has in the *Classification Principles 1997* (excluding paragraph (b) of that definition).

Note (1): the *Classification Principles 1997* are made under the *Aged Care Act 1997*.

Note (2): paragraph (b) of the definition of “high level of residential care” in the *Classification Principles 1997* relates to “high level residential respite care” but under the *MRCA Treatment Principles* “residential care” and “residential care (respite)” are separate treatments

Note (3) the classification of residential care (non respite) as a high or low level of residential care is worked out under section 9.3B of the *Classification Principles 1997*.

“high level of residential care (respite)” means high level residential respite care described in paragraph (b) of the definition “high level of residential care” in the *Classification Principles 1997*.

Note (1): the *Classification Principles 1997* are made under the *Aged Care Act 1997*.

Note (2): the classification of residential care that is respite care as a high or low level of residential respite care is worked out under section 9.3C of the *Classification Principles 1997*.

“home” includes:

- (a) the premises, or part of the premises, where the person normally resides; or
- (b) a share house where the person normally resides;

but does not include:

- (c) a hospital; or
- (d) the premises where the person is receiving residential care.

Note: ‘residential care’ is also defined in paragraph 1.4.1.”.

“Home and Community Care Program service” means a service of Home and Community Care provided under the auspices of the *Home and Community Care Act 1985*.

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"Home and Garden Maintenance" means the service, under the *MRCA Home Care Program*, of maintaining the home, garden or yard of an *entitled person*, and includes:

- (a) assistance with minor maintenance and minor repair of the home (e.g changing light bulbs, minor carpentry, minor painting, replacing tap washers, but not the supply of replacement items), garden or yard to keep the home, garden or yard safe and habitable;

- (b) lawn mowing;

but does not mean:

- (c) tree felling or tree removing or other major tasks related to a garden or yard;
- (d) provision of materials.

Note: recipients of MRCA Home Care services will be expected to supply materials used in home maintenance, eg replacement light bulbs and tap washers. Service providers will be required to provide any equipment needed, eg garden tools.

"home care" has the meaning given by section 45-3 of the *Aged Care Act 1997*.

"Home Care service (category A)" means the provision of *Domestic Assistance, Personal Care, Home and Garden Maintenance or Respite Care* to an *entitled person* pursuant to the *MRCA Home Care Program*.

"Home Care service (category B)" means the provision of treatment, pursuant to the *MRCA Home Care Program*, that would satisfy the description of a service within the scope of the Home and Community Care Program established under the *Home and Community Care Act 1985*, as amended from time to time, but does not mean the provision of treatment, pursuant to the *MRCA Home Care Program*, that would satisfy the description of an *excluded service*.

"Home Care service (category C)" means the provision by an *approved provider* of a service to an *entitled person* under the *MRCA Home Care Program* that is:

- (a) pursuant to an *LMO Home Care service (category C) Referral* and allocated to the provider by a *MHC assessment agency*; and

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- (b) aimed at reducing the person's social isolation by improving their social networks; and
- (c) provided to an *entitled person* by an *approved provider*.

"income support payment" has the same meaning it has in the *Social Security Act 1991*, save that it includes an income support supplement under the *VEA*;

Note: As at 1 January 2001 income support payments were: (a) a social security benefit; (b) a job search allowance; (c) a social security pension; (d) a youth training allowance; (e) a service pension.

"in force on the date in Schedule 1", in relation to a document, means that on the date in Schedule 1 for the document:

- (a) if the document may be approved under the *Principles* by the *Commission*, the *Repatriation Commission* or a member of the *Commission* or *Repatriation Commission* or by the Secretary to the *Department* – the document has been so approved.

Note: an example being the Notes for Local Medical Officers (para.1.4.1).

- (b) if the document is prepared on behalf of the *Commission*, the *Repatriation Commission* or the *Department* but is not required under the *Principles* to be approved in a manner in (a) – the document has been approved in a manner in (a).
- (c) if the document is not prepared under (b) and is not required under the *Principles* to be approved in a manner in paragraph (a) – the document exists.

"in-home respite" means care provided to a person in his or her own home for a maximum of 196 hours in a Financial year to provide rest or relief from the role of caring:

- (a) to the person; or
- (b) to the person's carer;

Note: *in-home respite* is not relevant to the calculation of *residential care amounts* for *residential care* or *residential care (respite)*.

"in-home telemonitoring equipment", for a *telemonitoring initiative participant*, means apparatus (including computer software) that, in

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conjunction with an *internet carriage service* provided by an *ISP Provider*, enables the user of the apparatus to utilise the *National Broadband Network* so that the user may participate in the *In-Home Telemonitoring for Veterans Initiative*, and includes a video-conferencing facility.

“In-Home Telemonitoring for Veterans Initiative” means the Initiative of that name established by the *Department* which has the following features:

- (a) *telemonitoring initiative participants* electronically transmit *telemonitoring initiative data* to the *data repository* using *in-home telemonitoring equipment* that utilises the *National Broadband Network*; and
- (b) *participating LMOs* (or *LMOs Practice Nurses*) electronically retrieve *telemonitoring initiative data* from the *data repository* and analyse it for the purpose of monitoring the health of *telemonitoring initiative participants*.

“inpatient” means a person formally admitted for treatment by a hospital.

“institution”, in Part 11, includes:

- (a) a *retirement village*;
- (b) a cluster of self-care units.

“internet carriage service” has the meaning it has in Schedule 5 to the *Broadcasting Services Act 1992*.

“ISP Provider” means “Internet Service Provider” as defined in Schedule 5 to the *Broadcasting Services Act 1992*.

“limited MHC-type service” means a service identical to *Domestic Assistance* or *Home and Garden Maintenance*, provided, or to be provided, by an *approved provider* to a person eligible to receive a limited MHC-type service.

“Local Medical Officer” or “LMO” means a *medical practitioner* who:

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- (a) is registered under the *Notes for Local Medical Officers* as a Local Medical Officer and who treats an *entitled person* in accordance with the terms, and subject to the conditions, in these *Principles* and in the “*Notes for Local Medical Officers*”; and
 - (b) has been given a *provider number*, in respect of being a *medical practitioner*, that has not been suspended or revoked.

Note: a *provider number* may be a number used by the *Department* and adopted by the *Department of Human Services*.

“LMO Care Leadership treatment” means treatment provided by an *LMO* to an *entitled person*, under the *Coordinated Veterans' Care Program*, comprised of:

- (a) preparing and managing the *GPMP* for the person under the Program;
- (b) overseeing a *practice nurse* in the implementation of the *GPMP* — where a *practice nurse* and not a *community nurse* or *aboriginal health worker* or the *LMO* co-ordinates treatment under the *GPMP* (*Practice Nurse Care Co-ordination treatment*);
- (c) referring the person to a *DVA-contracted community nursing provider* for *Community Nurse Care Co-ordination treatment* or to an *aboriginal health worker* for *Aboriginal Health Worker Care Co-ordination treatment*, if appropriate;
- (d) performing such other functions under the program that the *LMO* has under the *Notes for Coordinated Veterans' Care Program Providers*.

“LMO Home Care service (category C) Referral” means treatment comprised of an *LMO* preparing a written document that refers an *entitled person*, who the *LMO* has admitted to and is treating under the *Coordinated Veterans' Care Program*, to a *MHC assessment agency* for assessment for a *Home Care service (category C)* under the *MRCA Home Care Program* and which:

- (a) is in the form, if any, approved by the *Repatriation Commission* or *Commission*; and
 - (b) is sent to the *MHC assessment agency*, including as a facsimile message.
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"low level of residential care" means a level of residential care that is not a *high level of residential care*.

"MBS" and **"Medicare Benefits Schedule"** mean, in the context of amounts payable for treatment under the *Principles*, a *Fee Schedule*, and in any other context means:

- (a) Schedule 1 to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
- (b) Schedule 1A to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
- (c) the table of diagnostic imaging services prescribed under subsection 4AA(1) of that Act as in force from time to time.

Note: an example of where "Medicare Benefits Schedule" is used in a non-payment context is paragraph 4.2.1.

"medical practitioner" has the same meaning as "medical practitioner" has in the *Health Insurance Act 1973*.

"medical specialist" means a medical practitioner who is recognised as a consultant physician or as a specialist, in the appropriate specialty, for the purposes of the *Health Insurance Act 1973*.

"medicare benefit" has the meaning it has in the *Health Insurance Act 1973*.

"medicare program" has the meaning it has in the *Human Services (Medicare) Act 1973*.

"member" has the meaning it has in the *Act* save that it includes former member and a person with a *SRCA disability*.

"Memorandum of Understanding of 1995" means the Memorandum of Understanding between the Commonwealth of Australia as represented by the Department of Veterans' Affairs, the Repatriation Commission and the Australian Medical Association Ltd, relating to the provision of medical services by Local Medical Officers to entitled persons, dated 10 December 1995.

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“**MHC assessment agency**” means a person to whom the *Commission* has delegated its power to:

(a) assess whether a person needs:

- (i) a *Home Care service (category A)*; or
- (ii) a *Home Care service (category B)*; or
- (iii) a *Home Care service (category C)*;

under the *MRCA Home Care Program*; and

(b) allocate a service in (a) to an *approved provider*.

“**minor procedure**” means a surgical procedure that:

- (a) does not involve hospitalisation or theatre fees; and
- (b) is of a type that is undertaken routinely in doctors’ and specialists’ rooms; and
- (c) does not require general anaesthesia; and
- (d) is not undertaken in a private day facility centre.

“**MPPPs**” means the MRCA Private Patient Principles determined by the Commission under paragraph 286(1(b) of the *Act*.

“**MRCA Access Payment**” means the amount set out in the *DVA document* entitled “Department of Veterans’ Affairs Fee Schedules for Medical Services”, *in force on the date in Schedule 1*, and called the “MRCA Access Payment” — being an additional amount payable by the *Department* to an *LMO* for a medical service provided by the *LMO* to an *entitled person* in accordance with these *Principles* and the *Notes for Local Medical Officers*.

Note: a MRCA Access Payment is an amount additional to any amount otherwise payable by the *Department* to an *LMO* for a medical service provided by the *LMO* to an *entitled person* in accordance with these *Principles* and the *Notes for Local Medical Officers*.

“**MRCA Home Care Program**” means:

- (a) the treatment program under which the *Commission* ensures the provision of care and assistance services to *entitled*
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persons who are frail, or who have disabilities, with the aim of maintaining the independence of those people, allowing them to remain in their own home for as long as possible, and reducing avoidable illness and injury, and is comprised of paragraphs 7.3A to 7.3A.22 (inclusive) of the *Principles*, and other relevant paragraphs in the *Principles*, and the arrangements under section 285 of the *Act* in support thereof.

- (b) the treatment program under which the *Commission* ensures the provision of social support services to *entitled persons* referred to the program under a *LMO Home Care service (category C) Referral*.

"MRCA Pharmaceutical Benefits Scheme" means the scheme determined by the Commission under paragraph 286(1)(c) of the *Act*.

"MRCA Private Patient Principles" means the principles in the determination made by the Commission under paragraph 286(1)(b) of the *Act*.

"National Law" means a law of the Commonwealth, a State, or Territory, enacted pursuant to the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions made on 26 March 2008:

<http://www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/NATREG%20-%20Intergovernmental%20Agreement.pdf>

"National Broadband Network" has the meaning it has in the *National Broadband Network Companies Act 2011*.

"NBN" means *National Broadband Network*.

"NBN wave site" means an area, including part of an area, covered by the *NBN*.

"neuropsychologist" means a *person* who:

- (a) specialises in the assessment, diagnosis and treatment of psychological disorders associated with conditions affecting the brain such as difficulties with memory, learning, attention, language, reading, problem-solving, decision-
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making or other aspects of behaviour and thinking abilities;
and

- (b) in the opinion of an employee of, or consultant to, the *Department* or the *Department of Human Services*, has appropriate qualifications in clinical neuropsychology and practises as a neuropsychologist.

“nominated residence” means a residence nominated by an *entitled person* as the place where the person would participate in the *In-Home Telemonitoring for Veterans Initiative*.

“Notes for Allied Health Providers” means the document approved by the Secretary to the *Department* entitled “Notes for Allied Health Providers”, and *in force on the date in Schedule 1*, that sets out the terms on which, and the conditions subject to which, an *allied health provider* is to provide treatment to an *entitled person* in order for the *Commission* to accept financial responsibility for that treatment.

“Notes for Coordinated Veterans' Care Program Providers” means the document approved by the *Commission*, the *Repatriation Commission*, or a member of the *Commission* or *Repatriation Commission*, or by the Secretary to the *Department*, entitled “Notes for Coordinated Veterans' Care Program”, and *in force on the date in Schedule 1*, that sets out the terms on which:

- (a) an *LMO*;
- (b) a *practice nurse*;
- (c) a *community nurse* (via a *DVA-contracted community nursing provider*); and
- (d) an *aboriginal health worker*;

is to provide treatment to an *entitled person* under the *Coordinated Veterans' Care Program* in order for the *Commission* to accept financial responsibility for that treatment.

“Notes for Local Medical Officers” means the document:

- (i) approved by the *Commission* or a member thereof, the *Repatriation Commission* or a member thereof, or by the

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Secretary to the *Department*, entitled “Notes for Local Medical Officers”; and

- (ii) *in force on the date in Schedule 1*; and
- (iii) that sets out the terms on which, and the conditions subject to which, a *LMO* is to provide treatment to an *entitled person* in order for the *Commission* to accept financial responsibility for that treatment, except those parts of the document that deal with the formation of a contractual relationship between a *LMO* and the *Commission* or the *Department*.

Note: the intention is that the treatment provided by a Local Medical Officer (LMO) to an *entitled person* may be regarded as having been provided in accordance with the *Principles* and the “Notes for Local Medical Officers” despite the LMO not entering into any arrangement with the *Commission* or the *Department* as required by the Notes (without the parts mentioned above omitted). See: paragraph 5.3 of the Notes for Local Medical Officers.

“Notes for Providers” means a *DVA document* approved by the Secretary to the *Department*, or by the *Repatriation Commission* or the *Commission*, or a member of either Commission, with the word ‘Notes’ in its title, and *in force on the date in Schedule 1*, that sets out the terms on which, and the conditions subject to which, a *health care provider* is to provide treatment to an *entitled person* in order for the *Commission* to accept financial responsibility for that treatment.

“optical dispenser”, in the case of an individual, means a person who:

- (a) interprets optical prescriptions and fits and services optical appliances such as spectacle frames and lenses; and
- (b) holds a qualification that, in the opinion of the *Commission*, is appropriate for the skills needed to practise optical dispensing; and
- (c) is a member of a body established to supervise the occupation of optical dispenser; and
- (d) holds a *provider number* as an optometrist, ophthalmologist, orthoptist or optical dispenser.

“optical dispenser”, in the case of a company, means a company that:

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- (a) holds an *ABN* (*Australian Business Number*);
- (b) carries on a business of optical dispensing;
- (c) employs or engages for the optical dispensing aspects of the business — an individual who is an optical dispenser.

“optical dispensing” means interpreting optical prescriptions and fitting and servicing optical appliances such as spectacle frames and lenses.

“oral health therapist” means a person registered under the *National Law* that provides for the registration of dental practitioners but does not include a person:

- (a) whose registration to practice as an *oral health therapist* has been suspended, or cancelled, following an inquiry relating to his or her conduct: and
- (b) who has not, after that suspension or cancellation, again been authorised to practice as an *oral health therapist*.

Note: oral health therapists are practitioners who are dually qualified as *dental therapists* and *dental hygienists*.

“occupational therapist” means an occupational therapist who has been given a *provider number* in respect of being an occupational therapist.

“occupational therapist (mental health)” means an *occupational therapist*:

- (a) who has been given a *provider number* in respect of being an occupational therapist; and
- (b) who, in the opinion of an employee of, or consultant to, the *Department* or the *Department of Human Services*, has appropriate qualifications in occupational therapy in the area of mental health and who practises as an *occupational therapist* in the area of mental health.

“Optical Coherence Tomography” means the treatment comprised of a non-contact, non-invasive high resolution imaging technique that provides cross-sectional tomographic images of the ocular microstructure through the thickness of the retina.

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"ordinary income" has the same meaning it has under the definition of "ordinary income" in the *Social Security Act 1991* including where terms in that meaning are further defined save that "ordinary income" does not include a payment of Income support supplement.

Note: Income support supplement is described in Part IIIA of the VEA.

"other GP" means a *medical practitioner* who:

- (a) treats an *entitled person* in accordance with the terms, and subject to the conditions, in these *Principles*; and
- (b) has been given a *provider number*, in respect of being a *medical practitioner*, that has not been suspended or revoked.

Note: an *other GP*, unlike an *LMO*, does not provide treatment in accordance with the *Notes for Local Medical Officers*.

Note: a provider number may be a number used by the *Department* and adopted by the *Department of Human Services*.

"outpatient service" means a health service or procedure provided by a hospital but not involving admission to the hospital.

"outreach program counselling" means the treatment of that name established by paragraph 7.7A.1 of the *Principles* — comprised of mental health counselling under the *Veterans and Veterans Families Counselling Service* provided by an *outreach program counsellor* to an *entitled person* eligible for the treatment under the *Principles*.

"outreach program counsellor" means:

- (a) a *psychologist* who:
 - (i) is registered as a psychologist with the Psychology Board of Australia; and
 - (ii) has been given a *provider number* and is eligible to provide psychological services under the *Australian Government's Better Access initiative*; and
 - (iii) in the opinion of the *Commission*, has an adequate appreciation of veteran and military culture; or
- (b) a *social worker (mental health)* who:

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- (i) is accredited as a Mental Health Social Worker with the Australian Association of Social Workers; and
- (ii) has been given a *provider number* and is eligible to provide social work services under the *Australian Government's Better Access initiative*; and
- (iii) in the opinion of the *Commission*, has an adequate appreciation of veteran and military culture;

being a person who does not have a written contract (described as a Deed of Standing Offer) with the *Commission* or the *Department* in respect of the provision of a counselling service to an *entitled person* under the auspices of the *Veterans and Veterans Families Counselling Service*.

“participating LMO” means an *LMO*:

- (a) whose name is given as a participating GP in the form: “Application for Practice and Provider registration to In-Home Telemonitoring for Veterans Initiative” lodged with the Department of Human Services; and
- (b) who is approved in writing by the *Commission* to be a *participating LMO* in the *In-Home Telemonitoring for Veterans Initiative*.

Note: in practice a Commission delegate may grant the approval.

“patient care plan” means a document that is completed by a health provider who provides a service to a patient and that contains details of:

- (a) the patient's medical history;
- (b) the injury or disease in respect of which the service is to be provided;
- (c) the proposed management of the injury or disease; and
- (d) an estimation of the duration and frequency of the service to be provided.

“period of care” in relation to the care provided by:

- (a) an *LMO*; or

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- (b) a *practice nurse*; or
- (c) an *aboriginal health worker*; or
- (d) a *community nurse* (via a *DVA-contracted community nursing provider*);

to an *entitled person* under the *Coordinated Veterans' Care Program* (Program), means the period set out in the *Notes for Coordinated Veterans' Care Program Providers* in relation to the LMO, practice nurse, community nurse or aboriginal health worker, provided that any *subsequent period of care* by the same LMO is approved by the LMO for the person.

Note 1: the period of care is important for billing purposes. The *Notes for Coordinated Veterans' Care Program Providers* contain the detail of billing procedures. Generally, for an LMO the period is 3 months commencing on the patient's admission to the Program and for a community nurse the period is 28 days commencing on date of service. Generally previous care periods with different providers must expire before a new provider can claim for a care period except that, with *prior approval*, a community nurse can claim for a care period although a previous care period in respect of the relevant *entitled person* has not expired. A community nurse cannot claim for a period not covered by a period of care provided by an LMO.

Note 2: any period of care by an LMO other than the first period of care commencing on the date the entitled person is admitted to the Program (*admission date*) or the first period of care as a different LMO for the person (commencing on the date worked out under the *Notes for Coordinated Veterans' Care Program Providers*, is a subsequent period of care by an LMO and the LMO must approve it. By approving it, the periods of care provided by any care co-ordinator (practice nurse, community nurse or aboriginal health worker) during the period of care approved by the LMO are valid periods of care under the Program (sub-periods of care). A sub-period of care may only be provided under the Program during a period of care under the Program by an LMO.

"Personal Care" means the service under the *MRCA Home Care Program* consisting of assistance with daily self care tasks, such as eating, bathing, toileting, dressing, grooming, getting in and out of bed, and moving about the house.

"PBS" means the Pharmaceutical Benefits Scheme authorised under the *National Health Act 1953*.

"physiotherapy" includes hydrotherapy.

"practitioner" has the same meaning as in section 124B of the *Health Insurance Act 1973* in force from time to time.

"practice nurse" means a *registered nurse* or *enrolled nurse* employed or engaged by an *LMO* as a nurse in the *LMO's* practice.

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“Practice Nurse Care Co-ordination treatment” means treatment provided by a *practice nurse* to an *entitled person*, under the *Coordinated Veterans' Care Program*, comprised of:

- (a) implementing the *GPMP* for the person under the Program — in particular co-ordinating treatment services under the *GPMP*;
- (b) liaising, in relation to the *GPMP*, with the *LMO* supervising the *practice nurse* in relation to the implementation of the *GPMP*;
- (c) performing such other functions under the program that the *practice nurse* has under the *Notes for Coordinated Veterans' Care Program Providers*.

“Principles” means the *MRCA Treatment Principles*.

“prior approval” means that approval for the assumption by the Commission of the whole, or partial, financial responsibility for certain treatment must be given by the Commission before that treatment is commenced or undertaken.

“prisoner of war” means an *entitled member* who was captured by the enemy (including a terrorist) while rendering defence service.

“private hospital” means premises that have been declared specifically as private hospitals for the purposes of the *Health Insurance Act 1973*.

“proscribed amount” means, in relation to the *MRCA Home Care Program*:

- (a) subject to paragraph (b), an amount of money that if paid by an *entitled person* would mean the *entitled person* has paid in respect of a *Home Care service (category A)* comprised of *Domestic Assistance* provided to that *entitled person* by any *approved provider* or by any *sub-contractor* during a *week* or part thereof, an amount exceeding \$5;

Note: for the purpose of ascertaining if an amount of money is a proscribed amount where the amount demanded, received or assigned is in respect of a service (s) provided during two or more weeks, without the service (s) being related to the particular week in which the service(s) was delivered, the amount shall be apportioned pro rata to those weeks.

- (aa) subject to paragraph (b), an amount of money that if paid by an *entitled person* would mean the *entitled person* has paid in respect
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of a *Home Care service (category A)* comprised of *Home and Garden Maintenance*, provided to that *entitled person* by any *approved provider* or by any *sub-contractor* during the relevant period referred to in paragraph 7.3A.3 (2) of the *Principles*, an amount exceeding \$75;

Note (1): the "relevant period" is a period of 12 months.

Note (2): under paragraph 7.3A.8(a) of the *Principles*, an entitled person cannot be charged more than \$5 per hour of service.

