Australian Government

Department of Veterans' Affairs

Notes for General Practitioners 2019

I, Elizabeth Cosson AM, CSC President of the Repatriation Commission, Chair of the Military Rehabilitation and Compensation Commission and Secretary of the Department of Veterans' Affairs (DVA) hereby:

(a) revoke the Notes for Local Medical Officers November 2016; and

(b) approve these Notes to commence on 1 October 2019.

Elizabeth Cosson AM CSC

Dated this 5th day of September 2019

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The original Local Medical Officer (LMO) Scheme was established in 1918 to provide local general practitioner services to veterans, war widow(er)s and their dependants throughout Australia.

LMOs today are General Practitioners (GPs) who are registered with the Department of Human Services (DHS). Services provided by GPs attract higher fees under the Repatriation Medical Fees schedule in recognition of the enhanced services they provide to DVA clients.

DVA appreciates the key role GPs play in coordinating the delivery of health care services to its beneficiaries.

'Notes for General Practitioners' means the document:

(i) approved by the Commissions or a member thereof, or by the Secretary to the Department, entitled 'Notes for General Practitioners'; 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 GP is to provide treatment to an entitled person in order for the Commission(s) to accept financial responsibility for that treatment.

1. Purpose of the Notes for General Practitioners

1.1 DVA recognises health care providers play a key role in providing treatment for entitled persons. These 'Notes for General Practitioners ' (Notes) have been developed to define the parameters for providing health care treatment to the veteran and defence community and to describe the relationship between DVA, the patient and the provider.

1.2 These Notes provide information about the provision of services to entitled persons by GPs for DVA White and Gold Card holders. These Notes explain the procedures to be followed when health care providers render services to entitled persons under the following legislation:

(a) *Veterans' Entitlements Act 1986* (VEA); or

(b) *Military Rehabilitation and Compensation Act 2004* (MRCA)

(c) *Australian Participants in British Nuclear Tests (Treatment) Act 2006* (APBNT(T)A) ; or

(d) *Treatment Benefits (Special Access) Act 2019*.

These are collectively referred to as "the Acts".

The Commissions and DVA

1.3 The Repatriation Commission (RC) and the Military Rehabilitation and Compensation Commission (MRCC), collectively referred to as 'the Commissions', administer the Acts. DVA undertakes the administration of the Acts on behalf of the Commissions.

1.4 Under the Acts, the Commissions are authorised to prepare legislative instruments called the *Treatment Principles* for each Act as documents legally binding on providers, entitled persons and the Commissions. The *Treatment Principles* set out the circumstances under which financial responsibility is accepted for the health care treatment of entitled persons.

Status of the Notes

1.5 In addition to the *Treatment Principles*, these Notes are a legally binding document setting out the conditions under which GPs may provide treatment to entitled persons under DVA's health care arrangements.

1.6 GPs are required