- (b) an amount of money that if paid by an *entitled person* receiving a *Home Care service (category A)* that was similar to a *Home and Community Care Program service* provided to the person immediately before 1 January 2001 would mean the *entitled person* has paid in respect of the *Home Care service (category A)* provided to that *entitled person* by any *approved provider* or by any *sub-contractor*, an amount exceeding the maximum amount the person could have been required to pay over a particular period in respect of the *Home and Community Care Program service* formerly provided to the person that was similar to the *Home Care service (category A)* provided to the *entitled person*;

Note: for the purpose of ascertaining if an amount of money is a proscribed amount where the amount demanded, received or assigned is in respect of a service (s) provided during two or more weeks, without the service (s) being related to the particular week in which the service(s) was delivered, the amount shall be apportioned pro rata to those weeks.

- (c) subject to paragraph (b), an amount of money that if paid by an *entitled person* would mean the *entitled person* has paid, in respect of a *Home Care service (category A)* comprised of *Personal Care* provided to that *entitled person* by any *approved provider* or by any *sub-contractor* during a *week* or part thereof, an amount exceeding \$10;

Note: for the purpose of ascertaining if an amount of money is a proscribed amount where the amount demanded, received or assigned is in respect of a service (s) provided during two or more weeks, without the service (s) being related to the particular week in which the service(s) was delivered, the amount shall be apportioned pro rata to those weeks.

- (d) an amount of money in respect of *Respite Care* provided, or to be provided, by an *approved provider* or by a *subcontractor*, to an *entitled person*;

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Note: the intention is that any amount charged for *Respite Care* is a proscribed amount regardless of whether it would or would not exceed \$5 per hour of service.

- (e) an amount of money in respect of a *Home Care service (category A)* provided or to be provided to an *entitled person* that was a similar service to a *Home and Community Care Program service* the *entitled person* received immediately before 1 January 2001 and in respect of which the *entitled person* had not been required to pay a charge;

Note: the intention is that any amount charged for a service similar to a free former *Home and Community Care Program service* previously received is a proscribed amount regardless of whether it would or would not exceed \$5 per hour of service.

- (f) an amount of money, in respect of a *Home Care service (category A)* provided or to be provided to an *entitled person* that was a similar service to a *Home and Community Care Program service* the *entitled person* received immediately before 1 January 2001, that exceeds any amount of money the *entitled person* had been required to pay in respect of the *Home and Community Care Program service*;

Note: It is the intention that any amount charged for a service similar to a *Home and Community Care Program service* previously received that is over and above the amount the *entitled person* previously paid in respect of the *Home and Community Care Program service* is a proscribed amount notwithstanding that the sum of the amounts that could and could not be charged did not exceed \$5 per hour of service. The limitation on the maximum amount a person could be required to pay in (a), (aa) and (b) above applies to this situation (maximum amount payable over a period).

- (g) an *exempt amount*;

Note: the intention is that an exempt amount remains a proscribed amount and therefore not chargeable notwithstanding it would or would not exceed \$5 per hour of service.

“provider number” means the number:

- (a) allocated by:
 - (i) the *Chief Executive Medicare* or by his or her delegate or by a person authorised by the *Chief Executive Medicare* — to a *practitioner*; or

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(ii) the Chief Executive Officer of Medicare Australia under the *Medicare Australia Act 1973* — to a *practitioner*; and

(b) which identifies the *practitioner* and the places where the *practitioner* practises his or her profession.

Note: see regulation 2 of the *Health Insurance Regulations 1975*.

"provision of a Home Care service (category A) to an entitled person by an approved provider" includes the situation where an *approved provider* engages a *sub-contractor* to provide a *Home Care service (category A)* to an *entitled person*.

"provision of a Home Care service (category B) to an entitled person by the Commission" includes the situation where the *Commission* engages a *sub-contractor* to provide a *Home Care service (category B)* to an *entitled person*.

"provision of a Home Care service (category C) to an entitled person by an approved provider" includes the situation where an *approved provider* engages a *sub-contractor* to provide a *Home Care service (category C)* to an *entitled person*.

"psychologist" means a psychologist who has been given a *provider number* in respect of being a psychologist.

"public hospital" has the same meaning as "recognized hospital" as defined in the *Health Insurance Act 1973*.

Note: Section 3 of the *Health Insurance Act 1973* defines "recognized hospital" in terms of hospitals recognized for the purposes of the Medicare agreement, or hospitals declared by the Minister who administers the *Health Insurance Act 1973* to be recognized hospitals.

"MRCA Pharmaceutical Benefits Scheme" means the Scheme determined under paragraph 286(1)(c) of the *Act*.

"RAP National Schedule of Equipment" means the document of that name approved by the *Repatriation Commission* or the *Commission* or by a member of the *Repatriation Commission* or the *Commission* or by the Secretary to the *Department*, and *in force on the date in Schedule 1*, that lists the surgical aids and appliances for self-help and rehabilitation available to an *entitled person* under the *Department's* Rehabilitation Appliances Program.

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“registered nurse” means a person who is registered under a law of a State or Territory or of the Commonwealth to practise as a registered nurse.

"Rehabilitation Appliances Program (RAP) National Guidelines"

means the document of that name approved by the *Repatriation Commission* or the *Commission* or by a member of the *Repatriation Commission* or the *Commission* or by the Secretary to the *Department*, and *in force on the date in Schedule 1*, that assists *Commission* delegates when determining approval for surgical aids and appliances for self-help and rehabilitation (items) available under the *Department's* Rehabilitation Appliances Program and which informs prescribers and suppliers of the processes necessary for an item to be provided to an *entitled person*.

"Repatriation Commission" means the body corporate continued in existence by section 179 of the *Veterans' Entitlements Act 1986*;

"residential care" means personal care or nursing care, or both personal care and nursing care, that is provided to a person in a residential care facility in which the person is also provided with:

- (a) meals and cleaning services; and
- (b) appropriate staffing, furnishings, furniture and equipment for the provision of that care and accommodation;

but does not include any of the following:

- (c) care provided to a person in the person's private home; or
- (d) care provided in a hospital or psychiatric facility; or
- (e) care provided in a residential facility that primarily provides care to people who are not frail and aged.

"residential care amount" means:

- (a) in relation to a resident of a hospital — an amount determined under the *Health Insurance Act 1973* to be the resident contribution applicable under that Act to a nursing-home-type patient of that hospital; or

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- (b) in relation to a person in receipt of a high level of residential care — an amount equivalent to the maximum daily amount of resident fees worked out under Division 58 of the *Aged Care Act 1997*; or

Note: 'maximum daily amount of resident fees' is defined in section 58-2 of the *Aged Care Act 1997*.

Note: 'standard resident contribution' is defined in sections 58-3 and 58-4 of the *Aged Care Act 1997* and does not include the 'daily income tested reduction' (defined in sections 44-21 to 44-23 of the *Aged Care Act 1997*. The effect of this is that for the purposes of determining the Commonwealth's liability under the *Act* the income testing provisions of the *Aged Care Act 1997* do not apply.

- (d) in relation to an *entitled person* awarded the Victoria Cross who is receiving or received a high level of *residential care* — an amount equivalent to the sum of:

- (i) the standard resident contribution worked out under Division 58 of the *Aged Care Act 1997*, as that amount forms part of the maximum daily amount of resident fees; and
- (ii) any care fee payable by the *entitled person*, in respect of the *residential care*, that is calculated by reference to the person's income.

Note: if a standard resident contribution is payable daily because it forms part of the maximum daily amount of resident fees a person is to pay, then the Commission's financial responsibility for the standard resident contribution is for that contribution as it is incurred daily.

"residential care (respite)" means *residential care* provided as *respite* and includes *residential care (28 day respite)*.

"residential care (28 day respite)" means *residential care* provided as *respite* for up to 28 days in a Financial year pursuant to the *MRCA Home Care Program*.

"residential care subsidy" means an amount worked out under Chapter 3 of the *Aged Care Act 1997* (including any amount of *veterans' supplement*) that is payable by the Commonwealth in respect of an entitled person's residential care according to the classification level determined under Part 2.4 of that Act.

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“respite” means a rest, break or relief for a person’s carer or a person caring for himself or herself, from the role of caring.

"Respite Care" means the service under the *MRCA Home Care Program* consisting of *in-home respite*, *residential care (28 day respite)* or *emergency short term home relief*.

“respite admission” means the admission of an entitled person to an institution to provide rest or relief for that person’s carer, or admission to an institution of an entitled person caring for himself or herself.

“retirement village” has the same meaning it has in the *Veterans’ Entitlements Act 1986* and as applied by the *Treatment Principles*.

Note: retirement village is defined in section 5M of the *Veterans’ Entitlements Act 1986* (VEA) and is also applied by the *Treatment Principles*. The intention is that the *Commission* is to have the same power as the *Repatriation Commission* to determine premises have the same function as a retirement village for the purposes of Part 11 of the *Principles*.

“revoked MRCA Treatment Principles” means the *MRCA Treatment Principles* (Instrument 2004 No. M21).

"Rural Enhancement Scheme" means the scheme jointly established by the *Commission* (under section 285 of the *Act*) and the *Repatriation Commission*, in consultation with the Australian Medical Association Ltd, and which has the following features:

- (a) *LMOs* who provide medical services (services) to *entitled persons* under the *Rural Enhancement Scheme* (Scheme) receive higher payments (as set out in the *Principles*) from the *Department* for those services than they would receive if the services were not provided under the Scheme;
- (b) the Scheme only applies to *LMOs* who provide medical services to *entitled persons* at certain rural public hospitals (identified rural hospitals);
- (c) an identified rural hospital is a hospital at which a medical practitioner may provide a medical service (service) to the public and receive from the state or territory government that, respectively, administers the state or territory in which the hospital is located, an extra amount (extra amount) for that service.

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- (d) the extra amount is an amount representing the difference between the amount the State or Territory actually pays the medical practitioner for the service and the fee for the service listed in the *Medicare Benefits Schedule*.

Note: as at 1 January 2005 the Rural Enhancement Scheme only operated in NSW, Vic, SA and WA.

"service injury" has the meaning it has in section 5 of the *Act*.

"service disease" has the meaning it has in section 5 of the *Act*.

"social worker (general)" means a social worker who in the opinion of an employee of, or consultant to, the *Department*, has appropriate qualifications in social work and practises as a social worker.

"social worker (mental health)" means a *social worker*:

- (a) who has been given a *provider number* in respect of being a social worker; and
- (b) who, in the opinion of an employee of, or consultant to, the *Department* or the *Department of Human Services*, has appropriate qualifications in social work in the area of mental health and who practises as a social worker in the area of mental health.

"SRCA" means the *Safety, Rehabilitation and Compensation Act 1988*.

"SRCA disability" means an injury (within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*):

- (a) for which the Military Rehabilitation and Compensation Commission has accepted liability to pay compensation under that Act; and
- (b) for which the person with the injury is eligible to be provided with treatment under Part 3 of Chapter 6 of the *Act*.

Note 1: In the *Safety, Rehabilitation and Compensation Act 1988* the definition of *injury* includes a disease (see section 5A of that Act).

Note 2: Section 85(2A) of the *Act* provides eligibility for treatment of a person with an injury under the *Safety, Rehabilitation and Compensation Act 1988*.

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“sub-contractor” means, in relation to the *MRCA Home Care Program*, a State, Territory or Local Government, or incorporated organisation, or person, engaged by an *approved provider* or the *Commission* to provide a *Home Care service (category A)* or a *Home Care service (category B)* or a *Home Care service (category C)* to an *entitled person*.

“subsequent period of care”, in relation to the provision of care by an *LMO* to an *entitled person*, means a *period of care* that may be provided by the *LMO* after the expiry of a period of care that has already been provided by the *LMO* to the *entitled person*.

Note: a subsequent period of care must be approved by the *LMO* (see: 6A.3). A period of care by an *LMO* that is not a “subsequent period of care” would be the first period of care provided to a person under the *Coordinated Veterans' Care Program* (Program) and the first period of care provided to a person under the Program by a new *LMO* for the person i.e. where the person has changed *LMOs*.

“telemonitoring care plan” means a care plan prepared by a *participating LMO* in conjunction with a *telemonitoring initiative participant* that:

- (a) is based on the electronic transmission of *telemonitoring initiative data* and;
- (b) satisfies the minimum requirements for a *GPMP* (General Practitioner Management Plan), as if the telemonitoring care plan is to be a *GPMP*, as set out in the *Notes for Coordinated Veterans' Care Program Providers*.

“telemonitoring equipment”, for a *participating LMO*, means computer software and similar tools that will enable the *participating LMO* (or the *LMOs Practice Nurse*) to participate in the *In-Home Telemonitoring for Veterans Initiative*.

“telemonitoring initiative data” means physiological and behavioural data about a *telemonitoring initiative participant* (participant), assembled with reference to the *telemonitoring care plan* for the participant, and transmitted by the participant, or by a person on the participant’s behalf, to the *data repository* via the participant’s *in-home telemonitoring equipment* where it may be electronically retrieved by the *participating LMO* for the participant or the *LMOs Practice Nurse*.

“telemonitoring initiative participant” means an *entitled person* who has *in-home telemonitoring equipment* installed in the person’s *nominated residence* and who has been enrolled in the *In-Home Telemonitoring for Veterans Initiative* by a *participating LMO*.

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“telemonitoring treatment” means treatment provided by a *participating LMO* (or the LMO’s Practice Nurse), a *data repository controller*, a contractor or an *ISP provider*, as the case may be, under Part 6A.

“transition care” has the meaning it has in section 15.28 of the *Flexible Care Subsidy Principles 1997*.

Note: the *Flexible Care Subsidy Principles 1997* can be found on COMLAW: <http://www.comlaw.gov.au>

“Tier 1 Hospital” means a hospital in the category described as Tier 1 in 2.1 of the *MPPPs*.

“Treatment Principles” means the legislative instrument entitled ‘Treatment Principles’ made by the *Repatriation Commission* under section 90 of the *VEA*.

“VEA” means the *Veterans’ Entitlements Act 1986*.

“Veterans and Veterans Families Counselling Service” or **“VVCS”** means the service funded by the Department of Veterans’ Affairs that provides free, confidential and Australia-wide mental health counselling and group programs to Australian veterans, peacekeepers, their families, eligible current serving Australian Defence Force members and F-111 workers and their families.

“VVCS criterion” means a criterion in the *DVA document* “General information about VVCS – Veterans and Veterans Families Counselling Service” under the heading “Who can use VVCS?”, being a criterion that relates to a person who is eligible for treatment under the *Act*.

“VVCS OPC Provider Notes” means the document approved by the *Commission*, the *Repatriation Commission*, a member of the *Commission* or *Repatriation Commission* or by the Secretary to the *Department*, entitled “Veterans and Veterans Families Counselling Services (VVCS) Outreach Program Counsellors (OPC) Provider Notes”, and *in force on the date in Schedule 1*, that sets out the terms on which an *outreach program counsellor* is to provide *outreach program counselling* to an eligible *entitled person*.

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“service injury” and **“service disease”** are defined in section 5 of the *Act*; and in relation to a person with a *SRCA disability* mean the person’s injury (within the meaning of the *Safety, Rehabilitation and Compensation Act 1988*) that was caused by, or arose out of, the person’s employment in the Defence Force that is covered by the *Safety, Rehabilitation and Compensation Act 1988*.

Note: in the *Safety, Rehabilitation and Compensation Act 1988* the definition of *injury* includes a disease (see section 5A of that Act).

“veterans’ supplement”, in relation to an *entitled person*, means the supplement of that name that applies under the *Aged Care Act 1997* to the person as a care recipient under that Act.

Note (1): see s.44-5 of the *Aged Care Act 1997*.

Note (2): until 1 July 2014 the *Residential Care Subsidy Principles 1997* and the *Home Care Subsidy Principles 2013* under the *Aged Care Act 1997* may specify, in respect of a veterans’ supplement, the circumstances in which the supplement will apply to a care recipient in respect of a payment period. On/after 1 July 2014, the *Residential Care Subsidy Principles 1997* and the *Home Care Subsidy Principles 2013* will be consolidated in the *Subsidy Principles* under the *Aged Care Act 1997*.

“week” means the period from Sunday to Saturday, inclusive.

“White Card” means the identification card described as the Repatriation Health Card - For Specific Conditions and provided to a person who is eligible under the *Act* for treatment, subject to these Principles, of a *service injury* or a *service disease* and also means a written authorisation issued on behalf of the Commission under subparagraph 2.1.1(a)(iii) and provided to a person who is entitled under the *Act* for treatment.

Note: a White Card is issued to a person with a *SRCA disability*.

1.4.2 In the *MRCA Treatment Principles*, if a Note follows a principle, paragraph or subparagraph, the Note is taken to be part of that principle, paragraph or subparagraph, as the case may be.

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PART 2 — ENTITLEMENT TO TREATMENT

PART 2 — ENTITLEMENT TO TREATMENT

2.1 Treatment for entitled persons in Australia

2.1.1 Subject to these Principles, the Commission may provide or arrange for treatment in Australia of:

- (a) entitled persons who have been issued with:
 - (i) a Gold Card; or
 - (ii) a White Card; or
 - (iii) a written authorisation issued on behalf of the Commission;
and

2.2 Treatment for entitled persons residing or travelling overseas

2.2.1 Subject to these Principles, the Commission will accept financial responsibility for the treatment overseas of service injuries or service diseases only for:

- (a) a member or former member who is resident overseas; or
- (b) a member or former member who is travelling overseas.

2.2.2 Except where the Commission decides otherwise, the Commission will not accept financial responsibility under paragraph 2.2.1 for costs incurred in the treatment of a service injury or disease while a member or former member is temporarily absent from Australia unless, prior to departure, an office of the Department has been notified of the member's or former member's intention to travel.

2.2.3 Except in an emergency, for treatment other than *residential care* or *residential care (respite)*, financial responsibility under paragraph 2.2.1 will be limited to:

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Treatment that is residential care/residential care (respite)

- (a) the cost of treatment provided in accordance with the mode and duration that would have been provided or arranged, under these *Principles*, in Australia; or
- (b) the cost of treatment provided by a health authority or facility nominated by the *Commission*.

Treatment that is residential care/residential care (respite)

2.2.4 For treatment that is *residential care* or *residential care (respite)*, financial responsibility under paragraph 2.2.1 will be limited to:

- (a) in the case of *residential care* provided for a period to a member or former member, whether provided in an emergency or not — the lesser of:
 - (i) the amount charged the member or former member; or
 - (ii) an amount equal to the amount of *residential care subsidy* payable for a person given a *high level of residential care* for the same period in Australia plus any *residential care amount* the *Commission* would have accepted for the member or former member in Australia;
- (b) in the case of *residential care (respite)* provided for a period to a member or former member, whether provided in an emergency or not — the lesser of:
 - (i) the amount charged the member or former member; or
 - (ii) an amount equal to the amount of *residential care subsidy* payable for a person given a *high level of residential care (respite)* for the same period in Australia (not exceeding 63 days in a Financial year) plus any *residential care amount* the *Commission* would have accepted for the member or former member in Australia.

Note (1): Subject to the *Principles*, the *Commission* will not accept financial responsibility for medical or allied-health treatment applied to an injury or disease of a member or former member that is not a service injury or a service disease.

Note (2): By virtue of Part 10 of the *Principles* the *Commission*, in the first instance, rather than the Commonwealth, accepts financial responsibility for the provision of *residential care* and *residential care (respite)* under the *Aged Care Act 1997* to entitled persons.

Note (3): the "*residential care amount*", also commonly known as the "basic daily care fee" or "resident fee", is the amount to be worked out under section 58-3, or the amount to be worked out

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Treatment that is residential care/residential care (respite)

under subsection 58-4(1), of the *Aged Care Act 1997* as amended from time to time, depending on which of those provisions applied to the circumstances of the member or former member.

- (d) in the case of *residential care (respite)*, the cost of that care (as worked out under paragraph (c)) for only a maximum of 63 days in any Financial year.

Note (1): the intention is that the *Commission* will not accept any further financial responsibility for "a *respite admission*" in a Financial year where in that year the person had already spent 63 days in *residential care* as a *respite admission*.

Note (2): for the purpose of calculating the number of days spent by a member in *residential care (respite)* in a Financial year, any day spent in *residential care (respite)* in Australia in that year is also to be taken into account.

2.2.5 Notwithstanding paragraphs 2.2.2 or 2.2.3, the Commission will not be responsible for treatment costs incurred by any person who travels overseas from Australia where a significant reason for that travel is to obtain treatment or rehabilitation appliances.

No Overseas MRCA Home Care or HomeFront

2.2.8 The *Commission* will not accept financial liability for the provision overseas of treatment under the *MRCA Home Care Program* or under the HomeFront Program.

Note: the HomeFront Program is the common name given to accident prevention and personal safety treatment provided under paragraphs 11.9.1 to and including paragraph 11.9.8 of the Principles.

2.3 Treatment of associated non-service injury or disease injuries or diseases

2.3.1 Subject to these Principles, the Commission will provide, arrange, or accept financial responsibility for treatment of an injury or disease that is not a service injury or a service disease to the extent that it is a necessary part of treatment for a service injury or service disease.

2.6 Referrals by the Veterans and Veterans Families Counselling Service

2.6.1 The *Veterans and Veterans Families Counselling Service* may refer its clients who are members to other counselling services.

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Treatment that is residential care/residential care (respite)

2.6.2 The *Commission* will accept financial responsibility for counselling referred under paragraph 2.6.1 only where that referral is in accordance with guidelines prepared by the *Commission*.

Note: The guidelines are prepared by the *Commission* after, and subject to, consideration of advice from the National Advisory Committee on the *Veterans and Veterans Families Counselling Service*.

2.7A Centre for Military and Veterans' Health Treatment

2.7A.1 The *Commission* may accept financial liability for *CMVH treatment* provided for the benefit of an *entitled member* who is entitled to such treatment under the *Act*.

Note (1): under subsection 13(1) of the *Act* treatment can be action taken with a view to maintaining a person in physical or mental health.

Note (2): the intention is that the Commission may accept liability for *CMVH treatment* even though such treatment is not provided by the *Centre for Military and Veterans' Health*.

Note (3): prior approval for *CMVH treatment* is not required.

2.7B Australian Centre for Posttraumatic Mental Health Treatment

2.7B.1 The *Commission* may accept financial liability for *ACPMH treatment* provided for the benefit of an *entitled member* who is entitled to such treatment under the *Act*.

Note (1): under subsection 13(1) of the *Act* treatment can be action taken with a view to maintaining a person in physical or mental health.

Note (2): the intention is that the Commission may accept liability for *ACPMH treatment* even though such treatment is not necessarily provided by the *Australian Centre for Posttraumatic Mental Health* but under its auspices.

Note (3): prior approval for *ACPMH treatment* is not required.

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Treatment that is residential care/residential care (respite)

2.8 Loss of eligibility for treatment

- 2.8.1** The *Commission* will not accept financial responsibility for treatment provided to a person if that person is not, in the Commission's opinion, entitled to the treatment.
- 2.8.2** Where a person was entitled to treatment but is considered by the *Commission* to no longer be entitled to treatment or the person has received treatment for which, in the Commission's opinion, he or she was not entitled, the Commission or an employee of the Department must make a reasonable effort to notify the person that they are not entitled to treatment .

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PART 3 — COMMISSION APPROVAL FOR TREATMENT

PART 3 — COMMISSION APPROVAL FOR TREATMENT

3.1 Approval for treatment

3.1.1 The Commission's prior approval may be required for treatment.

3.2 Circumstances in which prior approval is required

3.2.1 Treatment requiring prior approval includes:

- (b) provision of services that are not made available under the Medicare Benefits Schedule except where otherwise stated.

Note: see paragraph 4.2.3.

- (d) outpatient treatment at a private hospital where the requirement for prior approval for such treatment is specified in a contract;
- (e) treatment at a hospital according to the requirements contained in section 4 of the *MPPPs*;

Note: where the patient is a holder of a *White Card* and eligibility for the treatment required is uncertain, the *Commission* will not accept financial responsibility for the cost of care unless the *Department* has verified eligibility.

- (f) admission to a hospital or the provision of hospital treatment not otherwise specified;

Note: see paragraph 9.1.9.

- (h) respite or convalescent admission to an institution;

Note: see paragraph 9.6.1.

- (j) in-home respite care;

- (ja) emergency short term home relief (ESTHR) to be provided within 24 hours after a previous service of ESTHR;

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Note: the intention is that 3 days (the max ESTHR per emergency) should be sufficient time for alternative respite care to be arranged and prior approval is required before a further immediately subsequent service of ESTHR may be provided.

- (k) provision of residential care in Australia or overseas;

Note: see paragraph 2.2.4 and Part 10.

- (n) dental treatment specified as requiring prior approval in Part 5 or in a *DVA document* incorporated into the *Principles*;
- (na) *diabetes educator services* specified in paragraph 7.6A.2;
- (o) community nursing services specified as requiring prior approval in Treatment Principle 7.3;
- (p) physiotherapy that exceeds the limits specified in paragraph 7.5.1;
- (q) podiatry that is not specified in paragraph 7.6.1;
- (r) provision of rehabilitation appliances specified as requiring *prior approval* in or under Part 11;
- (s) provision of a visual aid to an *entitled person* by an optometrist or an *optical dispenser* that is either:
 - (i) not available to the *entitled person* under the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*; or
 - (ii) available to the *entitled person* under the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*, but with the stipulation that *prior approval* is required.
- (t) repair of a rehabilitation appliance specified as requiring *prior approval* in or under Part 11;
- (w) ambulance transport, except for that provided by certain ambulance services specified in paragraph 12.1.1;
- (x) cosmetic surgery;

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PART 3 — COMMISSION APPROVAL FOR TREATMENT

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- (y) medical devices not included on the *Department's* schedule of 'Benefits Payable in Respect of Surgically Implanted Prostheses, Human Tissue Items and Other Medical Devices;
 - (z) psychiatric inpatient care or psychiatric day patient program care;
 - (za) treatment specified in any *Notes for Providers* (however described) and in any *Fee Schedule* as requiring *prior approval*.

3.2.2 In considering whether prior approval will or will not be given and what conditions, if any, will apply, the following will be taken into account:

- (a) any specific requirements contained in these Principles or the Act;
- (c) the extent of funds that are available;
- (d) reasonable control over expenditure;
- (e) the clinical need for the proposed treatment; and
- (f) the suitability and quality of the proposed treatment.

3.3 Circumstances in which prior approval is not required

3.3.2 Treatment not requiring prior approval includes:

- (a) treatment by Local Medical Officer or other GPs except where otherwise indicated in Part 4;
- (b) medical specialist consultations in country and Territory areas, except where otherwise indicated in principle 4.7;

Note: Prior approval is not required for medical specialist consultations in States or Territories where the MPPPs apply — see paragraph 1.2.2.

- (c) dental treatment specified as not requiring prior approval in Part 5 or in a *DVA document* incorporated into the *Principles*;
- (d) dental prosthetic treatment specified as not requiring prior approval in Part 5 or in a *DVA document* incorporated into the *Principles*;

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PART 3 — COMMISSION APPROVAL FOR TREATMENT

- (da) *diabetes educator services*, except where otherwise indicated in Principle 7.6A;
- (e) the prescription and supply of pharmaceutical items as set out in Part 6;
- (f) subject to paragraph 7.3.5, the provision of community nursing services by a nurse in accordance with paragraph 7.3.3 after the services have been provided;

Note: see principle 7.3.

- (fa) treatment under the *MRCA Home Care Program* except a service of *emergency short term home relief* (ESTHR) within 24 hours of a previous service of ESTHR;

Note: see principle 7.3A.

- (g) optometrical treatment provided by an optometrist to an *entitled person* in accordance with these *Principles* and the dispensing of optical products by an optometrist (or an *optical dispenser*) provided that, if an optical product is dispensed, any requirement for prior approval in relation to that product imposed by 3.2.1(s) is satisfied.

Note: see principle 7.4.

- (h) physiotherapy treatment, except where otherwise indicated in principle 7.5.
- (j) podiatry treatment, except where otherwise indicated in principle 7.6;
- (k) treatment at a hospital under the conditions set out in paragraph 9.1.8;
- (m) ambulance transport in an emergency or where that is the arrangement between ambulance service providers and the Commission;

Note: see paragraph 12.1.5.

- (n) referral to the Australian Hearing Service; and

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- (o) chiropractic or osteopathic treatment.

3.4 Other retrospective approval

3.4.1 On application, the Commission may approve, and pay the cost of, any treatment that was undertaken in the period between:

- (a) the effective date of eligibility under the Act; and
- (b) the date on which the person is notified of entitlement.

3.4.2 The Commission may provide approval for treatment that has already been given or has commenced to be given in circumstances where:

- (a) it would have accepted financial responsibility if prior approval had been sought before the service was provided; and
- (b) there are exceptional circumstances justifying the failure to seek prior approval;

or where:

- (c) a request for prior approval was incorrectly processed or failed to be processed due to an administrative error or processing error on the part of the Department or an officer of the Department.

3.4.3 The Commission will accept financial responsibility for emergency treatment for entitled persons and, subject to principle 2.2, for emergency treatment overseas for a service injury or service disease without prior approval only if approval is sought as soon as possible after the event.

Note: this Principle does not apply to residential care or residential care (respite) provided overseas or in Australia. In such cases the extent of Commission liability is determined under paragraphs 2.2.3 (c) and (d), and Part 10, of the Principles.

3.4.4 The Commission's financial liability under paragraphs 3.4.1 and 3.4.3 is limited to the difference between:

- (a) the reasonable cost of treatment; and

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PART 3 — COMMISSION APPROVAL FOR TREATMENT

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- (b) the amount that an entitled person has claimed or is entitled to claim from the *Department of Human Services* as a *medicare benefit*, a health insurance fund or another third party.

3.4.5 The Commission’s financial liability under paragraph 3.4.2 is limited to the difference between:

- (a) the cost of treatment for which it is financially responsible under paragraph 3.5.1; and
- (b) the amount that an entitled person has claimed or is entitled to claim from the *Department of Human Services* as a *medicare benefit*, a health insurance fund or another third party.

3.4.6 The *Commission* will not pay or reimburse the Medicare levy or the Medicare levy surcharge or pay or reimburse health insurance fund premiums.

Note: see the *Medicare Levy Act 1986* for the Medicare levy and Medicare levy surcharge.

3.4.7 The Commission will accept financial responsibility under paragraphs 3.4.1, 3.4.2, and 3.4.3 if an application is supported by accounts, receipts, declarations or other evidence of the condition treated.

3.5 Financial responsibility

3.5.1 The extent of the financial liability accepted by the *Commission* for the provision of treatment to an *entitled person* by a *health care provider* is as follows:

- (1) for fees charged by:
 - (a) a chiropractor — the amount worked out under the *DVA document* entitled “Chiropractors Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(b)(Chiropractors));
 - (b) a dentist (Local Dental Officer), including for dental services provided by a *dental hygienist*, *dental therapist* or *oral health therapist* on behalf of the *dentist* — the amount worked out under the *DVA document* entitled “Fee Schedule

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- of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(c)(as section 2(c) affects dentists));
- (c) a dental prosthetist — the amount worked out under the *DVA document* entitled “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(c)(as section 2(c) affects dental prosthetists));
- (d) a dental specialist, including for dental services provided by a *dental hygienist, dental therapist or oral health therapist* on behalf of the *dental specialist* — the amount worked out under the *DVA document* entitled “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(c)(as section 2(c) affects dental specialists, including as dentists));
- (e) a diabetes educator — the amount worked out under the *DVA document* entitled “Diabetes Educators Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(d)(Diabetes Educators));
- (f) a dietitian — the amount worked out under the *DVA document* entitled “Dietitians Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(e)(Dietitians));
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- (g) an exercise physiologist — the amount worked out under the *DVA document* entitled “Exercise Physiologists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(f)(Exercise Physiologists));
- (h) a LMO — the amount worked out under the *DVA document* entitled “Department of Veterans’ Affairs Fee Schedules for Medical Services”, *in force on the date in Schedule 1*, pursuant to the following parts of that document:

Chronic Pain Honorarium Fees;
Clinical Note Fees;
Compensation Consultation Fees;
Diagnostic Imaging Fee Schedule
Dose Administration Aid (DAA) Service Fees for GPs and LMOs;
Guide to the Assessment of Rates of Veterans' Pensions (GARP) Fee;
Kilometre Allowance;
Local Medical Officers (LMOs) Fee Schedule;
Medication Review Fees;
Pathology Fee Schedule;
Ready Reckoner for LMOs
Relative Value Guide Fee Schedule;
Repatriation Medical Fee Schedule;

on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Local Medical Officers*;

- (i) a medical specialist — the amount worked out under the *DVA document* entitled “Department of Veterans’ Affairs Fee Schedules for Medical Services”, *in force on the date in Schedule 1*, pursuant to the following parts of that document:

Chronic Pain Honorarium Fees;
Clinical Note Fees;
Compensation Consultation Fees;
Diagnostic Imaging Fee Schedule
Dose Administration Aid (DAA) Service Fees for GPs and LMOs;
Guide to the Assessment of Rates of Veterans' Pensions (GARP) Fee;
Kilometre Allowance;
Medication Review Fees;
Pathology Fee Schedule;
Ready Reckoner for LMOs
Relative Value Guide Fee Schedule;
Repatriation Medical Fee Schedule;

on condition that the treatment was provided in accordance with the *Principles*;

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- (ia) a neuropsychologist — the amount worked out under the *DVA document* entitled “Neuropsychologists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects a neuropsychologist));
- (ja) an occupational therapist — the amount worked out under the *DVA document* entitled “Occupational Therapists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles*, as they affect an occupational therapist other than as an *occupational therapist (mental health)*, and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(g)(Occupational Therapists));
- (j) an occupational therapist (mental health) — the amount worked out under the *DVA document* entitled “Occupational Therapists (Mental Health) Schedule of Fees”, *in force on the date in Schedule 1*, as the document relates to an occupational therapist (mental health), on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects occupational therapists (mental health));
- (k) an optical dispenser of visual aids — the amount worked out under the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles*, the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*, and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects optical dispensers));
- (l) an optometrist — the amount worked out under the *DVA document* entitled “Optometrist Fees for Consultation”, *in force on the date in Schedule 1*, on condition that the

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treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects optometrists));

- (m) an orthoptist — the amount worked out under the *DVA document* entitled “DVA Schedule of Fees Orthoptists”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects orthoptists));
- (n) an osteopath — the amount worked out under the *DVA document* entitled “Osteopaths Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(i)(Osteopaths));
- (o) an other GP — the amount worked out under the *Notes for Local Medical Officers* in respect of an *other GP*;
- (oa) an outreach program counsellor — the amount worked out under the *DVA document* entitled “Veterans and Veterans Families Counselling Service (VVCS) Outreach Program Counsellors (OPC) Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *VVCS OPC Provider Notes* as the *Notes* apply to the person as a *psychologist* or *social worker (mental health)*, as the case may be;
- (p) a physiotherapist — the amount worked out under the *DVA document* entitled “Physiotherapists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and section 2(j)(Physiotherapists));
- (q) a podiatrist — the amount worked out under the *DVA document* entitled “Podiatrists Schedule of Fees”, *in force on*

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the date in Schedule 1, on condition that the treatment was provided in accordance with the Principles and the Notes for Allied Health Providers (Section 1 General Information and Section 2(k)(Podiatrists));

- (ra) a clinical psychologist — the amount worked out under the *DVA document* entitled “Clinical Psychologists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects clinical psychologist (including as a psychologist));
- (r) a psychologist — the amount worked out under the *DVA document* entitled “Psychologists Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects psychologists (other than as a clinical psychologist));
- (sa) a social worker (general) — the amount worked out under the *DVA document* entitled “Social Workers Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects social workers (other than as a social worker (mental health));
- (s) a social worker (mental health) — the amount worked out under the *DVA document* entitled “Social Workers (Mental Health) Schedule of Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(a)(as section 2(a) affects social workers (mental health));
- (u) a speech pathologist — the amount worked out under the *DVA document* entitled “Speech Pathologists Schedule of

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Fees”, *in force on the date in Schedule 1*, on condition that the treatment was provided in accordance with the *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(1)(Speech Pathologists));

except where the *Commission*, having regard to the matters specified in paragraph 3.2.2, is satisfied that there are exceptional circumstances justifying payment of a higher fee.

3.5.2 The Commission will only accept financial responsibility for treatment:

- (a) that is reasonably necessary for the adequate treatment of the entitled person;
- (b) that is given by an appropriate category of *health care provider*; and
- (c) if a claim for payment in respect of treatment:
 - (i) is in the form, if any, approved by the Commission for this purpose ('approved form'); and
 - (ii) contains, or is accompanied by, any information required by any direction in any approved form; and
 - (iii) is lodged at an appropriate place or with an appropriate person within the period of 5 years (or such longer period as is allowed in accordance with paragraph 3.5.2A) from the date of rendering the service to which the claim relates.

Note 1: a claim is taken to have been lodged on the day it is received.

Note 2: 'appropriate place' means an office of the Department in Australia, the *Department of Human Services* or a place approved by the *Commission* for the purpose of lodging claims.

Note 3: 'appropriate person' means a person approved by the *Commission* for the purpose of lodging claims.

Note 4: a claim may be lodged by means of an electronic transmission.

3.5.2A Upon application in writing, by a claimant, to the Commission, the Commission may, in its discretion, by notice in writing served on the claimant, allow a longer period for lodging a claim than the period of 5 years referred to in subparagraph 3.5.2(c).

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PART 3 — COMMISSION APPROVAL FOR TREATMENT

Note: 'claimant' means an appropriate category of health provider seeking payment in respect of treatment provided under the Principles.

3.5.2B In exercising its power under paragraph 3.5.2A to allow a longer period for lodging a claim, the Commission shall have regard to all matters that it considers relevant, including, but without limiting the generality of the foregoing, any hardship that might be caused to the claimant if a longer period is not allowed.

Note: 'claimant' means an appropriate category of health provider seeking payment in respect of treatment provided under the Principles.

3.5.3 The Commission will not accept financial responsibility for the cost of the following treatment by *health care providers*, including treatment by dentists, physiotherapists and podiatrists:

- (a) services that have been paid for, wholly or partly, by the *Department of Human Services*, as a *medicare benefit*, or by a health insurance fund; or
- (b) services where the cost is otherwise recoverable, wholly or partly, by way of a legal claim; or
- (c) examination for employment purposes; or
- (d) examination for a medical certificate for membership of a friendly society.

3.5.4 Where the Commission accepts financial responsibility under these MRCA Treatment Principles, it does so on behalf of the Commonwealth.

PART 4 — MEDICAL PRACTITIONER SERVICES

4.1 Medical Practitioner Services

4.1.2 Outline

- 4.1.3** The aim of the medical services program is to ensure that as far as practicable *entitled persons* have access to free, safe and cost-effective treatment.

To achieve this objective the *Commission* or the *Department* deals with medical practitioners on three levels.

At the first level the *Commission* or the *Department* deals with medical practitioners called *LMOs*. Services provided by these medical practitioners must be in accordance with these *Principles* and the *Notes for Local Medical Officers* if the Department is to pay for the services.

The second level of engagement is where the *Commission* or the *Department* deals with medical practitioners who are willing to treat *entitled persons* under these *Principles* eg without charging the *entitled person*, but who are not prepared to provide their services in accordance with the *Notes for Local Medical Officers*. These medical practitioners are called *other GPs*.

Because *LMOs* provide services in accordance with the *Notes for Local Medical Officers*, which impose various requirements, some of which are exacting but which are aimed at maintaining a high quality of service and ensuring accountability, they receive higher rates of remuneration from the *Department* than do *other GPs*.

The feature that distinguishes *LMO*-treatment or *other GP*-treatment from treatment provided by medical practitioners not included in

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PART 4 — MEDICAL PRACTITIONER SERVICES

these categories is that *LMOs* and *other GPs* do not charge the *entitled person* for that treatment. They charge the *Commission*, the *Department* or *Department of Human Services* (hereafter in this Outline these bodies are referred to collectively as DVA).

It should be noted that while it is the *Commission* that accepts financial liability for treatment it is the *Department* (Commonwealth) that actually pays for the treatment.

The third level of interaction between the *Commission* or the *Department* and medical practitioners is where the medical practitioner is a specialist.

Unlike LMOs, medical specialists (as at 1 April 2006) are not prepared to submit to the same level of regulation as LMOs regarding services to *entitled persons* (at DVA expense) but if they are prepared to treat an *entitled person* at the rate set out in the *Principles* and charge DVA and not the *entitled person*, then the relationship between DVA and the specialist is covered by the *Principles*.

- 4.1.4** Subject to paragraph 3.5.1, the *Commission* may accept financial liability for medical treatment provided to an *entitled person* by an *LMO*, an *other GP* or a *medical specialist*.

Note: paragraph 3.5.1 sets out the financial limits on Commission liability for treatment.

4.2 Providers of services

- 4.2.1** Unless otherwise indicated in these Principles, an entitled person may be provided with only those services included in the Medicare Benefits Schedule.
- 4.2.2** The services referred to in paragraph 4.2.1 may be provided only by:
- (a) a Local Medical Officer or other GP; or
 - (b) a medical specialist.

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PART 4 — MEDICAL PRACTITIONER SERVICES

4.2.3 (1) An *entitled person* may be provided with services that are not made available under the *Medicare Benefits Schedule* ("unlisted services").

(2) Unlisted services are not to be provided to an *entitled person* if the *Commission* is satisfied that they are:

(a) a mere improvement on existing *Medicare Benefits Schedule* listed services; or

(b) experimental and have not been demonstrated to be effective or safe by extensive clinical trials.

4.2.4 Subject to paragraph 4.2.3(2), unlisted services are to be provided to an *entitled person* under paragraph 4.2.3(1) if the *Commission* is satisfied that the services will provide a substantial benefit to the health of the *entitled person*.

Note 1: the prior approval of the *Commission* is required before unlisted services may be provided (Paragraph 3.2.1 (b)).

Note 2: the availability of funds and the need to reasonably control expenditure are factors to be considered in granting prior approval (Subparagraphs 3.2.2 (c) and (d))

4.2.5 The services referred to in paragraph 4.2.3 may be provided only by:

(a) a Local Medical Officer or other GP; or

(b) a medical specialist.

4.2.6 Optical Coherence Tomography

4.2.7 The *Commission* may accept financial responsibility for *Optical Coherence Tomography* (OCT) provided to an *entitled person* by an Ophthalmologist for the assessment or management of retinal disease.

Note: While OCT remains an unlisted treatment it is subject to all the requirements for an unlisted treatment except *prior approval*.

4.3 Financial responsibility

4.3.1 Subject to paragraph 3.5.1, and unless otherwise indicated in these Principles, the Commission will accept financial responsibility for treatment costs

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where a Local Medical Officer or other GP or specialist provides or arranges for treatment of:

- (a) an entitled person who has been issued with a Gold Card; or
- (b) an entitled person who has been issued with a White Card for any service injury or service disease; or
- (c) a person who has been issued with a written authorisation on behalf of the Commission;

Note: Principle 3.5.1 also deals with financial liability for medical practitioner fees.

4.3.2 In relation to any occasion of service to an entitled person under these Principles, a Local Medical Officer or other GP or specialist shall bill only:

- (a) the *Department*; or
- (b) the *Commission*; or
- (c) the *Department of Human Services*,

and that bill shall be for full settlement of the account for the service provided to the entitled person.

4.3.3 Any billing method described in paragraph 4.3.2 may be used on each occasion of service.

4.3.4 Subject to paragraph 4.7.3, the *Commission* will accept financial responsibility for any of the services described in paragraph 4.4.1, irrespective of the billing arrangement chosen under paragraph 4.3.2 by the referring Local Medical Officer or other GP or specialist.

4.3A Disqualified Medical Practitioners

4.3A.1 The *Commission* is not to accept financial responsibility for the cost of a medical service provided to an *entitled person* by, or on behalf of, a *LMO*, *other GP* or a *medical specialist* if, at the time the service was provided, a *medicare benefit* would not have been payable in respect of the service under section 19B or section 19C of the *Health Insurance Act 1973* (in force from time to time) if the *LMO*, *other GP* or *medical specialist* had provided the service as a *practitioner* under that Act.

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PART 4 — MEDICAL PRACTITIONER SERVICES

4.4 Referrals

4.4.1 A Local Medical Officer or other GP may refer an entitled person for:

- (a) treatment from a medical specialist, subject to paragraph 4.7.1, and principles 4.5 to 4.8; or
- (b) treatment from a Local Medical Officer or other GP who has expertise or recognition in a particular field but is not a qualified medical specialist, subject to principles 4.5 to 4.8; or
- (c) treatment in a hospital or other institution as indicated in these Principles; or
- (d) other health-care services not requiring prior approval, as indicated in principles 7.3, 7.5 and 7.6.

4.5 Referrals by medical specialists

4.5.1 In providing treatment, a medical specialist, to whom an entitled person is referred under these Principles, may:

- (a) arrange diagnostic tests; or
- (b) refer the entitled person to another specialist in the same way as may a Local Medical Officer or other GP; or
- (c) arrange treatment in a hospital or other institution as indicated in these Principles; or
- (d) refer the entitled person to a health-care provider in accordance with principles 7.3, 7.5 or 7.6, in the same way as may a Local Medical Officer or other GP.

4.7 Referrals: prior approval

4.7.1 In all instances other than those described in paragraph 4.7.3 and the *MRCA Private Patient Principles 2004*, prior approval is required for the referral of entitled persons to medical specialists.

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4.7.2 Prior approval is required for:

- (a) the provision of psychotherapy treatment to entitled persons; or
- (b) the provision of services under paragraph 4.2.3.

4.7.3 Prior approval is not required when a *LMO, other GP or medical specialist* refers an *entitled person* to a *medical specialist* for diagnostic imaging or pathology services not requiring admission and the *medical specialist* direct bills the *Department of Human Services* at 100 per cent or less of the fee set out in the *Medicare Benefits Schedule* as full settlement of the account for the service rendered.

4.8 Other matters

4.8.1 The *Commission* will not accept financial responsibility for the cost of:

- (a) elective surgery undertaken without prior approval with the exception of elective surgery in a public hospital, minor procedures carried out in a Local Medical Officer or other GP's or specialist's rooms where the only charge is equivalent to the charge that would be applicable under the Medicare Benefits Schedule for that procedure; or
- (b) examination for a medical certificate for life assurance purposes; or
- (c) examination for a medical certificate for membership of a friendly society; or
- (d) examination for employment purposes; or
- (e) multi-phasic screening; or
- (f) services where the cost is otherwise recoverable wholly or partly, by way of a legal claim; or
- (g) services that have been paid for, wholly or partly, by the *Department of Human Services*, as a *medicare benefit*, or by a health insurance fund; or

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(ga) *diabetes educator services* under this Part that may be provided under Part 7 (Treatment Generally From Other Health Providers).

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PART 5 — DENTAL TREATMENT

PART 5 — DENTAL TREATMENT

5.1 Providers of services

5.1.1 The *Commission* may accept financial responsibility for dental treatment provided to an *entitled person* by a *dental prosthetist, dentist or dental specialist* where the treatment is provided in accordance with these *Principles* and in accordance with the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(c)(as section 2(c) affects a dental prosthetist, dentist or dental specialist, as the case may be)).

5.1.1A For paragraph 5.1.1, dental treatment provided by a *dentist or dental specialist* includes dental treatment provided by a *dental hygienist, dental therapist or oral health therapist* on behalf of the *dentist or dental specialist*, as the case may be.

5.1.2 The *Commission* will accept financial responsibility for dental treatment provided to an *entitled person* in a *Tier 1 Hospital* or *Contracted Day Procedure Centre* without the need for *prior approval*.

Note: the *Notes for Allied Health Providers*, the “Fee Schedule of Dental Services for Dentists and Dental Specialists” and the “Fee Schedule of Dental Services for Dental Prosthetists”, as incorporated-by-reference into the *Principles*, could be relevant to dental treatment provided to an *entitled person* in a hospital.

5.1.2A Except in an emergency, the *Commission’s prior approval* is required before dental treatment is provided to an *entitled person* in a hospital other than a *Tier 1 Hospital* or on premises other than a *Contracted Day Procedure Centre* unless the “Fee Schedule of Dental Services for Dentists and Dental Specialists” or the “Fee Schedule of Dental Services for Dental Prosthetists” provides that *prior approval* is not required for the treatment.

5.1.3 Subject to prior approval, an *entitled person* may be referred to a *dental specialist* by a *dental prosthetist, dentist or other dental specialist*.

5.2 Financial responsibility

5.2.1 The *DVA document* entitled “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1*, and comprised of Dental Schedules A, B and C, lists the dental services provided by

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dentists, or dental specialists, for which the Commission will accept financial responsibility, when provided to an entitled person, and sets out the limits of that financial responsibility.

5.2.2 The *DVA document* entitled “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1*, lists the dental services provided by *dental prosthetists* for which the *Commission* will accept financial responsibility, when provided to an *entitled person*, and sets out the limits of that financial responsibility.

5.2.3 Dental Schedule C in 5.2.1 imposes a monetary limit (annual monetary limit) in respect of dental services provided to an *entitled person* under that Schedule in a Calendar year.

5.2.4 Subject to 5.1.2 and 5.1.2A (treatment in *Tier 1 Hospital/Contracted Day Procedure Centre*), where a Schedule in 5.2.1 or 5.2.2 specifies a need for *prior approval* in respect of a service, the *Commission* is not to accept financial liability for the service unless it has granted *prior approval* or retrospective approval for the service.

5.2.5 The annual monetary limit set under Dental Schedule C in 5.2.1 will not apply in relation to a dental service where that service is for a service injury or service disease.

5.2.6 Subject to paragraph 5.5.1, the *Commission* will not accept financial responsibility for dental treatment after a person is no longer entitled to the treatment.

5.2A Disqualified Dental Practitioners

5.2A.1 The *Commission* is not to accept financial responsibility for the cost of a dental service provided to an *entitled person* by, or on behalf of, a *dental prosthetist, dentist or a dental specialist* if, at the time the service was provided, a *medicare benefit* would not have been payable in respect of the service under section 19B of the *Health Insurance Act 1973* (in force from time to time) if the *dental prosthetist, dentist or dental specialist* had provided the service as a *practitioner* under that Act.

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5.3 Entitlement

5.3.1 Subject to these Principles, an entitled person who holds a *Gold Card*, *White Card* or written authorisation issued on behalf of the *Commission*, may be provided with dental services at the expense of the *Commission*.

5.3.2 A person who holds a *Gold Card* will be provided with the following dental services:

- (a) for treatment of an injury or disease that is not a service injury or a service disease:
 - (i) the dental services listed in Schedules A, B and C of the *DVA document* entitled “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with those Schedules;
 - Note: Schedule C imposes an annual monetary limit.
 - (ii) the dental services listed in the *DVA document* entitled “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with that Schedule.
- (b) for treatment of a service injury or service disease:
 - (i) the dental services listed in Schedules A, B and C of the *DVA document* entitled “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with those Schedules (but without the annual monetary limit in the Schedule C);
 - (ii) the dental services listed in the *DVA document* entitled “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with that Schedule.

5.3.3 A person who holds a *White Card* is entitled to dental treatment of a service injury or service disease and will be provided with:

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- (a) the dental services listed in the *DVA document* entitled “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with that Schedule; and

Note: Schedule C of the Fee Schedule imposes an annual monetary limit

- (b) the dental services listed in the *DVA document* entitled “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1* — on condition the services are provided in accordance with that Schedule.

5.4 Emergency dental treatment

5.4.1 *Prior Approval* is not necessary for emergency dental treatment provided to an *entitled person* where the treatment is provided in accordance with:

- (a) the *Principles*;
- (b) the “Fee Schedule of Dental Services for Dentists and Dental Specialists”, *in force on the date in Schedule 1*;
- (c) the “Fee Schedule of Dental Services for Dental Prosthetists”, *in force on the date in Schedule 1*; and
- (d) the *Notes for Allied Health Providers*;

as those documents relate to the treatment, but if *prior approval* is required for the treatment then the *Commission’s* retrospective approval for the treatment must be sought as soon as possible after the treatment is provided and approval must be granted if the *Commission* is to accept financial liability for the emergency dental treatment.

Note: Schedule C of the “Fee Schedule of Dental Services for Dentists and Dental Specialists” imposes an annual monetary limit

5.4.2 Financial responsibility for emergency dental treatment for persons who hold a *White Card* will only be accepted for treatment of a service injury or service disease.

5.5 Orthodontic treatment for children

5.5.1 Orthodontic treatment will continue to be provided for an *eligible young person* of a deceased member if the eligible young person has ceased to be

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PART 5 — DENTAL TREATMENT

eligible for treatment because he or she has turned sixteen years of age or has ceased full-time education if:

- (a) the treatment is approved by the *Commission* while the eligible young person is still eligible; and
- (b) the treatment is commenced while the eligible young person is still eligible; and
- (c) the treatment will be completed within two years of commencement of treatment or such longer time as the *Commission* considers reasonable.

5.6 General anaesthesia

5.6.1 Financial responsibility for a general anaesthetic provided as part of dental treatment will be accepted only if:

- (a) the anaesthetic is administered by a specialist anaesthetist or approved medical practitioner in a hospital, *Day Procedure Centre* or dental surgery where adequate resuscitation equipment is provided; and
- (b) unless the anaesthetic is administered in a *Tier 1 Hospital* or *Contracted Day Procedure Centre* — *prior approval* has been obtained.

5.7 Prescribing of pharmaceutical benefits by dentists

5.7.1 Local Dental Officers or dental specialists may prescribe Pharmaceutical Benefits for *entitled persons*.

5.7.2 Subject to paragraph 5.7.4, prescriptions prescribed under paragraph 5.7.1 must be in accordance with the PBS.

5.7.3 The *Commission* will accept financial responsibility for Pharmaceutical Benefits, available under the PBS that are required as part of dental treatment:

- (a) for a service injury or service disease of an entitled person who holds a *White Card*; or

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- (b) for an entitled person who holds a *Gold Card*;

other than the amount that would have been payable by the person if the person were a “concessional beneficiary” under the *National Health Act 1953*.

5.7.4 The Commission will accept financial responsibility for Pharmaceutical Benefits that are not available under the PBS and are required as part of dental treatment:

- (a) for a service injury or service disease of a person who hold a *White Card*; or
- (b) for a person who holds a *Gold Card*;

but such a prescription must be written on a private prescription.

5.8 Other dental services

5.8.1 The *Commission* will not accept financial responsibility for dental treatment that involves the use of intravenous sedation or relative analgesia technique in a Local Dental Officer’s or dental specialist’s surgery.

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PART 6 — PHARMACEUTICAL BENEFITS

6.1 MRCA Pharmaceutical Benefits Scheme

6.1.1 The MRCA Pharmaceutical Benefits Scheme (prepared by the Commission under paragraph 286(1)(c) of the *Act*) relates to the supply of Pharmaceutical Benefits to entitled persons by community pharmacists as defined in that Scheme.

6.2 Entitlement under the MRCA Pharmaceutical Benefits Scheme

6.2.1 A person is eligible to receive Pharmaceutical Benefits under the MRCA Pharmaceutical Benefits Scheme if that person holds:

- (a) a *White Card* for a service injury or service disease; or
- (b) a *Gold Card*.

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6A.1 Outline

The “Coordinated Veterans' Care Program” (program) is an initiative that aims to improve the health of a class of entitled persons so they have fewer hospital admissions.

The entitled persons are Gold Card holders with complex care needs due to diagnosis of a particular chronic condition (set out in 6A.5).

The element of the program intended to reduce hospital admissions is external oversight of a person’s health regimen for a period of care of 3 months (carried over to consecutive periods of 3 months if the treatment is proving positive).

The oversight will be performed by a Local Medical Officer (LMO) and the LMO’s practice nurse (or a community nurse (via a DVA-contracted community nursing provider) or an aboriginal health worker, if more appropriate).

Essentially the LMO will prepare a comprehensive care plan (GPMP) for the entitled person and the LMO’s practice nurse (or a community nurse or aboriginal health worker) will co-ordinate health care services under the plan. The LMO will provide oversight throughout. In cases where an LMO is unable to obtain the services of a nurse or aboriginal health worker as a care co-ordinator, the LMO may provide that care co-ordination.

In addition to having their health care services overseen and co-ordinated, some entitled persons in the program who the LMO considers are socially isolated and would benefit from a service under a particular community care program aimed at providing the person with more social contact, may be referred by the LMO to a MHC assessment agency (an agency under the MRCA Home Care Program) for an assessment as to the suitability of the person for a social support service under that Program.

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Accordingly, two main treatments are provided under the program:

- LMO Care Leadership treatment
- practice nurse/community nurse/aboriginal health worker/care co-ordination treatment

An ancillary treatment under the program is:

- LMO referral for social support service assessment

The main treatments relate to the oversight and co-ordination of health care services under the entitled person's comprehensive care plan (GPMP) and are in addition to existing treatments available to the entitled person under the Medicare Benefits Schedule and the MRCA Treatment Principles.

The ancillary treatment may be provided by an approved provider of MRCA Home Care services following a request for social support services from a MHC assessment agency. The LMO will have decided the person is socially isolated and that a social support service might prevent the person from being admitted or re-admitted to hospital. The MHC assessment agency will assess the person's suitability for a social support service.

Note: an identical program for veterans exists under the *Treatment Principles* made under the *Veterans' Entitlements Act 1986*.

6A.2 Treatments under the Coordinated Veterans' Care Program

6A.2.1 LMO Care Leadership treatment/LMO Home Care service (category C) Referral

6A.2.2 An *LMO* may, under the *Coordinated Veterans' Care Program*, provide:

- (a) *LMO Care Leadership treatment*; and/or
- (b) an *LMO Home Care service (category C) Referral*;

for an *entitled person*.

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6A.2.3 Practice Nurse Care Co-ordination treatment

6A.2.4 A *practice nurse* may, under the *Coordinated Veterans' Care Program*, provide *Practice Nurse Care Co-ordination treatment* to an *entitled person*.

6A.2.5 Community Nurse Care Co-ordination treatment

6A.2.6 A *DVA-contracted community nursing provider* may, under the *Coordinated Veterans' Care Program*, provide *Community Nurse Care Co-ordination treatment* to an *entitled person*.

6A.2.7 Aboriginal Health Worker Care Co-ordination treatment

6A.2.8 An *aboriginal health worker* may, under the *Coordinated Veterans' Care Program*, provide *Aboriginal Health Worker Care Co-ordination treatment* to an *entitled person*.

6A.3 LMO Approval of Subsequent Period of Care

6A.3.1 Before any *subsequent period of care* of an *entitled person* by an *LMO* commences, being an *LMO* who is treating the person under the *Coordinated Veterans' Care Program* (Program), the *LMO* is to decide if the person's continued participation in the Program would meet the aims of the Program (i.e. reduce hospitalisation of the person/avoid duplication of services/provide cost-effective treatment).

Note 1: the first period of care by an *LMO* commences on the date the *LMO* decides to admit the *entitled person* to the Program (admission date). Any following period of care by the same *LMO* is a subsequent period of care. The first period of care by an *LMO* may also occur where the *LMO* is a different *LMO* for the person. Any following period of care by the same *LMO* is a subsequent period of care.

Note 2: the period of care by an *LMO* is set out in the *Notes for Coordinated Veterans' Care Program Providers* and is a period of 3 months.

6A.3.2 For making the decision in 6A.3.1, the *LMO* is to:

- (a) review the *entitled person's* file maintained by the *LMO* and any other information the *LMO* considers relevant; and

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- (b) ascertain if the person is eligible for a subsequent period of care by the LMO.

Note: see 6A.6.2

6A.3.3. If the *LMO* decides the *entitled person* should continue to participate in the Program, because the person meets the aims of the Program and is eligible for a *subsequent period of care* by the LMO, the LMO is to:

- (a) approve a subsequent period of care by the LMO of the entitled person before the period commences (approval);
- (b) make a record of the approval (which may be in electronic form), containing the date of the approval;
- (c) store the approval in a readily retrievable form; and
- (d) take any necessary steps to facilitate the provision of the subsequent period of care by the LMO to the entitled person.

6A.3.4. Where an LMO approves a *subsequent period of care* by the LMO for an entitled person, before the expiry of a current period of care by the LMO for the person, the subsequent period of care commences on the day following the day on which the current period of care expired.

6A.3.5. Where an LMO approves a *subsequent period of care* by the LMO for an entitled person (approval), after the expiry of a current period of care by the LMO for the person, the subsequent period of care commences on the date of the approval.

6A.3.6. If the *LMO* decides not to approve a *subsequent period of care* by the LMO of the *entitled person*, because the person does not meet the aims of the Program or is ineligible for a subsequent period of care by the LMO, the LMO is to:

- (a) notify (including by telephone) any *DVA-contracted community nursing provider* who may have co-ordinated care for the entitled person under the Program immediately before the potential subsequent period of care by the LMO, of the decision;
- (b) if the entitled person was receiving a *Home Care service (category C)* immediately before the potential subsequent

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period of care by the LMO, notify (including by telephone) the *MHC assessment agency* for the person, of the decision;

- (c) notify the entitled person, in a manner the LMO considers appropriate, of the decision.

6A.4 Commission Financial Responsibility for Treatment under the Coordinated Veterans' Care Program

6A.4.1 The *Commission* will accept financial responsibility for:

- (a) *LMO Care Leadership treatment*;
- (b) *Practice Nurse Care Co-ordination treatment*;
- (c) *Community Nurse Care Co-ordination treatment*;
- (d) *Aboriginal Health Worker Care Co-ordination treatment*;

provided to an *entitled person*, during a *period of care* of the person by the *LMO*, the *practice nurse*, the *community nurse* or the *aboriginal health worker*, as the case may be, if the treatment is provided:

- (a) in accordance with the *Principles* and the *Notes for Coordinated Veterans' Care Program Providers*; and
- (b) during a period of care provided to the entitled person by the LMO under the *Coordinated Veterans' Care Program* (Program).

6A.4.2 The financial amounts the *Department* will pay for:

- (a) *LMO Care Leadership treatment*, *Practice Nurse Care Co-ordination treatment* and *Aboriginal Health Worker Care Co-ordination treatment* — are set out in the *DVA document* entitled: “Department of Veterans’ Affairs Fee Schedules for Medical Services”, *in force on the date in Schedule 1*;
- (b) *Community Nurse Care Co-ordination treatment* — are set out in the *DVA document* entitled: “Australian Government Department of Veterans’ Affairs Classification System and Schedule of Item Numbers and Fees — Community Nursing Services”, *in force on the date in Schedule 1*.

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Note: the *Department of Human Services* will pay fees on behalf of the *Department* under a Services Agreement.

6A.4.3 Subject to 6A.4.4, the Commission is only to accept financial responsibility for a period of care provided to an entitled person by an *LMO, practice nurse, community nurse or aboriginal health worker* under the *Coordinated Veterans' Care Program* (Program) if any previous period of care provided by, respectively, an *LMO, practice nurse, community nurse or aboriginal health worker* under the Program in respect of the entitled person has expired.

Note: Under the *Coordinated Veterans' Care Program* a period of care provided by an *LMO, practice nurse, community nurse or aboriginal health worker* must be in respect of the *Coordinated Veterans' Care Program treatment* the health care provider may provide under the Program.

6A.4.4 A *practice nurse or community nurse* (collectively called “nurse 2”) may provide a period of care comprised of, respectively, *Practice Nurse Care Co-ordination treatment or Community Nurse Care Co-ordination treatment*, to an entitled person under the Program, where a period of care comprised of, respectively, *Practice Nurse Care Co-ordination treatment or Community Nurse Care Co-ordination treatment* being provided in respect of the entitled person by another practice nurse or community nurse, as the case requires, (collectively called “nurse 1”) under the Program has not expired — if the *LMO or DVA-contracted community nursing provider*, as the case requires, for nurse 2, has obtained *prior approval*.

Note 1: Where a period of care provided by nurse 2 and nurse 1 overlaps, and *prior approval* has been obtained for nurse 2’s period of care, the *Commission* may accept financial responsibility for the two simultaneous periods of care.

Note 2: “prior approval” is defined in 1.4.1 and 3.2.2 is also relevant. The grant of prior approval is discretionary and for 6A.4.4 will be considered on a case-by-case basis.

6A.4.5 The payment of a fee for *Practice Nurse Care Co-ordination treatment* and *Aboriginal Health Worker Care Co-ordination treatment* will be made by the *Department* to the *LMO* who employed or engaged the *practice nurse or aboriginal health worker*, as the case may be, at the time the treatment was provided.

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6A.4.6 The payment of a fee for *Community Nurse Care Co-ordination treatment* provided by a *community nurse* will be made by the *Department* to the *DVA-contracted community nursing provider* who employed or engaged the nurse at the time the treatment was provided.

6A.4A Arrangements with Service Providers

6A.4A.1 For the purpose of facilitating the provision of *Coordinated Veterans' Care Program treatment* to *entitled persons*, the *Commission* or the *Department* may enter into an arrangement with a person to:

- (a) assist in identification of possible participants in the *Coordinated Veterans' Care Program* and provide general support to the *Commission* or *Department* in respect of the program including:
 - (i) data analysis to identify and notify potential participants and their usual *LMO* or *medical practitioner*;
 - (ii) undertaking ongoing analysis and reporting to support program evaluation and monitoring;
 - (iii) promoting the program and providing supplementary support materials for *LMOs* and participants in the Program; or
- (b) deliver training modules and resources in Chronic Disease Management to *LMOs*, *medical practitioners*, Practice Nurses and *Community Nurses*; or
- (c) undertake ongoing and independent monitoring and evaluation of the *Coordinated Veterans' Care Program*.

6A.5 Entitlement to Participation in the Coordinated Veterans' Care Program and to Coordinated Veterans' Care Program Treatment under the program

6A.5.1 Subject to 6A.3 and 6A.6, an *entitled person* is entitled to participation in the *Coordinated Veterans' Care Program* (program) and to *Coordinated Veterans' Care Program treatment* under the program if:

- (1) in the opinion of an *LMO* treating the person:
 - (a) the *entitled person* has one or more of the following conditions:

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- (i) congestive heart failure; or
 - (ii) coronary artery disease; or
 - (iii) pneumonia; or
 - (iv) chronic obstructive pulmonary disease; or
 - (v) diabetes; or
 - (vi) some other chronic condition; and
- (b) the condition in (1)(a) has resulted in the person being admitted frequently to hospital or could reasonably result in the person being admitted frequently to hospital; and
- (c) the *entitled person* has complex care needs for the condition in (1)(a), being:
 - (i) one or more of:
 - (aa) multiple co-morbidities that complicate the treatment regimen for the person;
 - (bb) the person's condition is unstable with a high risk of acute exacerbation;
 - (cc) the condition is contributed to by frailty, age and/or social isolation factors;
 - (dd) there are limitations in self management and monitoring;and:
 - (ii) needs which require a treatment regimen that involves one or more of the following complexities of ongoing care:
 - (aa) multiple care providers;
 - (bb) complex medication regimen;
 - (cc) frequent monitoring and review;
 - (dd) support with self management and self monitoring.

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- (2) the person is eligible for treatment under the *Act* for any injury suffered, or disease contracted, by the person (i.e. person has been granted a *Gold Card*); and
- (3) the person is an Australian resident and living in Australia; and
- (4) the person has consented to participation in the program and the *admitting LMO* has recorded the consent (which may be an electronic record); and

Note: under the Notes for Coordinated Veterans' Care Program Providers the LMO is to store the consent.

- (5) the *LMO* treating the person has prepared, in consultation with the person, a comprehensive care plan (*GPMP*); and
- (6) the *LMO* admits the person to the program by making a decision to that effect and keeping a record of it.

6A.6 Ineligibility for participation in the Coordinated Veterans' Care Program (program) and for Coordinated Veterans' Care Program Treatment and LMO Home Care service (category C) Referral under the program

6A.6.1 An *entitled person* is ineligible to be admitted to the *Coordinated Veterans' Care Program* (Program) by an *LMO* for the person if any one of the following applies to the person:

- (a) the person is receiving *residential care*; or
 Note: receiving *residential care* (*respite*) does not disentitle a person to participation in the program.
- (b) the person has been diagnosed by a *medical practitioner* as having a condition that, in the opinion of the *LMO*, would be likely to be terminal within 12 months after the person is admitted to the program, if the person were to be admitted; or
- (c) the person is participating in a health care program provided by the *Department of Health* or the *Department of Social Services* known as:

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- (i) “Coordinated Care for Patients with Diabetes”
(including as a pilot program); or
- (ii) “Transition Care”;

or in a similar coordinated health care program provided by that Department that is essentially the same as one in (i) or (ii) but with a different name.

- 6A.6.2 An entitled person is not eligible for a subsequent period of care by an LMO under the Program if immediately before the commencement of the potential period of care the matters in (a) or (c) of 6A.6.1 apply to the person.

Note: the period of a period of care by an LMO is set out in the *Notes for Coordinated Veterans' Care Program Providers* and is a period of 3 months.

6A.7 Date of Admission for Participation in the Coordinated Veterans' Care Program

6A.7.1 Subject to 6A.3 and 6A.6, treatment of an *entitled person* under the *Coordinated Veterans' Care Program* (program) commences on the *admission day* for the person and continues throughout any *period of care* provided by an *LMO* to the entitled person under the program.

Note: treatment under the program provided by a *practice nurse*, *community nurse* or *aboriginal health worker* can only occur during a period of care provided by an LMO under the program.

6A.8 LMO Home Care service (category C) Referral

6A.8.1 An *LMO* treating an *entitled person* under the *Coordinated Veterans' Care Program* may decide the person would benefit from a *Home Care service (category C)* and may refer the person to a *MHC assessment agency* for an assessment as to the person's suitability for the service and, depending on the outcome, the agency may allocate responsibility for providing the *Home Care service (category C)* to an *approved provider*. The referral is treatment known as: LMO Home Care service (category C) Referral.

Note: for the purposes of 7.3A.1(1)(a)(iii) the referral to a MHC assessment agency is also taken to be a referral to the Commission.

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6A.8.2 The *LMO* may provide an *LMO Home Care service (category C) Referral* for an *entitled person* if:

(1) the person is admitted to the *Coordinated Veterans' Care Program*; and

(2) in the opinion of the *LMO*:

- (a) the person has a limited or inadequate social support network and could reasonably be at risk of hospitalisation for a condition in 6A.5.1(1)(a) because of that social situation; and
- (b) the risk of the person being hospitalised for a condition in 6A.5.1(1)(a) may be significantly reduced if the person received a *Home Care service (category C)*.

Note: a referral must comply with the requirements in the definition of *Home Care service (category C) Referral*.

6A.9 Procedures under the Coordinated Veterans' Care Program.

6A.9.1 An *LMO* may medically assess an *entitled person* the *LMO* is treating to determine if the person would benefit from participation in the *Coordinated Veterans' Care Program* (program).

6A.9.2 If the *LMO* decides the *entitled person* would benefit from participation in the program, and the person is entitled to participate in the program, then the *LMO* is to inform the entitled person that the person's participation in the program is conditional upon the person consenting to personal information about the person that is relevant to the person's treatment under the program being provided to bodies such as:

- the *Department*;
- Contractors to the *Department* who provide services related to the administration of the Program or who would provide a *Home Care service (category C)* (social support service) to the person;
- the *Department of Human Services* (which pays treatment costs for the *Department*);
- health care providers associated with the person's treatment under the program.

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The LMO is to obtain the person's consent, if the person is to participate in the program, and record it and store it in a readily retrievable form.

Note: consent may be recorded and stored in electronic form.

6A.9.3 Once an *entitled person's* consent is obtained the LMO is to admit the person to the program. This takes the form of the LMO recording in writing (including in electronic form) that the person has been admitted to the program. Participation in the program commences on and from the admission date.

6A.9.4 The LMO is to prepare, in consultation with the person, a comprehensive care plan for the person (*GPMP*).

6A.9.5 A *practice nurse* (nurse working for the *LMO*) or, if appropriate, a *community nurse* (nurse working for a *DVA-contracted community nursing provider*) or an *aboriginal health worker* (working for the *LMO*) will co-ordinate care services under the *GPMP* (care co-ordinator). The LMO may need to refer co-ordination of the *GPMP* to a *DVA-contracted community nursing provider* if, for example, the LMO does not employ a *practice nurse*. In some cases the LMO may not be able to secure the services of a care co-ordinator and may need to provide the service themselves but the main role of the *LMO* is to provide oversight of the care co-ordination under the *GPMP*.

6A.9.6 Part of the monitoring mechanism for the program involves the LMO assessing the progress an entitled person is making (progress assessment). This is to occur toward the end of a period of care by the LMO and before the LMO provides a further period of care to the person. More details of the procedure is at 6A.3. A progress assessment is not a prerequisite to the commencement of an initial period of care.

6A.9.7 If the *LMO* decides that the *entitled person* is socially isolated and that because of that situation the person could be reasonably at risk of being hospitalised for a condition in 6A.5.1(1)(a) and that the risk of hospitalisation may be significantly reduced by the provision of a *Home Care service (category C)* to the person — then the *LMO* may refer the person to a *MHC assessment agency* for an assessment as to the person's suitability for the service. The referral is called: LMO Home Care service (category C) Referral.

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6A.9.8 The *MHC assessment agency* is to assess a person pursuant to a *LMO Home Care service (category C) Referral* and is to determine if the person is suitable for a *Home Care service (category C)*, using the standard assessment process that the agency applies to all assessments for services under the *MRCA Home Care Program*, and is to determine the type, duration and frequency of any *Home Care service (category C)* to be provided to a person.

6A.9.9 When providing treatment under the *Coordinated Veterans' Care Program* an *LMO*, a *practice nurse*, a *DVA-contracted community nursing provider* (for a *community nurse*), and an *aboriginal health worker* are to comply with the requirements in these *Principles* and any requirements in the *Notes for Coordinated Veterans' Care Program Providers* that relate to them.

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PART 6B – TELEMONITORING TREATMENT INITIATIVE

6B.1 Telemonitoring Treatment

6B.1.1 A treatment (*telemonitoring treatment*) is established by this Part and may be arranged by the *Commission* for an *entitled person*, in the circumstances, and subject to the conditions, set out in this Part.

6B.1.2 Telemonitoring treatment is comprised of:

- (a) in respect of a *participating LMO* (or the LMO's Practice Nurse):
 - (i) monitoring the health of a *telemonitoring initiative participant* (participant) in accordance with the *telemonitoring care plan*, including monitoring the *telemonitoring initiative data* for the participant;
 - (ii) taking any appropriate healthcare action in response to *telemonitoring initiative data*;

Note: an example of appropriate action could be the LMO arranging a face-to-face consultation or video consultation with the *telemonitoring initiative participant*.

- (iii) disclosing the *telemonitoring initiative data* to the *Department* or to any consultant acting for the *Department* in the *In-Home Telemonitoring for Veterans Initiative*; and
- (iv) taking action reasonably incidental to any of the above actions.

Note: in practice an *LMO* could delegate some of the *LMO's* functions in the *In-Home Telemonitoring for Veterans Initiative* to the *LMO's* Practice Nurse e.g. electronically retrieving *telemonitoring initiative data* from the *data repository*, evaluating it and instituting care planning based on that evaluation. In this situation the Practice Nurse, as the employee or agent of the *LMO*, is acting on the *LMO's* behalf and the Practice Nurse's actions constitute *telemonitoring treatment* as if those actions had been performed by the *participating LMO*.

- (b) in respect of the *data repository controller*:

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- (i) training a *participating LMO* (including staff of the *participating LMO* such as a Practice Nurse) in:
 - (a) the use of *telemonitoring equipment*; and
 - (b) the electronic retrieval of *telemonitoring initiative data* from the *data repository*; and
 - (c) electronically accessing and using any video consultation between the *participating LMO* and the *telemonitoring initiative participant*; and
 - (d) the use of any other tools necessary for monitoring the *telemonitoring initiative participant's* condition for the *In-Home Telemonitoring for Veterans Initiative*;
 - (ii) training a *telemonitoring initiative participant* (participant) or a person on behalf of the participant, in the use of *in-home telemonitoring equipment* necessary for the participant's participation in the *In-Home Telemonitoring for Veterans' Initiative* and, if need be, supplying that equipment (including leasing it);
 - (iii) maintaining *in-home telemonitoring equipment* (equipment) and providing technical assistance in respect of that equipment when necessary;
 - (iv) maintaining the *data repository*;
 - (v) taking action reasonably incidental to any of the above actions.
- (c) in respect of a person (contractor) engaged by the *Department* to train Practice Nurses for the purposes of the *In-Home Telemonitoring for Veterans' Initiative*:
- (i) training a *participating LMO's* Practice Nurse in *telemonitoring initiative data* evaluation and care planning and care planning co-ordination based on that evaluation;
-

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- (d) in respect of an *ISP provider*, its action of enabling a *telemonitoring initiative participant* to use *in-home telemonitoring equipment*.

Note: the *ISP provider* would connect the *telemonitoring initiative participant's* equipment to the NBN.

6B.2 Participation in the In-Home Telemonitoring for Veterans Initiative

6B.2.1 An *entitled person* is eligible for participation in the *In-Home Telemonitoring for Veterans Initiative* as a *telemonitoring initiative participant* if the person:

- (a) holds a *Gold Card*; and
- (b) is admitted to, or in the opinion of the *participating LMO* for the person is likely to be admitted to, the *Coordinated Veterans' Care Program*; and
- (c) has one or more of the following chronic conditions:
 - (i) congestive heart failure;
 - (ii) coronary artery disease;
 - (iii) chronic obstructive pulmonary disease;
 - (iv) diabetes; and
- (d) does not have a severe unstable co morbidity; and
- (e) is not receiving *residential care*; and
- (f) has been assessed by a *participating LMO* for the person to be suitable for the *In-Home Telemonitoring for Veterans Initiative* in terms of, among other relevant factors, the person's cognitive ability to be trained in the use of *in-home telemonitoring equipment*, where the equipment will not be operated by a person on behalf of the *entitled person*; and

Note: where a person (carer) will operate *in-home telemonitoring equipment* on behalf of the potential *telemonitoring initiative participant* (participant), the carer must be assessed by the *participating LMO* as having the cognitive ability to be trained in the use of the

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equipment in order for the participant to be eligible for participation in the *In-Home Telemonitoring for Veterans Initiative*.

- (g) is the subject of a *telemonitoring care plan* prepared by the *participating LMO* for the person which was prepared in conjunction with the person; and
- (h) resides in an *NBN wave site*; and
- (i) nominates a residence (*nominated residence*) for the purposes of the person participating in the *In-Home Telemonitoring for Veterans Initiative*; and
- (j) consents to the disclosure to the *Department*, the Department of Human Services, and to any person acting for the *Department* in the *In-Home Telemonitoring for Veterans Initiative*, of *telemonitoring initiative data* in relation to the person.

Note: the *participating LMO* is to obtain the consent and keep evidence of it.

6B.2.2 Where a person is eligible for participation in the *In-Home Telemonitoring for Veterans Initiative* (eligible person), it is necessary for the eligible person's participation to be approved by the *Commission*.

Note: in practice a Commission delegate may grant approval.

6B.2.3 Where the *Commission* gives (or does not give) its approval it is to notify the *participating LMO* for the eligible person accordingly.

6B.2.4 Upon being notified of the *Commission*'s approval, the *participating LMO* for the person is to enrol the person in the *In-Home Telemonitoring for Veterans Initiative*.

6B.2.5 Enrolment consists of the *participating LMO* for the person making a record (which may be in electronic form) that the person is enrolled in the *In-Home Telemonitoring for Veterans Initiative*.

6B.2.6 The record is to be dated and stored by the *participating LMO*. The date on the record is the *enrolment day* for the relevant *telemonitoring initiative participant*.

6B.3 Approval of LMO as Participating LMO

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6B.3.1 The *Commission* may approve an *LMO* as a *participating LMO* if:

- (a) the *LMO*'s name is given as a participating GP in the form:
“Application for Practice and Provider registration to In-Home Telemonitoring for Veterans Initiative” lodged with the Department of Human Services; and
- (b) in the *Commission*'s opinion, all necessary steps have been taken to enable the *LMO* (and a Practice Nurse of the *LMO*) to effectively participate in the *In-Home Telemonitoring for Veterans Initiative* such as appropriate training and installation of any necessary *telemonitoring equipment*.

6B.4 Payment for telemonitoring treatment

6B.4.1 If the *Commission* arranges with a *participating LMO* for the *LMO* (or the *LMO*'s Practice Nurse) to provide the *telemonitoring treatment* described in 6B.1.2(a) to an *entitled person* who is eligible for the treatment under this Part, the terms of payment to the *LMO* for the treatment are set out in the *DVA document* entitled “Department of Veterans’ Affairs Fee Schedules for Medical Services”.

Note 1: payments to *participating LMOs* for providing *telemonitoring treatment* for a person are in addition to any payments to the *LMO* for the *LMO* (or the *LMO*'s Practice Nurse) providing treatment to the person under the *Coordinated Veterans’ Care Program* or for the *LMO* providing consultations to the person (including teleconsultations) other than pursuant to a *telemonitoring care plan*.

Note 2: payments to *participating LMOs* for providing *telemonitoring treatment* will be comprised of a *DVA Telemonitoring Practice Incentive* (made to the *LMO*'s Practice) and other relevant payments (general payments) as set out in the Department of Veterans’ Affairs Fee Schedules for Medical Services.

Note 3: the general payments for telemonitoring treatment (i.e. exclusive of the *DVA Telemonitoring Practice Incentive*) will be made on the similar basis as payments to *LMOs* under the *Coordinated Veterans’ Care Program* i.e. quarterly payments in arrears.

6B.4.2 An *Authorised Representative* for the Practice in which a *participating LMO* is employed (the *LMO*) is only to be paid a *DVA Telemonitoring Practice Incentive* if the *Commission* is of the opinion that all necessary steps have been taken to enable the *LMO* (including a Practice Nurse of the *LMO*) to effectively participate in the *In-Home Telemonitoring for Veterans Initiative*.

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6B.4.3 If the *Commission* arranges with a person (*data repository controller*) for the person to provide the *telemonitoring treatment* described in 6B.1.2(b) to an *entitled person* who is eligible for the treatment under this Part (or to a person on the entitled person's behalf) or to a *participating LMO*, the terms of payment to the person are those agreed to by the *Department* and the person.

6B.4.4 If the *Commission* arranges with a person (trainer in data evaluation) for the person to provide the *telemonitoring treatment* described in 6B.1.2(c) to a *participating LMO* or to a *participating LMO* and the LMO's Practice Nurse, the terms of payment to the person are those agreed to by the *Department* and the person.

6B.4.5 If the *Commission* arranges with an *ISP provider* to provide the *telemonitoring treatment* described in 6B.1.2(d) to an *entitled person* who is eligible for the treatment under this Part, the *Department* will pay the reasonable costs of such treatment for the duration of the *entitled person's* participation in the *In-Home Telemonitoring for Veterans Initiative* where the treatment is provided to the person on or after the *enrolment day* for the person.

Note: the cost of an NBN connection for an *entitled person* will only be paid by the *Department* to an *ISP provider* and only for a connection on or after the *enrolment day* for the *entitled person* in the *In-Home Telemonitoring for Veterans' Initiative*.

6B.5 Coordinated Veterans' Care Program Rules to Apply

6B.5.1 Subject to 6B.5.2, the rules in the *DVA document* entitled "*Notes for Coordinated Veterans' Care Program Providers*" are to apply to *participating LMO's* and *telemonitoring initiative participants* to the extent practical as if *participating LMO's* and *telemonitoring initiative participants* under the *In-Home Telemonitoring for Veterans Initiative*, are, respectively, *LMOs* and *entitled persons* under the *Coordinated Veterans' Care Program*.

Note: the rules would include those governing patient transfers between *participating LMOs*.

6B.5.2 In the application of the *Notes for Coordinated Veterans' Care Program Providers* to a *participating LMO* under the *In-Home Telemonitoring for Veterans Initiative*, the date of service for a quarterly period in respect of *telemonitoring treatment* provided by a *participating LMO* to an *entitled person* is taken to be the most recent date of service

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for a quarterly period in respect of which the *LMO* provided *LMO Care Leadership treatment* to the *entitled person*.

Note (1) Under the *Notes for Coordinated Veterans' Care Program Providers* the "date of service for the quarterly period" is the first day of the quarterly period.

Note (2): the purpose of 6B.5.2 is to align, for billing purposes, the date of service for a quarterly period in respect of *telemonitoring treatment* provided by an *LMO* to an *entitled person* (i.e. the first day of the period) with the date of service for a quarterly period in respect of *LMO Care Leadership treatment* (*Coordinated Veterans' Care Program treatment*) provided by the *LMO* to the *entitled person* despite the *telemonitoring treatment* not actually being provided on that date. Telemonitoring treatment may only be provided to an *entitled person* who is also receiving *Coordinated Veterans' Care Program treatment*.

6B.6 Authorised Representative - Agent of LMO

6B.6.1 For the purpose of:

- (a) the *Commission* arranging *telemonitoring treatment* with a *participating LMO* or the *LMOs Practice Nurse* or for taking action incidental thereto;
- (b) the *Department* or the Department of Human Services making payments to the *participating LMO* (including for the services of the *LMOs Practice Nurse*) or for taking action incidental thereto;

if the *Commission*, the *Department* or the Department of Human Services, as the case may be, deals with the *Authorised Representative* for the Practice in which the *participating LMO* and Practice Nurse is employed, then for the purposes of these *Principles* the *Commission*, the *Department* or the Department of Human Services is taken to have dealt with the *participating LMO* (including the *LMO's Practice Nurse*).

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PART 7 — TREATMENT GENERALLY FROM OTHER HEALTH PROVIDERS

7.1 Prior approval and financial responsibility for health services

7.1.1 Except where provided in:

- (1) the *Principles*;
- (2) the *Notes for Allied Health Providers*; or
- (3) a *Fee Schedule*;

the Commission's *prior approval* for a treatment under this Part is not required.

7.1.1A In relation to any occasion of service to an entitled person under these Principles, except an occasion of service that is a service under the *MRCA Home Care Program*, a health provider shall bill only the *Department* and that bill shall be for full settlement of the account for the service provided to the entitled person but in relation to any occasion of service to an *entitled person* under these *Principles* that is the provision of a service under the *MRCA Home Care Program*, a *health provider* shall bill the *Department* but not for any *co-payment* payable by an *entitled person* to the *health provider* and the bill presented to the *Department* shall be for full settlement of the account for the service provided to the *entitled person*.

7.1.2 Subject to these *Principles* and in addition to services provided under principle 2.6 and paragraph 5.1.3, the *Commission* may provide, arrange, or accept financial responsibility for the following:

- (a) audiology
 - (aa) *diabetes educator services*;
- (b) dietetics;

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- (c) chiropractic services;
- (d) community nursing;
- (dd) exercise physiology;
- (e) occupational therapy;
- (f) optometry;
- (g) orthoptics;
- (h) osteopathic services;
- (i) Home Care service (category A); Home Care service (category B);
- (j) physiotherapy;
Note: Physiotherapy includes hydrotherapy (see paragraph 1.4.1)
- (k) podiatry;
- (l) psychology;
- (m) social work;
- (n) speech pathology.

7.1.3 The *Commission* will not accept financial responsibility for services listed in paragraph 7.1.2 for an entitled person receiving a high level of residential care where the provision of those services is covered by a State or Commonwealth subsidy.

7.1.4 Treatment in an entitled person's *home* may be approved where the entitled person is medically unable to attend the relevant facilities or where the *entitled person* is entitled to treatment at *home* under the MRCA *Home Care Program*.

7.1A.1 In order for the *Commission* to be taken to have arranged treatment provided to an *entitled person* by a *health care provider* in an item (denoted by a number) in Column A below, the treatment must have been provided in

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accordance with the section of the *Notes for Allied Health Providers* or with the *VVCS OPC Provider Notes*, as the case may be, for that item in Column B below:

Column A**Column B**

		Notes for Allied Health Providers	
	Provider Type	General section	Provider specific section
1	Chiropractors	Section 1 - General Information	Section 2(b) – Chiropractors
2	Clinical Psychologists (except where providing service as <i>outreach program counsellors</i>)	“	Section 2(a) – Allied Mental Health Care Providers
3	Dentists, Dental Specialists & Dental Prosthetists	“	Section 2(c) – Dentists, Dental Specialists and Dental Prosthetists
4	Diabetes Educators	“	Section 2(d) - Diabetes Educators
5	Dietitians	“	Section 2(e) – Dietitians
6	Exercise Physiologists	“	Section 2(f) – Exercise Physiologists
7	Neuropsychologists	“	Section 2(a) – Allied Mental Health Care Providers
8	Occupational Therapists	“	Section 2(g) – Occupational Therapists
9	Occupational Therapists – Mental Health	“	Section 2(a) – Allied Mental Health Care Providers
10	Optometrists, Orthoptists & Optical Dispensers	“	Section 2(h) - Optometrists, Orthoptists & Optical Dispensers
11	Osteopaths	“	Section 2(i) – Osteopaths
12	Physiotherapists	“	Section 2(j) – Physiotherapists
13	Podiatrists	“	Section 2(k) – Podiatrists
14	Psychologists (except where providing service as <i>outreach program counsellors</i>)	“	Section 2(a) – Allied Mental Health Care Providers
15	Social Workers (General) (except where providing service as <i>outreach program counsellors</i>)	“	Section 2(a) – Allied Mental Health Care Providers
16	Social Workers (Mental Health) (except where providing service as <i>outreach program counsellors</i>)	“	Section 2(a) – Allied Mental Health Care Providers
17	Speech Pathologists	“	Section 2(l) – Speech Pathologists
		VVCS OPC Provider Notes	
18	Outreach Program Counsellor	VVCS OPC Provider Notes	

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7.1B Disqualified Health Care Providers

7.1B.1 The *Commission* is not to accept financial responsibility for the cost of a service provided to an *entitled person* by, or on behalf of, a *health care provider* if, at the time the service was provided, a *medicare benefit* would not have been payable in respect of the service under section 19B of the *Health Insurance Act 1973* (in force from time to time) if the *health care provider* had provided the service as a *practitioner* under that Act.

7.2 Registration or enrolment of providers

7.2.1 Where a provider of a service specified in principle 7.1 (other than a service of community nursing) is practising in a State or Territory that has legislation requiring the registration of the occupation, the provider must be registered under that legislation.

Note: the occupational registration of *DVA-contracted community nursing providers* is dealt with in the arrangements between the *Commission* and *DVA-contracted community nursing provider*.

7.2.2 Where a State or Territory does not have legislation concerning registration, a provider of a service specified in principle 7.1 (other than a service of community nursing) must be registered in another State or possess qualifications that would permit registration in another State or must be registered in another Territory or possess qualifications that would permit registration in another Territory, if that other State or other Territory has legislation requiring the registration of the occupation in question

Note: the occupational registration of *DVA-contracted community nursing providers* is dealt with in the arrangements between the *Commission* and the *DVA-contracted community nursing provider*.

7.2.3 Where the provider of a service specified in principle 7.1 (other than a service of community nursing) is a corporate entity and is practising in a State or Territory that has legislation enabling registration of the corporate entity, both the person actually delivering the service and the corporate entity must be registered under the relevant legislation.

Note: the occupational registration of *DVA-contracted community nursing provider* is dealt with in the arrangements between the *Commission* and the *DVA-contracted community nursing provider*.

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7.3 Community nursing

7.3.3 The *Commission* will accept financial responsibility for community nursing services for an *entitled person* only if:

- (a) the person has been referred to a *DVA-contracted community nursing provider* by a *Local Medical Officer or other GP*, a treating doctor in a hospital, a hospital discharge planner, an *authorised nurse practitioner*, or a *MHC assessment agency*; and

Note: paragraph 7.3.6 sets out the *DVA-contracted community nursing provider* to whom an *entitled person* can be referred under paragraph 7.3.3(a).

- (b) a *DVA-contracted community nursing provider*, pursuant to an arrangement with the *Commission*, has undertaken a nursing assessment of the *entitled person* prior to the commencement of care and assessed that the person has a clinical need or a personal care need, or both, for the *community nursing service*.

7.3.4 All of an *entitled person's* care documentation prepared by a *DVA-contracted community nursing provider* shall be provided to the *Department* upon request by the *Department* to the *DVA-contracted community nursing provider*.

7.3.5 An *entitled person* whose care needs, due to their complexity and care regime, are significantly outside of the scope of the community nursing classification to which they belong, is treated under the *exceptional case process*. Before a person can be treated under the *exceptional case process*, *prior approval* must be obtained from the *Commission*.

7.3.6 A referral to a *DVA-contracted community nursing provider* is to be made only to a *DVA-contracted community nursing provider* that has entered into, and is bound by, a contract with the *Commission* or the *Department* to provide community nursing services during the relevant period of treatment and in the geographical area in which the *entitled person* resides.

7.3.6A If no *DVA-contracted community nursing provider* referred to in paragraph 7.3.6 can provide the relevant community nursing care within a reasonable time, the *Commission* may approve a referral to another *DVA-contracted community nursing provider*.

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7.3.7 The *Commission* will not accept, as part of a community nursing service, financial responsibility for any domestic help services such as cooking, shopping, cleaning, laundry, transport and companionship.

7.3A MRCA Home Care Program

7.3A.1 (1) The *Commission* may:

- (a) examine the circumstances of an *entitled person* and assess the suitability of the person for:
 - (i) a *Home Care service (category A)*; or
 - (ii) a *Home Care service (category B)*; or
 - (iii) pursuant to a *LMO Home Care service (category C) Referral*, a *Home Care service (category C)*.

Note: the Commission has delegated its assessment power to a contractor known as a VHC assessment agency.

- (2) The *Commission* may determine that an assessment made under paragraph (1) is to be effective from a date before or after the date on which the assessment is made.
- (3) The *Commission* shall ensure a record is made of any assessment under paragraph (1) and any determination under paragraph (2).
- (4) A record under paragraph (3) may be made and maintained in electronic form.

7.3A.3 (1) An *entitled person* is not entitled to a service of *Home and Garden Maintenance* if the provision of the service would mean the person had received *Home and Garden Maintenance* for a period or periods that would exceed, or cumulatively exceed, 15 hours over the relevant period.

- (2) For the purposes of paragraph 7.3A.3 (1), the relevant period is a period of 12 months commencing on the date when the Commission accepted financial liability for the provision of *Home and Garden Maintenance* to the *entitled person*, or on the anniversary of that date.

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Note: the intention is that unused hours of Home and Garden Maintenance in a 12 month period are not carried over into the next 12 month period.

7.3A.3A Dual Services

- (1) If, under section 214 of the *Act*, the Commonwealth is liable to pay weekly compensation for household services provided to a person, the person is not entitled to *Domestic Assistance* or *Home and Garden Maintenance*.
- (2) If, under section 217 of the *Act*, the Commonwealth is liable to pay weekly compensation for attendant care services provided to a person, the person is not entitled to *Personal Care*.

7.3A.4 Outcome of Assessment

- (1) Where under 7.3A.1(1) the *Commission* decides that an *entitled person* is not suitable for a relevant service, it shall inform the *entitled person* accordingly and give reasons for its decision.
- (2) Where under 7.3A.1(1) the *Commission* decides that an *entitled person* is suitable for a relevant service, it shall:
 - (a) determine the type, duration and frequency of the service;
 - (b) in the case of a *Home Care service (category A)* or a *Home Care service (category C)* — allocate responsibility for providing the service to an appropriate *approved provider*; and
 - (c) in the case of a *Home Care service (category B)* — provide the service.

Note (1): in practice the *Commission* may delegate its power to assess a person's suitability for a service to contractors (called MHC assessment agency).

Note (2): The *Commission* may also delegate its power to allocate the task of providing any "category A or C service" to contractors (called a MHC assessment agency).

Note (3): The *Commission* may delegate its power to provide a *Home Care service (category B)* to a contractor (e.g. an instrumentality of a State or Territory).

Note (4): Contractors may, in turn, sub-contract the responsibility to provide a relevant service.

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7.3A.4A An *approved provider* may provide a *Home Care service (category A)*, a *Home Care service (category B)* or a *Home Care service (category C)* to an *entitled person*.

7.3A.5 The *Commission* may accept financial responsibility for the *provision of a Home Care service (category A)* to an *entitled person* by an *approved provider* if the service is supplied:

- (i) in accordance with the arrangement between the *approved provider* and the *Commission*; and
- (ii) in accordance with the terms of a decision under paragraph 7.3A.1(1) that the *entitled person* is suitable for the service; and
- (iii) in accordance with the *Principles*.

7.3A.6 The *Commission* may accept financial responsibility for the *provision of a Home Care service (category B)* to an *entitled person* by the *Commission*.

Note: in practice the *Commission* may delegate its power to assess "Home Care need" to a contractor and may delegate its power to supply a *Home Care service (category B)* to a contractor. Those contractors may, in turn, sub-contract the obligation to supply the relevant services.

7.3A.6B The *Commission* may accept financial responsibility for the *provision of a Home Care service (category C)* to an *entitled person* by an *approved provider*, for a period of care provided by an *LMO* to the *entitled person* under the *Coordinated Veterans' Care Program*, if:

- (1) the *approved provider* has an arrangement with the *Commission* or the *Department* to provide a *Home Care service (category A)* or *Home Care service (category B)* to an *entitled person*; and
- (2) the service has been requested for the person by a *MHC assessment agency* pursuant to a *LMO Home Care service (category C) Referral* and pursuant to an assessment by the agency of the person's suitability for the service; and
- (3) the service is in accordance with the request from the *MHC assessment agency*; and

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Note: it will be the MHC assessment agency's responsibility to inform the approved provider of the terms on which the service is to be provided e.g. frequency of service.

- (4) the service is in accordance with any requirements in the *Notes for Coordinated Veterans' Care Program Providers* (Notes) that relate to an *approved provider* delivering a *Home Care service (category C)* to an *entitled person*; and
- (5) the *entitled person* is otherwise entitled to the service and is not, at the time of the service, receiving *residential care*; and
- (6) the service is not essentially the same as a *Home Care service (category A)* or *Home Care service (category B)* the person is entitled to receive.

7.3A.7 For the purposes of the *Principles*, an *approved provider* is deemed to be a *health care provider*.

7.3A.8 Subject to paragraph 7.3A.9, a condition of any arrangement between the *Commission* and an *approved provider* for the provision of a *Home Care service (category A)* or *Home Care service (category C)* to an *entitled person* by the *approved provider* or any *sub-contractor* engaged by it, is that:

- (a) the *approved provider*, and any such *sub-contractor*, shall not demand, receive or assign, an amount from the *entitled person* in relation to the provision of the *Home Care service (category A)* or *Home Care service (category C)* that exceeds \$5 per hour of service; and
- (b) the *approved provider*, and any such *sub-contractor*, shall not demand, receive or assign a *proscribed amount* from the *entitled person* in relation to the provision of the *Home Care service (category A)* or *Home Care service (category C)*.

7.3A.9 For the purposes of paragraph 7.3A.8, in relation to a *proscribed amount* that is an *exempt amount*, it is only a condition of an arrangement not to demand, receive or assign such a *proscribed amount* if the *Commission* has made a determination under paragraph 7.3A.10 and notified the *approved provider*, whether by electronic means or otherwise, of the effect of that determination.

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7.3A.10 Pursuant to a request in writing from an *entitled person* or an *approved provider*, the *Commission* shall determine whether, in the opinion of the *Commission*, an *entitled person* is or is not an *exempt entitled person* and such a determination shall be recorded in writing and shall be *prima facie* evidence of the matters contained therein.

Note: an *exempt entitled person* is not required to pay an amount the person would otherwise be required to pay to an *approved provider* in respect of a *Home Care service (category A)* or *Home Care service (category C)*.

7.3A.11 Where:

- (a) under paragraph 7.3A.8, an *entitled person* cannot be required to pay an amount of money in respect of a *Home Care service (category A)* or *Home Care service (category C)* provided or to be provided to that person by an *approved provider* or a *sub-contractor*, because:
 - (i) the person is an *exempt entitled person*; or
 - (ii) the *Home Care service (category A)* or *Home Care service (category C)* provided or to be provided to the *entitled person* is a similar service to a *Home and Community Care Program service* the *entitled person* received immediately before 1 January 2001 and in respect of which the *entitled person* had not been required to pay a charge ("similar service no charge"); or
 - (iii) the *Home Care service (category A)* or *Home Care service (category C)* provided or to be provided to the *entitled person* is a similar service to a *Home and Community Care Program service* the *entitled person* received immediately before 1 January 2001 and in respect of which the *entitled person* had been required to pay a charge ("similar service some charge") but the amount of money that could have been required of the person under the *MRCA Home Care Program*, but for it being a proscribed amount, exceeds that charge; and
- (b) a *Home Care service (category A)* or a *Home Care service (category C)* is provided to the *entitled person* by an *approved provider* or a *sub-contractor*;

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the *Commission* will accept responsibility to pay to the *approved provider* in respect of the *Home Care service (category A)* or *Home Care service (category C)*:

- (c) in the case where the *entitled person* could not be required to pay an amount because the person was an *exempt entitled person* — an amount equal to the amount the person could have been required to pay if the person had been an *entitled person* who was not an *exempt entitled person*;
- (d) in the case where the *entitled person* could not be required to pay an amount because the person was provided with a "*similar service no charge*" — an amount equal to the amount the person could have been required to pay if the *Home Care service (category A)* or *Home Care service (category C)* provided to the *entitled person* had not been a "*similar service no charge*";
- (e) in the case where the *entitled person* could not be required to pay a certain amount because the person was provided with a "*similar service some charge*" and the amount the person could not be required to pay was a *proscribed amount* because it exceeded the amount the person was charged when the person received the *Home and Community Care Program service* on which the "*similar service some charge*" was based — an amount equal to that proscribed amount;

Note: it is the intention that the *Commission* accept responsibility for a *proscribed amount* referred to in paragraph (f) of the definition of "proscribed amount" (part of charge per hour) and not for the proscribed amount referred to in paragraph (b) of the definition of "proscribed amount" (amount exceeding maximum amount payable weekly or over a longer period).

7.3A.12 A condition of any arrangement between the *Commission* and an *approved provider* for the provision of a *Home Care service (category A)* to an *entitled person* by the *approved provider* or any *sub-contractor* engaged by it, is that a *Home Care service (category A)* will not be provided to an *entitled person* receiving residential care under the *Aged Care Act 1997* including where the *Commission* accepts financial responsibility for the provision of that residential care pursuant to the *Principles*.

7.3A.13 The *prior approval* of the *Commission* for:

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- (a) the *provision of a Home Care service (category A) to an entitled person by an approved provider*;
- (b) the *provision of a Home Care service (category B) to an entitled person by an approved provider*; or
- (c) the *provision of a Home Care service (category C) to an entitled person by an approved provider*;

is not required except that in the case of the *provision of a Home Care service (category A) to an entitled person by an approved provider* that is *emergency short term home relief (ESTHR)*, the *prior approval* of the *Commission* is required for the provision of ESTHR within 24 hours after a previous service of ESTHR.

Note: the fact that the Commission's prior approval for treatment is not required does not mean an assessment is not required.

Limited MHC-type services for dependants and former dependants

7.3A.19A Definitions

For the purposes of paragraphs 7.3A.19A to 7.3A.22 (inclusive):

eligible person means a person who is eligible for a service.

service means a *limited MHC-type service*.

7.3A.19 Subject to paragraph 7.3A.21, the *Commission* may accept financial responsibility for the provision of a *limited MHC-type service* to a person eligible to receive the service.

7.3A.20 A person eligible for a *limited MHC-type service* is a person who the *Commission* decides is:

- (a) a former partner who was a dependant of a deceased *entitled member* — in circumstances where the deceased *entitled member* was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; or

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- (b) an *eligible young person* who was a dependant of a deceased *entitled member* — in circumstances where the deceased *entitled member* was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; or
- (c) a former *eligible young person* who was a dependant of a deceased *entitled member* — in circumstances where the deceased *entitled member* was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both and the former *eligible young person* is a person with a serious disability; or
- (d) a former *eligible young person* who was a dependant of a deceased *entitled member* — in circumstances where the deceased *entitled member* was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both and the former *eligible young person* was a full-time *carer* of the deceased *entitled member* immediately prior to the death of the *entitled member*; or
- (e) the partner of an *entitled member* — who resided with that member immediately before the member needed to leave the *home* in order to receive treatment, and at or about the time of the member's departure the member was being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; or
- (f) either: (i) an *eligible young person* who is a dependant of an *entitled member*; or
(ii) a former *eligible young person* who is a dependant of an *entitled member*;

who resided with the *entitled member* immediately before the *entitled member* needed to leave the *home* in order to receive treatment and at or about the time of the departure of the *entitled member*:

- (iii) the *entitled member* was being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; and
- (iv) in the case of a former *eligible young person* who is a dependant of an *entitled member* and who is residing with the member — the former *eligible young person* is a person with

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a serious disability or was the full-time carer of the *entitled member*.

7.3A.21 The conditions on which the *Commission* will accept financial responsibility for the provision of a *limited MHC-type service* to a person eligible to receive the service are:

- (1) in respect of an eligible person in paragraph 7.3A.20 (a) — the service is provided for a period of no longer than 12 weeks commencing on the day after the day on which the *entitled member* died ("commencement day"), unless, within the period of 12 weeks commencing on the commencement day, the person makes a claim for compensation under section 319 of the *Act* in which case the service is provided for no longer than the period commencing on the commencement day and ending at the end of the day on which the *Commission* determines the claim.

Note (1): in practice a Commission delegate will determine a claim and the Department will communicate details of the determination to the delegate of the Commission who arranged provision of the *limited MHC-type service*.

Note (2): in practice the Commission will be a delegate exercising the Commission's assessment powers.

- (2) in respect of an eligible person in paragraphs 7.3A.20 (e) or (f), the service is provided over a period no longer than 12 consecutive weeks commencing on the day the *entitled member* left the *home* for treatment.
- (3) the service is identical to either *Domestic Assistance* or *Home and Garden Maintenance* (or both) that the relevant *entitled member* was receiving at or about the time of his or her death or at or about the time of his or her departure from the *home* for treatment, as the case may be.
- (4) the service is provided on the same terms, including any liability to make a *co payment*, that the *Domestic Assistance* or *Home and Garden Maintenance* (or both) was provided to the relevant *entitled member* at or about the time of his or her death or at or about the time of his or her departure from the *home* for treatment, as the case may be.
- (5) the eligible person resided in the *home* of the relevant *entitled member* at the time of the death of the relevant *entitled member* or at the time the relevant *entitled member* departed from the *home* for treatment, as the case may be.

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- (6) in order for an eligible person referred to in paragraph 7.3A.20 (d) to be provided with a service, the eligible person must have been the full-time carer of the *entitled member* immediately prior to the death of the member at or about the time the service is required.

7.3A.22 For the purposes of paragraph 7.3A.21, a particular entitled member is a "relevant entitled member" in relation to a particular eligible person, where the eligible person was residing with that member at the time of the death of the member or at the time of the departure of the member from the *home* for treatment, and the eligible person is relying on that fact as constituting an element necessary to establish the basis for the person's entitlement to a service.

Note (1): the intention is to ensure that the conditions for providing a service to an eligible person are related to that person's particular circumstances. For example, a former *eligible young person* who resided with an entitled member before his/her death is only entitled to the domestic-type assistance that member was receiving and is not entitled to the domestic-type assistance some other entitled member was receiving.

Similarly, a former *eligible young person* is not entitled to Home and Garden-type maintenance if the relevant entitled member had not been receiving Home and Garden Maintenance. The entitlement of the eligible person is to reflect the entitlement of the primary beneficiary ie the entitled member.

7.4 Optometrical services

7.4.1 The *Commission* may accept financial responsibility for optometrical services provided by an optometrist (with a current *provider number*) to an *entitled person* in accordance with these *Principles* and the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects optometrists)).

7.4.2 The *Commission* may accept financial responsibility for optometrical products provided by an optical dispenser (who may be an optometrist) to an *entitled person* if those products have been provided in accordance with:

- (a) the *Principles*; and
- (b) the *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects optometrists and optical dispensers)); and
- (c) the *DVA document* entitled "Pricing Schedule for Visual Aids", *in force on the date in Schedule 1*.

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7.4.3 Optometrical products are those referred to in the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*.

Note: the *Pricing Schedule for Visual Aids* is available at any office of the *Department*.

7.4.4 An optometrist or an optical dispenser may render the account for services provided to an *entitled person* either to the *Department* or to the *Department of Human Services* under the direct billing arrangements.

7.4.5 When an optometrist or an optical dispenser direct bills the *Department of Human Services* and visual aids are prescribed, these may be provided under paragraph 7.4.2.

7.5 Physiotherapy

7.5.1 The *Commission* will accept, subject to paragraph 7.5.3, financial responsibility for physiotherapy treatment for a period, where an *LMO* or medical practitioner refers an *entitled person* to a registered physiotherapist who has a *provider number*.

Note: Physiotherapy includes hydrotherapy (see paragraph 1.4.1).

7.5.2 The period referred to in paragraph 7.5.1 commences on the date of the Local Medical Officer or other GP’s, or medical specialist’s, referral.

7.5.3 *Prior approval* is required for physiotherapy treatment:

- (a) where those services are to be provided to an *entitled person* classified as a high care patient in a residential aged care facility; or
- (b) where those services are to be provided in a public hospital.

7.5.4 The Commission may accept financial responsibility for hydrotherapy treatment that does not include recreational water exercises or recreational swimming.

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7.6 Podiatry

7.6.1 Subject to paragraph 7.6.6, the *Commission* will accept financial responsibility for podiatry treatment where a *Local Medical Officer* or *other GP* or *medical specialist* refers an *entitled person* to a registered podiatrist who has a *provider number*, for an *episode of care*.

7.6.2 *Prior approval* is required for podiatry treatment:

- (a) where those services are to be provided to an *entitled person* given a *high level of residential care* in a *residential care facility*;
- (b) where those services are to be provided in a public hospital;
- (c) when prescribing temporary footwear, prescribing more than two pairs of medical grade footwear;
- (d) prescribing more than three pairs for entitled persons living in remote areas;
- (e) repairing depth and custom footwear if the cost is over \$100;
- (f) modifying depth and custom footwear if the cost is over \$100;
- (g) providing an Electrodynographic Analysis and Report;
- (h) providing a Video Gait Analysis and/or Treadmill Analysis and Report;
- (i) delivering services valued at over \$60 under the Miscellaneous Items listed in the Deed of Agreement between the Commission and the podiatrist.

7.6.3 The *Commission* will accept financial responsibility for surgical removal of the toenail plate (either partial or total) by a registered podiatrist who has a *provider number*, with or without sterilisation of the matrix, only if *prior approval* has been obtained.

7.6.5 The *Commission* will accept financial responsibility for footwear, and footwear repairs, only if the footwear is:

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- (a) medical grade footwear;
- (b) prescribed by a registered podiatrist, or a medical specialist who is a rehabilitation specialist, orthopaedic surgeon or rheumatologist; and
- (c) provided by a supplier approved by the *Commission*.

7.6.6 Except where the *Commission* decides otherwise, financial responsibility will not be accepted for routine toenail cutting.

7.6A Diabetes Educator services

7.6A.1 Subject to paragraph 7.6A.2 the *Commission* may accept financial responsibility for *diabetes educator services* provided to an *entitled person* with diabetes where:

- (a) a referer, being a *LMO, other GP, medical specialist, discharge planner, a treating doctor in a hospital or another diabetes educator* with a current referral, refers the *entitled person* to a *diabetes educator* for *diabetes educator services*; and
- (b) except where the referer is of the opinion that the *entitled person* suffers from chronic diabetes that needs ongoing treatment, twelve months has not elapsed from the date of the referral or, where an *entitled person* is referred by a *diabetes educator* to another *diabetes educator*, twelve months has not elapsed from the date of the original referral; and
- (c) the *diabetes educator* has a *provider number*.

7.6A.2 Prior approval is required for *diabetes educator services* where:

- (a) those services are to be provided to an *entitled person* given a *high level of residential care* in a *residential care facility*; or
- (b) those services are to be provided to an *entitled person* in a *public hospital*.

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7.7 Chiropractic and osteopathic services

7.7.1 The *Commission* will accept financial responsibility for chiropractic or osteopathic services where a *Local Medical Officer* or *other GP* or *medical specialist* refers an *entitled person* to a registered chiropractor or osteopath who has a *provider number*.

7.7.2 The *Commission* will only accept financial responsibility for chiropractic and osteopathic services involving treatment of the musculo-skeletal system. No other treatment will be accepted.

7.7.3 The *Commission* will only accept financial responsibility for x-rays taken by a registered chiropractor who is licensed to take x-rays under relevant State or Territory legislation.

7.7.5 The *Commission* will not accept financial responsibility for the provision of concurrent courses of physiotherapy and chiropractic services or physiotherapy and osteopathic services for the same condition to any *entitled person*.

7.7A Outreach Program Counselling

7.7A.1 The treatment of *outreach program counselling* is established under this Part and may be provided by an *outreach program counsellor* to an eligible *entitled person* in accordance with the *Principles*.

Note: paragraph 7.1A.1 requires *outreach program counselling* to be provided in accordance with the *VVCS OPC Provider Notes*.

7.7A.2 An *entitled person* is eligible for *outreach program counselling* if:

- (a) the *entitled person* is eligible for *VVCS*; and

Note: see paragraph 7.7A.3

- (b) in the opinion of the *Commission*:

- (i) the *entitled person* is unable to reasonably have access to a *VVCS Centre* due to the physical isolation of the person's place of residence in Australia; or

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(ii) despite the *entitled person* having reasonable access to a VVCS Centre, there is a special reason for the person requiring *outreach program counselling*; and

(c) the *outreach program counselling* is provided to the *entitled person* by an *outreach program counsellor* pursuant to a referral from the *Veterans and Veterans Families Counselling Service*.

7.7A.3 An *entitled person* is eligible for VVCS if he or she satisfies a VVCS *criterion*.

7.7A.4 For paragraph 7.1.1, *prior approval* for *outreach program counselling* is not required.

7.8 Other services

7.8.1 The *Commission* will not accept financial responsibility for certain services, including:

- (a) herbalist services;
- (b) homeopathy;
- (c) iridology;
- (d) massage that is not performed as part of authorised physiotherapy, chiropractic or osteopathy services; and
- (e) naturopathy.

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9.1 Admission to a hospital or institution

9.1.1 Subject to these Principles, the *Commission* will accept financial responsibility for the provision of treatment to *entitled persons* at a hospital or an institution.

9.1.2 The *Commission* will not approve, or accept financial responsibility for, admission to a hospital or an institution if:

- (b) the person could have been provided with suitable outpatient treatment; or
- (c) the person could have been suitably cared for at home, with or without supporting community health care services, unless the admission would provide respite for a carer of an *entitled person*.

9.1.3 Notwithstanding other provisions of these Principles, the *Commission* will accept financial responsibility for the emergency admission to the nearest hospital of an entitled person for treatment if an office of the *Department* is notified on the first working day after the admission, or as soon thereafter as is reasonably practicable if that admission is to a private hospital requiring prior approval as set out in Part 3 of these *Principles*.

9.1.4 Where hospital treatment of an *entitled person* has been arranged under these Principles, and the person's partner is an inpatient at another hospital within reasonable proximity, the *Commission* may arrange the admission or transfer of the person to the hospital at which the person's partner is an inpatient.

9.1.5 If such arrangements are made under paragraph 9.1.4, the *Commission* will accept financial responsibility for the hospital treatment of the *entitled person*.

9.1.6 The *Commission* will accept financial responsibility for the admission of an entitled person to a Tier 2 or Tier 3 hospital, as set out in Principle 2 of the *MPPPs*, only if prior approval for the admission is obtained.

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9.1.7 When giving consideration of prior approval under paragraph 9.1.6, the *Commission* will have regard to the matters set out in paragraph 3.2.2 and in Principle 2 of the *MPPPs*.

9.1.8 Subject to this Part, the *Commission* will accept financial responsibility for inpatient treatment of an entitled person in a country or a Territory public hospital or in a private hospital with which arrangements have been previously agreed with the Commission and according to the preferences and requirements set out in Part 3 of these *Principles* and in Principle 2 of the *RPPPs*.

9.1.9 The *Commission's* approval is required before it will accept financial responsibility for the admission to hospital, or for hospital treatment, of *entitled persons* in all other circumstances.

9.1.10 Where prior approval is required, the *Commission* will not accept financial responsibility for any additional charges where an admission for treatment is arranged according to these Principles and then non-Medicare Benefits Schedule surgery or cosmetic surgery is performed subsequently without the *Commission's* approval.

9.2 Financial Responsibility For Treatment In Hospital

9.2.1 Subject to paragraph 9.2.5, the *Commission* will accept financial responsibility for any usual and reasonable hospital treatment that takes place at the hospital for persons admitted in accordance with these Principles.

9.2.2 The *Commission* may accept financial responsibility for any usual and reasonable treatment that takes place outside the hospital if it is prescribed as a necessary part of inpatient treatment.

9.2.4 Subject to paragraph 9.2.5, the *Commission* will accept financial responsibility for hospital charges on the basis of:

- (a) for a public hospital — an amount in accordance with arrangements made with the appropriate State/Territory authority; or
- (b) for a contracted private hospital — the rate agreed between the *Commission* and the hospital; or

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- (c) for a non-contracted private hospital, when neither a public nor a contracted private hospital can provide the treatment required — the rate agreed from time to time between the *Commission* and the hospital; or
- (d) for a non-contracted hospital, when chosen by an entitled person in preference to a contracted private hospital — a rate to be determined by the *Commission*.

9.2.5 The *Commission* will not accept financial responsibility for the whole, or that portion, of:

- (a) hospital charges; or
- (b) charges for any surgically implanted prostheses; or
- (c) charges paid by health fund benefits,

in circumstances where the *entitled person*:

- (d) is insured by private health insurance for hospital charges or surgically implanted prostheses; and
- (e) agrees to assign to the hospital or other institution the benefits available from private health insurance in respect of all or part of the hospital charges or surgically implanted prostheses.

9.3 Nursing-home-type care

9.3.1 Where:

- (a) an *entitled person* remains an inpatient in excess of 35 consecutive days and there is no acute care certificate under section 3B of the *Health Insurance Act 1973* in force stating reasons approved by the *Commission* for the continuing need for acute care; or
- (b) the *medical practitioner* responsible for treating the *entitled person* agrees at any time after admission that the entitled person no longer requires acute care;

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the person will be regarded as receiving nursing-home-type care.

9.3.2 If an *entitled person*:

- (a) is eligible for a residential care subsidy under the *Aged Care Act 1997*; and
- (b) is receiving nursing-home-type care as defined in paragraph 9.3.1;

the *Commission* will accept financial responsibility for the standard hospital fee for nursing-home-type patients under the *National Health Act 1973*, or other agreed fee, less the residential care amount, unless:

- (c) the *Commission* has granted an exemption under paragraph 10.2.1;

in which case the *Commission* will accept financial responsibility for the full amount of the hospital charge.

9.3.3 Nothing in this Part is to be taken to permit payments to be made by the Commonwealth under both the *Act* and either the *Aged Care Act 1997* or the *National Health Act 1953* in respect of the same amount for which the Commonwealth has become liable in respect of nursing-home-type care under these Principles or the *Aged Care Act 1997* or the *National Health Act 1953*.

9.5 Convalescent care

9.5.1 Subject to *prior approval* and subject to paragraph 9.2.5, the *Commission* will accept financial responsibility for the costs of convalescent care for an entitled person at an institution for a maximum of 21 days during any financial year.

9.6 Other matters

9.6.1 The *Commission* may withdraw its approval, at any time, for an *entitled person's* continued inpatient treatment in a hospital or other institution.

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Part A — *residential care* not involving *residential care* (*respice*)

Note: this heading is intended to be an aid in interpretation.

10.1 Residential care arrangements

10.1.1 Residential care may be provided in accordance with this Part to:

- (a) a person who has a current valid Gold Card; or
- (b) a person who has a current valid White Card.

Note : '*residential care*' is defined in paragraph 1.4.1.

10.1.2 Subject to paragraph 10.1.3 and paragraph 10.1.5, a person referred to in paragraph 10.1.1 may be provided with residential care under the *Aged Care Act 1997* and the *Principles*.

10.1.3 Upon the Commonwealth becoming liable to pay an amount under the *Aged Care Act 1997* (e.g. *veterans' supplement*) in respect of residential care for a person referred to in paragraph 10.1.1, the Commission is taken to have:

- (a) arranged for the provision of that residential care in accordance with this Part; and
- (b) accepted financial responsibility for that amount.

Note: The effect of paragraph 10.1.3 is to provide for payment to be made under the *Act* instead of the *Aged Care Act 1997*. Section 96-10 of the *Aged Care Act 1997* provides that subsidies (which would include the *veterans' supplement*) payable under Chapter 3 of the *Aged Care Act 1997* in respect of treatment under Division 4 of Part 3 of Chapter 6 of the *Act* are not payable as an automatic appropriation out of the Consolidated Revenue Fund under the *Aged Care Act 1997* but are payable out of that Fund in accordance with the relevant appropriation provisions relating to the arrangement of treatment by the Commission under the *Act*.

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10.1.4 Paragraph 10.1.3 does not permit payments to be made by the Commonwealth under both the *Act* and the *Aged Care Act 1997* in respect of the same amount for which the Commonwealth has become liable.

10.1.5 Despite paragraph 10.1.3, where *residential care* is provided to an *entitled person* under the *Aged Care Act 1997* and the Commonwealth is not liable to pay an amount under that Act in respect of an amount incurred by the *entitled person* in relation to that care, the *Commission* may accept financial liability for any such amount incurred by the *entitled person* where the *Principles* so provide.

Note: under the *Aged Care Act 1997* the Commonwealth is not necessarily liable to pay resident fees such as the *residential care amount*. Liability to pay that amount may be accepted by the *Commission* under the *Principles*.

10.2 Payment of residential care amount for certain entitled members with dependants

10.2.1 The *Commission* may, in exceptional circumstances, accept financial responsibility for the residential care amount for an *entitled member* who:

- (a) has a dependant; and
- (b) is receiving a high level of residential care because of a service injury or a service disease or both.

Part B — residential care involving residential care (respite)

Note (1): this heading is intended to be an aid in interpretation.

Note (2): in Part B *respite admission* and *residential care (respite)* are interchangeable terms.

10.3 Residential care (respite) arrangements

10.3.1 *residential care (respite)* may be provided to an *entitled person* in accordance with this Part.

Note: *residential care (respite)* includes *residential care (28 day respite)* under the *MRCA Home Care Program*.

10.3.2 The *Commission* may, in accordance with the following Table and subject to this Part, accept financial liability for the provision of *residential care (respite)* to an *entitled person* for a period not exceeding 63 days in a Financial

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year or not exceeding such further period in a Financial year for which *residential care* provided as *respite* to the person is permitted under the *Residential Care Subsidy Principles 1997*.

Note (1): in calculating the maximum period of residential care (respite) available to an entitled person for which the *Commission* may meet certain costs, periods of *residential care (28 day respite)* (where the *Commission* paid the *residential care amount*) and *in-home respite* will be counted.

Note (2) in Part B *respite admission* and *residential care (respite)* are interchangeable terms and *residential care (respite)* includes *residential care (28 day) respite*.

Note (4): the *Residential Care Subsidy Principles 1997* (Principles) are made under subsection 96-1 (1) of the *Aged Care Act 1997*. Under Part 7 of the Principles the Secretary may increase the number of days a person may be provided with residential care as respite care by 21.

LIMITS OF FINANCIAL RESPONSIBILITY ACCEPTED BY THE COMMISSION FOR RESPITE ADMISSION

<i>category of patient</i>	<i>type of care; max.period of care permitted; type of care costs accepted</i>	<i>type of care; max.period of care permitted; type of care costs accepted</i>
	<i>residential care (28 day respite)</i> up to 28 days (inclusive) in a Financial year	<i>residential care (respite) other than residential care (28 day respite)</i> upon an entitled person exhausting 28 days of <i>residential care (28 day respite)</i> in a Financial year — between and including 29 to 63 days* in that Financial year
entitled person	RCS + RCA	RCS

For the purposes of this table:

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‘RCA’ means the *Commission* will accept financial responsibility for the residential care amount.

‘RCS’ means the *Commission* will accept financial responsibility for the residential care subsidy (including any *veterans’ supplement*).

‘RCS + RCA’ means the *Commission* will accept financial responsibility for the residential care subsidy (including any *veterans’ supplement*) and the residential care amount.

* or for such further period permitted under the *Residential Care Subsidy Principles 1997*.

10.3.4 Where the *Commission* could accept financial liability for a *residential care amount* otherwise payable by an *entitled person* in respect of a day in *residential care*, but does not accept liability because the *entitled person* chooses to accept that liability, then that day:

- (a) is not to be taken into account in calculating if the person has been a *respite admission* for 63 days or such further period permitted under the *Residential Care Subsidy Principles 1997*; and
- (b) is not to be taken into account in calculating if the person has been provided with *in-home respite* for a period exceeding 28 days in a Financial year.

10.3.5 Where the *Commission* accepts financial liability for a *residential care amount* otherwise payable by an *entitled person* in respect of a day in *residential care* in a Financial year, then that day is to be taken into account in calculating if the person would receive *in-home respite* for more than 28 days in that Financial year.

10.3.6 Where the *Commission* accepts financial liability for the provision of *in-home respite* to an *entitled person* on a day, then that day is to be taken into account in calculating if the person has been a *respite admission* for 63 days (or such further period permitted under the *Residential Care Subsidy Principles 1997*).

10.3.7 Where the *Commission* accepts financial liability for the provision of *emergency short term home relief* on a day, then that day is not to be taken into account in calculating if the person has been a *respite admission* for 63 days (or

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such further period permitted under the *Residential Care Subsidy Principles 1997*) or if the person has received *in-home respite* for more than 28 days.

10.3.8 (1) For the purposes of paragraphs 10.3.1 to 10.3.7 (inclusive) and subject to paragraph (2), a day means:

- (a) in relation to *residential care (respite)* — a period of 24 hours; or
- (b) in relation to *in-home respite* — a period of 7 hours.

- (2) For the purpose of determining if the limit of days for *residential care (respite)* has been reached by reference to the number of days an *entitled person* spent in *in-home respite*, a day of 7 hours in *in-home respite* is taken to have been a day of 24 hours, and for the purpose of determining if the limit of days for *in-home respite* has been reached by reference to the number of days an *entitled person* spent in *residential care (respite)*, a day of 24 hours in *residential care (respite)*, is taken to have been a day of 7 hours.

Note: the "limit of days" for *residential care (respite)* or for *in-home respite* means the maximum number of days for which the Commission may accept financial liability for - in the case of *residential care (respite)*, the *residential care subsidy* or the *residential care subsidy* and the *residential care amount*, or for - in the case of *in-home respite*, the cost of *respite*

10.3.9 Upon the Commonwealth or an *entitled person* becoming liable to pay an amount under the *Aged Care Act 1997* in respect of *residential care (respite)* provided to that person and the Commission assuming financial responsibility for that amount, the *Commission* is taken to have arranged for the provision of that *residential care (respite)* to that *entitled person* in accordance with this Part.

Note (1): the effect of paragraph 10.3.9 is to provide for payment to be made under the *Act* instead of the *Aged Care Act 1997*. Section 96-10 of the *Aged Care Act 1997* provides that subsidies payable under Chapter 3 of the *Aged Care Act 1997* in respect of treatment under Division 4 of Part 3 of Chapter 6 of the *Act* are not payable as an automatic appropriation out of the Consolidated Revenue Fund under the *Aged Care Act 1997* but are payable out of that Fund in accordance with the relevant appropriation provisions relating to the arrangement of treatment by the Commission under the *Act*.

Note (2): the amount an *entitled person* could be liable to pay for *residential care (respite)* is the *residential care amount*, being a resident's contribution to his or her care.

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10.3.10 Nothing in this Part is to be taken to permit payments to be made by the Commonwealth under both the *Act* and the *Aged Care Act 1997* in respect of the same amount for which the Commonwealth has become liable in respect of *residential care (respite)* under these *Principles* or the *Aged Care Act 1997*.

Part C — *respite admissions not involving residential care (respite)*

Note (1): this heading is intended to be an aid in interpretation.

Note (2): an example of a *respite admission* not involving *residential care (respite)* would be an admission to a hospital. The definition of *residential care* does not include hospital care.

10.4 The *Commission* may accept, in whole or in part, financial responsibility for *respite* for a maximum period of 28 days in a Financial year in an institution in respect of which a *residential care subsidy* is not payable if, in the opinion of the *Commission*, it is a cost-effective and appropriate alternative to *residential care (respite)* under paragraph 10.3.1 and to *Respite Care* under the *MRCA Home Care Program*.

Part D – HOME CARE

Definition:

“*co-payment*” means an amount a person must pay for *home care* but does not include an amount payable to the provider of the *home care* as subsidy under the *Aged Care Act 1997*.

10.5 The *Commission* may accept financial responsibility for the *co-payment* a former *prisoner of war*, or an *entitled member* awarded the Victoria Cross for Australia (VC veteran), paid, or is to pay, for *home care* for the person pursuant to an agreement with the provider of the *home care* — to the extent the *co-payment* does not exceed any limit under:

- (a) the *Aged Care Act 1997*;
- (b) instruments under the *Aged Care Act 1997*; or
- (c) any agreement between the provider of the care and the Secretary of the Department that administers the *Aged Care Act 1997*.

10.6 In deciding whether to accept financial responsibility for a *co-payment* for *home care* provided to a former *prisoner of war* or VC recipient the *Commission* should take into account:

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- (a) whether the care was provided in accordance with the relevant provisions of the *Aged Care Act 1997* and the relevant instruments thereunder;
- (b) whether the care complies with the requirements of any agreement between the provider of the care and the Secretary of the Department that administers the *Aged Care Act 1997*; and
- (c) whether the care essentially duplicates treatment the former *prisoner of war* or VC recipient is receiving under other provisions of the *Principles* (double-dipping).

10.7 Billing

10.7.1 The provider of a service of *home care* should bill the *Department of Human Services* for the *co-payment* rather than the former *prisoner of war* or VC recipient (client) but if the client is billed, the *Commission* may, subject to paragraph 10.5 and 10.6, accept financial responsibility for the *co-payment*.

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“co-payment” means an amount a person must pay for *transition care* but does not include an amount payable to the provider of the *transition care* as subsidy under the *Aged Care Act 1997*.

10.8 Financial Responsibility for Co-Payment

10.8.1 The *Commission* may accept financial responsibility for the *co-payment* an *entitled member* who is former *prisoner of war* (POW), or an *entitled member* awarded the Victoria Cross for Australia (VC recipient), paid, or is to pay, to an *approved provider* for *transition care* provided to the person:

- (a) on condition that the care is provided on a day in respect of which flexible care subsidy is payable for the care under the *Flexible Care Subsidy Principles 1997*, in force from time to time; and

Note (1): as at December 2010 the maximum number of days for which flexible care subsidy was payable for transition care was 126 days.

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Note (2): as at 1 July 2013 there was a proposal to consolidate the various legislative instruments under the *Aged Care Act 1997* in one set of Subsidy Principles. If that occurs, the intention is that the new Subsidy Principles as they relate to flexible care will be the *Flexible Care Subsidy Principles 1997* as in force from time to time.

(b) to the extent:

- (i) the *co-payment* does not exceed the amount the approved provider is permitted to charge the POW or VC recipient under section 56-3 of the *Aged Care Act 1997*; and
- (ii) the *co-payment* does not exceed the amount the approved provider is permitted to charge the POW or VC recipient under any agreement between the Secretary of the Department that administers the *Aged Care Act 1997* and the approved provider pursuant to section 15.33 of the *Flexible Care Subsidy Principles 1997*.

10.8.2 In deciding whether to accept financial responsibility for a *co-payment for transition care* (care) provided to a POW or VC recipient the *Commission* should take into account:

- (a) whether the care was provided in accordance with the relevant provisions of the *Aged Care Act 1997* and the relevant instruments thereunder;

Note 1: Part 3.3 of Chapter 3 of the *Aged Care Act 1997* deals with *transition care* (flexible care)

Note 2: The *Approval of Care Recipients Principles 1997*, the *Flexible Care Subsidy Principles 1997* and the *User Rights Principles 1997* are relevant to *transition care* (flexible care).

(b) whether the care complies with:

- (i) any agreement between the *approved provider* of the care and the Secretary of the Department that administers the *Aged Care Act 1997* — under the *Aged Care Act 1997* and under 15.33 of the *Flexible Care Subsidy Principles 1997*; and

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- (c) whether, if there is an agreement mentioned in (b)(i) and the agreement (Provider/Secretary Agreement) sets out requirements for agreements (client agreement) between an approved provider and a recipient of *flexible care* or flexible care that is transition care:
 - (i) the client agreement satisfies any requirements in respect of it in the Provider/Secretary Agreement; and
 - (ii) the provision of care complies with the client agreement.
- (d) whether the care essentially duplicates treatment the POW or VC recipient is receiving under other provisions of the *Principles* (double-dipping).

10.9 Billing

10.9.1 An *approved provider* should bill the *Department of Human Services* for the *co-payment* for *transition care*, rather than the POW or VC recipient (client) but if the client is billed, the *Commission* may, subject to 10.8.1 and 10.8.2, accept financial responsibility for the amount.

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11.1 Rehabilitation Appliances Program

11.1.1 The *Commission* may provide:

- (a) a surgical appliance; and
- (b) an appliance for self-help and rehabilitation purposes;

to an *entitled person*, for an injury or disease of the person, unless the appliance could be provided to the person, for that injury or disease, by the *Commission* under a Part of the Act, other than Part 3 of Chapter 6 of the Act, or under SRCA.

Note (1): an appliance could be provided as part of a rehabilitation program under Chapter 3 of the Act or as a modification to a motor vehicle under Chapter 4 of the Act and could be provided under Part III or s.148 of SRCA (but not under s.16(1) by virtue of s.144B(5) SRCA).

Note (2): the *Commission* providing an appliance means the *Commission* arranges for its provision or accepts financial responsibility for the cost of the appliance where its provision is arranged by a third party.

Note (3): the *RAP National Schedule of Equipment* and the *Rehabilitation Appliances Program (RAP) National Guidelines* are *DVA documents* that provide guidance to the *Commission* and to prescribers and suppliers in relation to the provision of surgical aids and appliances for self-help and rehabilitation to *entitled persons*.

11.1.2 The aim of the Rehabilitation Appliances Program is to restore, facilitate or maintain functional independence and/or minimise disability or dysfunction as part of the provision of quality care to entitled persons.

11.1.3 Appliances shall be provided:

- (a) according to an assessed clinically indicated need; and
- (b) in an efficient manner of delivery; and
- (c) towards meeting health care objectives; and
- (d) in a cost effective manner; and

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- (e) on a timely basis.

11.1.4 An appliance that is provided should be:

- (a) appropriate for its purpose; and
- (b) safe for the particular entitled beneficiary; and
- (c) part of the overall management of health care for the *entitled person*;

but should not be an item that is customarily used for domestic purposes and would be used merely for such a purpose by the *entitled person*.

11.2 Supply of rehabilitation appliances

11.2.1 Unless otherwise indicated in these Principles, the *Commission* will arrange the supply of rehabilitation appliances on the condition that these are returned when no longer needed or if the *Commission* so requests.

Note: an example where the *Commission* could request the return of a rehabilitation appliance is where it cannot be accommodated in an institution.

11.2A Prior Approval

11.2A.1 If under this Part or under the *DVA documents* entitled, respectively, the “RAP National Schedule of Equipment” *in force on the date in Schedule 1* and the “Rehabilitation Appliances Program (RAP) National Guidelines” *in force on the date in Schedule 1*, the *Commission's prior approval* is required for the supply of a rehabilitation appliance to an *entitled person* or the alteration to, replacement or repair of a rehabilitation appliance, then the *Commission* is not to accept financial liability for the supply, alteration, replacement or repair, as the case may be, unless it has granted that *prior approval*.

Note: in granting *prior approval* the *Commission* must consider the matters in paragraph 3.2.2.

11.2A.2 A grant of *prior approval* must be recorded in writing by the *Department* within 7 days after it has been made.

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11.2A.3 The record may be maintained in electronic form and must be stored by the *Department* for a period of at least 12 months commencing on the 8th day after the grant of *prior approval* was made.

11.3 Restrictions on the supply of certain items

11.3.1 Subject to this Part, the *Commission* will provide or accept financial responsibility for the following appliances only to entitled members who have a medically assessed need for these items due to a service injury or service disease:

- (a) the supply of electric wheelchairs or electric scooters;
- (b) the supply of a guide dog, provided that the *Commission* will not be responsible for costs associated with keeping the dog;
- (c) the supply of special vehicle driving controls and devices, if the entitled member owns the vehicle and is licensed under relevant State or Territory law to drive a modified vehicle.

11.3.2 Subject to this Part, the *Commission* will provide or accept financial responsibility for the provision of electronic communication equipment only to entitled members who are:

- (a) legally blind; or
- (b) severely handicapped.

11.3.3 For the purposes of paragraph 11.3.2, a legally blind *entitled member* means an *entitled member*:

- (a) whose legal blindness is *service injury* or *service disease*; and
- (b) who has a medically assessed need for the electronic communication equipment; and
- (c) who has been assessed by the *Commission* as being able to benefit from use of the electronic communication equipment.

11.3.4 For the purposes of paragraph 11.3.2, a severely handicapped *entitled member* means an *entitled member*:

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- (a) whose severe handicap was a *service injury* or *service disease*; and
- (b) who has a medically assessed need for the electronic communication equipment; and
- (c) who has been assessed by the *Commission* as being able to benefit from the use of the equipment because it would substantially improve the member's:
 - (i) communication skills; and
 - (ii) quality of life.

11.3.6 Subject to 11.3.6A and 11.3.7, the *Commission* will not approve the supply of a rehabilitation appliance to an *entitled person* who is in an *institution* or who has entered a Commonwealth, State or Territory program if the *Commission* is satisfied that:

- (a) for an *institution*, the appliance should be supplied by the owner or operator of the *institution* because:
 - (i) any Commonwealth, State or Territory legislation under which the *institution* (or owner or operator) is registered, licensed or otherwise authorised enables the appliance to be supplied; or
 - (ii) due to charges made by or subsidies received by the owner or operator of the *institution* under Commonwealth, State or Territory legislation, it is fair for the owner or operator of the *institution* to bear the cost of supplying the appliance; or

Note: the *DVA document* known as “RAP Business Rules” provides a guide to decision making in respect of the supply of appliances and is contained in the RAP Schedule of Equipment at:

http://www.dva.gov.au/service_providers/rap/Pages/Schedule_Guidelines.aspx
- (iii) installing the appliance would involve an alteration to the structure of part of the *institution*; or
- (iv) it is otherwise appropriate for the appliance to be supplied by the owner or operator.

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Note (1): “institution” includes a retirement village, premises the *Commission* considers have similar functions to a retirement village, and a cluster of self-care units.

Note (2): the *DVA document* known as “RAP Business Rules” provides a guide to decision making in respect of the supply of appliances and is contained in the RAP Schedule of Equipment at:

http://www.dva.gov.au/service_providers/rap/Pages/Schedule_Guidelines.aspx

- (b) for an institution, where the appliance is a hand rail, ramp, non-slip surface or similar appliance, the appliance should be supplied by the *entitled person* or the owner or operator of the *institution* because the *entitled person* should have known, by reason of the person’s state of health or frailty at the time the person arranged to enter the *institution*, that such an appliance would have been likely to have been needed by the person upon being admitted to the institution or a short time thereafter.

Note (1): “institution” includes a retirement village, premises the *Commission* considers have similar functions to a retirement village, and a cluster of self-care units.

Note (2): The policy is that *entitled persons* entering *institutions* should ensure the *institution* caters to their needs before they take up residence.

Note (3): A guide to a “short time” is a period within 6 months after entering the institution.

Note (4): the *DVA document* known as “RAP Business Rules” provides a guide to decision making in respect of the supply of appliances and is contained in the RAP Schedule of Equipment at:

http://www.dva.gov.au/service_providers/rap/Pages/Schedule_Guidelines.aspx

- (c) for a program, it is more appropriate that the appliance is provided under the program because:
- (i) the Commonwealth financially contributed to the program, if the case; or
 - (ii) the program’s budget appears sufficient to reasonably absorb the cost of the appliance; or
 - (iii) the *Department* is under a short-term financial constraint; or
 - (iii) it is otherwise appropriate for the appliance to be supplied under the program.

Note: the *DVA document* known as “RAP Business Rules” provides a guide to decision making in respect of the supply of appliances and is contained in the RAP Schedule of Equipment at:

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http://www.dva.gov.au/service_providers/rap/Pages/Schedule_Guidelines.aspx

11.3.6A The *Commission* will approve the supply of a rehabilitation appliance to an *entitled person* in an *institution* or participating in a Commonwealth, State or Territory program, if:

- (a) the *Commission* approved the appliance for the person before the person entered the *institution* or the program and that approval has not been revoked; and
- (b) for a person in an *institution*, any alteration to the structure of part of the *institution* necessary to install or attach the appliance satisfies the requirements in (a) and (b) of 11.3.7; and

Note: (a) and (b) deal with compliance with relevant laws and approval by owner of property to installation/attachment together with an undertaking by the owner not to seek compensation if the appliance is removed.

- (c) the rehabilitation appliance is not a *consumable rehabilitation appliance*.

Note (1): “institution” includes a retirement village, premises the *Commission* considers have similar functions to a retirement village, and a cluster of self-care units.

Note (2): 11.3.6A is relevant in relation to the maintenance or repair of the appliance. Generally, only an approved appliance may be maintained or repaired at *Commission* expense.

11.3.7 Subject to other conditions specified in this Part, the *Commission* may approve the installation or the attachment of a rehabilitation appliance to property when:

- (a) the installation or the attachment conforms to Commonwealth, State or Territory laws relating to alterations to property; and
- (b) the property owner has given approval and an undertaking not to seek compensation for restoration of the property when the appliance is no longer required by the *entitled person* to whom the aid was supplied.

11.3.8 Subject to this Part, the *Commission* may provide or accept financial responsibility for the installation of a telephone deaf aid and/or touch phone and the rental of the aid for the first year, in the workplace of an entitled member who has a medically assessed need for these items because of a service injury or service disease.

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11.4 Visual aids

11.4.1 The *Commission* may accept financial liability for visual aids dispensed by an optical dispenser (who may be an optometrist) to an *entitled person* on the prescription of an ophthalmologist or an optometrist (with a current *provider number*) where the visual aids have been provided in accordance with:

- (a) the *Principles*; and
- (b) *Notes for Allied Health Providers* (Section 1 General Information and Section 2(h)(as section 2(h) affects optometrists and optical dispensers)); and
- (c) the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*.

11.4.2 Visual aids may be prescribed from the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*.

11.4.3 The *Commission’s prior approval* is required for the prescription of items not listed in the *DVA document* entitled “Pricing Schedule for Visual Aids”, *in force on the date in Schedule 1*, except in the circumstances referred to in paragraph 11.4.6.

11.4.4 Subject to paragraph 11.4.5, in any two year period, the *Commission* shall not provide an entitled person with:

- (a) more than one pair of distance spectacles and one pair of readers; or
- (b) more than one pair of bifocals, trifocals or progressive power lenses.

11.4.5 The *Commission* will provide an *entitled person* with renewed lenses before the expiration of two years if:

- (a) in the opinion of the treating practitioner, there has been a change in;
 - (i) the person’s refraction; or
-

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- (ii) the condition of the person's eyes,
that necessitates new lenses; or
- (b) there has been accidental loss or breakage.

11.4.6 If an *entitled person* chooses spectacle frames or lenses that differ from those listed in the *DVA document* entitled "Pricing Schedule for Visual Aids", *in force on the date in Schedule 1*, or that have not been medically prescribed, the *Commission* will accept financial responsibility only to the financial limits set out in the schedule.

11.5 Hearing aids

11.5.1 The *Commission* will approve the supply of a spectacle hearing aid when it is the only type of hearing aid appropriate and the person is entitled to the treatment:

- (a) of all injuries or diseases; or
- (b) of deafness that is a *service injury* or *service disease*; or
- (c) of a visual defect that is a service injury or service disease and the need for a spectacle hearing aid arises from the person's inability to accommodate spectacles and a separate hearing aid.

11.5.2 Where a person who has a hearing defect that is a *service injury* or *service disease* is provided with a spectacle hearing aid under paragraph 11.5.1:

- (a) new lenses will be provided; or
- (b) the existing spectacle lenses will be fitted as part of the aid.

11.5.3 The *Commission* will not be responsible, under paragraph 11.5.2, for the further supply or the fitting of lenses if the person is not entitled to the supply of spectacles.

11.5.4 Subject to *prior approval*, the *Commission* may accept financial responsibility for the supply of a hearing aid from an audiology provider if the

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hearing aid is unable to be supplied to the entitled person under the *Hearing Services Administration Act 1997* or the *Hearing Services Act 1991*.

11.5.5 The *Commission* may accept financial responsibility for service charges in respect of a hearing aid that has been supplied under paragraph 11.5.4.

11.5.6 The *Commission* may accept financial responsibility for service charges in respect of a hearing aid following the supply of that hearing aid under paragraph 11.5.4 or 11.5.5.

11.6 Other rehabilitation appliances

11.6.1 Subject to this Part, the *Commission* may arrange for a wig to be supplied to an *entitled person* who:

- (a) became bald as a result of a *service injury* or *service disease* or as a result of the treatment of a *service injury* or *service disease*; or
- (b) requires a wig as part of medical treatment for disfigurement.

11.6.2 The *Commission* will not accept financial responsibility for the cleaning and setting of a wig.

11.6.3 Subject to this Part, the *Commission* may:

- (a) provide medically suitable footwear as an aid; or
- (b) approve the repair of an *entitled person's* own footwear as part of medically prescribed alterations to the footwear.

11.6.4 Where the *Commission* approves the provision of stoma appliances and consumables, the provision will be through:

- (a) a stoma association; or
- (b) the Pharmaceutical Benefits Scheme; or
- (c) the MRCA Pharmaceutical Benefits Scheme.

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11.6.5 The *Commission* will accept financial responsibility for the cost of membership of a stoma association and for the cost of postage of stoma supplies.

11.7 Repair and replacement

11.7.1 The *Commission* may approve the provision of more than one of the same rehabilitation appliance if the *entitled person* depends completely on the appliance, and:

- (a) it is necessary to maintain the appliance in a hygienic condition because of domestic or occupational circumstances; or
- (b) the *entitled person* lives in an isolated country area and would be handicapped by loss or breakage; or
- (c) there are other circumstances where the *Commission* considers it reasonable to do so.

11.7.2 Subject to paragraphs 11.7.6 and 11.7.7, the *Commission* will not be financially responsible for the alteration to, or the repair of, a treatment aid without prior approval.

11.7.3 The *Commission* will not be financially responsible for, or reimburse, the cost of an alteration to, or a repair of, a rehabilitation appliance for which it has not accepted financial responsibility, unless there are circumstances where the *Commission* considers it reasonable to accept financial responsibility.

11.7.4 The *Commission* will not be financially responsible for repair or replacement of a rehabilitation appliance for a non service injury or disease injury or disease while an *entitled person* is travelling overseas.

11.7.5 *Prior approval* will be given for the repair or replacement of an appliance where repair or renewal is necessary because:

- (a) the appliance was damaged by normal wear and tear;
- (b) the appliance inadvertently was damaged or lost; or

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-
- (c) the health-care practitioner treating the *entitled person* considers that a replacement is required because the person's condition has changed.

11.7.6 The *Commission* will not give approval for the repair or replacement of an appliance if repair or renewal is necessary as the result of:

- (a) a wilful act of the *entitled person* using or wearing the appliance; or
- (b) a negligent act of the *entitled person* using or wearing the appliance and the person has damaged or lost a similar appliance in the past as a result of negligence or wilfulness.

11.7.7 Prior approval is not required for repairs to spectacles.

11.8 Treatment aids from hospitals

11.8.1 The *Commission* may provide, or accept financial responsibility for, treatment aids as part of inpatient treatment where the aids expedite discharge from hospital.

11.8.2 The conditions for the supply of treatment aids are the same as those normally applied by the hospitals for patients not covered by these Principles.

11.8.3 The *Commission* will not provide, or accept financial responsibility for, a treatment aid as part of inpatient or outpatient treatment where the treatment solely comprises the provision of the treatment aid.

11.9 Provision of aids and appliances for accident prevention and personal safety

11.9.1 The *Commission* may assist in providing aids and appliances for accident prevention and personal safety for an *entitled person* by approving, only once in any period of 12 months, financial assistance towards the cost of such aids or appliances to a maximum amount of \$200 (maximum amount) — increased annually (if the following formula results in an increase) on 1 January by an amount worked out in accordance with the following formula:

maximum amount (including as indexed) x the movement (expressed as a percentage) in the Wage Cost Index 5 for the previous financial year (as advised to the *Department* by the Australian Government Treasury), rounded to the nearest dollar = increase.

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11.9.1A For the purposes of paragraph 11.9.1:

- (a) a period of 12 months commences on the date the *Commission* approves financial assistance; and
- (b) the *Commission* is not to approve financial assistance for an *entitled person* if 12 months has not elapsed from and including the date of any previous approval.

11.9.1B Where the *Commission* approves financial assistance under paragraph 11.9.1 of the *revoked MRCA Treatment Principles* before the commencement of the *MRCA Treatment Principles (Instrument 2013 No. MRCC 53)* (commencement date), and on the commencement date a period of 12 months had not expired from and including the date of that approval, the approval is taken to have been granted under the *MRCA Treatment Principles (Instrument 2013 No. MRCC 53)* and the period of 12 months commences on the date of the approval.

11.9.2 The *Commission* may give approval under paragraph 11.9.1 only if it has received a report from a home and safety assessor and the *Commission* is satisfied that the aid or appliance for which assistance is sought:

- (a) is needed by the person for accident prevention or personal safety as part of the person's preventive health care management; and
- (b) is appropriate for its purpose; and
- (c) is safe and appropriate for the person's particular circumstances; and
- (d) is customarily used for domestic purposes and would be used for such purposes by the person; and
- (e) would be provided or installed efficiently, cost effectively, and on a timely basis.

11.9.3 The *Commission* may enter into arrangements with a person or persons:

- (a) to provide the *Commission* with reports from home and safety assessors; and

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-
- (b) for the provision of aids and appliances for accident prevention and personal safety.

11.9.4 Subject to Principle 3.4, the Commonwealth will not be financially responsible, either partly or wholly, for the purchase, supply, or installation of an aid or appliance for accident prevention and personal safety unless:

- (a) financial assistance has been approved under paragraph 11.9.1; and
- (b) the appliance is provided under an arrangement entered into under paragraph 11.9.3.

11.9.5 The *Commission* will not accept financial responsibility, either partly or wholly, for the purchase, supply, or installation of an aid or appliance for accident prevention and personal safety in respect of an *entitled person* who is in an *institution* or who has entered a Commonwealth, State or Territory program if, had the appliance been a rehabilitation appliance considered for supply under 11.3.6, the *Commission* would not, under 11.3.6, have approved its supply in respect of the person.

Note (1): “institution” includes a retirement village, premises the *Commission* considers have similar functions to a retirement village, and a cluster of self-care units.

Note (2): the intention is that only the “rehabilitation appliance provisions” in respect of institutions/programs apply to “accident prevention and personal safety appliances” in institutions or under programs, not that any other rehabilitation appliance provision applies to accident prevention and personal safety appliances in institutions or under programs.

11.9.7 The Commonwealth will not be financially responsible for the maintenance or repair of any aid or appliance for which the *Commission* has approved financial assistance under this Principle.

11.9.8 The Commonwealth will not be responsible for any damage caused by:

- (a) the installation, operation, non-operation, use, or misuse of an aid or appliance for which the *Commission* has approved financial assistance under this Principle; or
- (b) any delay in installing such an aid or appliance or approving financial assistance under this Principle.

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PART 12 — OTHER TREATMENT MATTERS

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12.1 Ambulance transport

12.1.1 With the exception of arrangements for medical emergency under paragraph 12.1.4 and special arrangements under paragraph 12.1.5, prior approval must be obtained in all cases before ambulance transport is used by an *entitled person*.

12.1.2 Approval for ambulance transport normally will be given where the *entitled person*:

- (a) is a stretcher case; or
- (b) requires treatment during transport; or
- (c) is grossly disfigured; or
- (d) is incontinent to a degree that precludes the use of other forms of transport.

12.1.3 Other than in exceptional circumstances, air ambulance will be approved only to transport an *entitled person* with acute medical and surgical complaints for admission to, or discharge from, a hospital.

12.1.4 The *Commission* will accept financial responsibility for the use of ambulance transport in a medical emergency for an entitled person if an office of the *Department* is notified on the first working day after the ambulance transport is used or as soon thereafter as is reasonably practicable.

12.1.5 *Prior approval* for ambulance transport for entitled persons is not required where the transport is provided under arrangements between the ambulance service provider and the *Commission*.

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12.2 Treatment under Medicare Program

12.2.1 *Entitled persons* may choose to have their treatment arranged through the *Department* or under a *medicare program*.

12.2.2 Subject to these *Principles*, *entitled persons* who are treated under a *medicare program* may also receive services that are not covered by the *MBS* at the *Commission's* expense.

12.2.3 When part or all of the cost of a treatment item has been paid as a *medicare benefit*, the *Commission* will not pay for the same professional or ancillary service regardless of the person's entitlement under the *Act*.

12.4 Prejudicial or unsafe acts or omissions by patients

12.4.1 The *Commission* may refuse to be financially responsible for, or provide treatment to, or any further treatment to, an entitled person who, by an act or omission, deliberately prejudices his or her own, or a fellow patient's, treatment or the safety of persons providing treatment.

12.6 Recovery of moneys

12.6.1 Where a payment has been made to any person or body, purportedly as payment for treatment, the *Commission* may recover (up to the extent that the payment exceeds the amount, if any, that should have been paid to that person or body) any moneys, the payment of which was induced or affected at all by:

- (a) any misrepresentation; or
- (b) any mistake of fact; or
- (c) any mistake of law; or
- (d) any other cause.

12.6.2 Further to paragraph 12.6.1, the *Commission* may recover moneys for any excess amounts that should not have been paid to that person or body:

- (a) in a single demand; or
- (b) by instalments; or

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- (c) subject to section 317 of the *Act*, by offsetting moneys for any excess amounts against any later claims for payment by that person or body; or

Note: Section 317 provides, in effect, that where amounts have been overpaid, the Commission may, if the person agrees, offset money owed against later payments.

- (d) by a combination of any of these methods of recovery.

12.6.3 Nothing in this principle is to be taken to restrict any other right or action for recovery of moneys.

Transitional Provisions

(1) MRCA Treatment Principles (2013 No. MRCC 53)

- (a) any arrangement entered into, or taken to have been entered into, by the *Commission* or the *Department* (on behalf of the Commission) with a *health provider*, under the *revoked MRCA Treatment Principles*, being an arrangement that is in force immediately before the commencement of these *Principles* — is taken to have been entered into under these *Principles*.
- (b) any action taken (e.g. issue of a notice, grant of approval, giving of a receipt), and any document produced in the course of that action, by the *Commission*, the *Department* (on behalf of the Commission), a *health provider* or an *entitled person*, under the *revoked MRCA Treatment Principles*, being action or a document that is in effect or in force immediately before the commencement of these *Principles* — is deemed, respectively, to have been taken or produced under these *Principles*.
- (c) a Scheme (eg Local Medical Officer Scheme, Local Dental Officer Scheme) prepared by the Repatriation Commission under the *Treatment Principles* under section 90 of the *Veterans' Entitlements Act 1986*, that is in force immediately before the commencement of these *Principles* and is referred to in these *Principles*, is taken to have been made by the *Commission* under these *Principles*.
- (d) a person who was receiving care under a *Community Aged Care Package* or *Extended Aged Care at Home Package* under the *revoked MRCA Treatment Principles* immediately before the commencement of these Principles, is, on the commencement of these Principles, entitled to a continuation of that care as if it is *home care* under these *Principles*.

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(e) a requirement in a provision under the *Principles* for a person to hold a qualification (current qualification), being a different qualification required by the provision in the *revoked MRCA Treatment Principles* (former qualification) in the state the *revoked MRCA Treatment Principles* existed immediately before the commencement of these *Principles* under 1.1.4, is satisfied where a person holds a former qualification.

Note: under the *revoked MRCA Treatment Principles* an aboriginal health worker needed to have undertaken an “aboriginal health care course” at an institution recognised by the Department of Health and Ageing but under these *Principles* the institution must be recognised by the Department of Prime Minister and Cabinet. The qualification of an aboriginal health worker obtained at an institution recognised by the former Department of Health and Ageing is recognised under these *Principles* as if the institution had been recognised by the Department of Prime Minister and Cabinet.

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SCHEDULE 1 DATES FOR INCORPORATED DOCUMENTS
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The date for :

1. Notes for Local Medical Officers (paragraph 1.4.1);
2. Department of Veterans' Affairs Fee Schedules for Medical Services (paragraph 3.5.1);
3. Notes for Allied Health Providers (paragraphs 3.5.1 and 7.1A.1);
4. Optometrist Fees for Consultation (paragraph 3.5.1);
5. DVA Schedule of Fees Orthoptists (paragraph 3.5.1);
6. Pricing Schedule for visual aids (paragraph 3.5.1);
7. ...
8. Fee Schedule of Dental Services for Dentists and Dental Specialists (paragraph 3.5.1);
9. Fee Schedule of Dental Services for Dental Prosthetists (paragraph 3.5.1);
10. Chiropractors Schedule of Fees (paragraph 3.5.1);
11. Diabetes Educators Schedule of Fees (paragraph 3.5.1);
12. Dietitians Schedule of Fees (paragraph 3.5.1);
13. Exercise Physiologists Schedule of Fees (paragraph 3.5.1);
14. Occupational Therapists Schedule of Fees (paragraph 3.5.1);
15. Osteopaths Schedule of Fees (paragraph 3.5.1);
16. Physiotherapists Schedule of Fees (paragraph 3.5.1);
17. Psychologists Schedule of Fees (paragraph 3.5.1);
18. Podiatrists Schedule of Fees (paragraph 3.5.1);

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19. Social Workers Schedule of Fees (paragraph 3.5.1);
20. Clinical Counsellors Schedule of Fees (paragraph 3.5.1);
21. Speech Pathologists Schedule of Fees (paragraph 3.5.1);
22. Australian Government Department of Veterans' Affairs Classification System and Schedule of Item Numbers and Fees — Community Nursing Services (paragraph 6A.4.2(b));
23. Notes for Coordinated Veterans' Care Program Providers (Part 6A);
24. Rehabilitation Appliances Program (RAP) National Guidelines (paragraph 11.2A.1);
25. RAP National Schedule of Equipment (paragraph 11.2A.1);
26. Veterans and Veterans Families Counselling Services (VVCS) Outreach Program Counsellors (OPC) Provider Notes (paragraph 1.4.1 and 7.1A.1);
27. Veterans and Veterans Families Counselling Service (VVCS) Outreach Program Counsellors (OPC) Schedule of Fees (paragraph 3.5.1);
28. General information about VVCS – Veterans and Veterans Families Counselling Service (paragraph 1.4.1);
29. Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative
<http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1>;

is 1 November 2013.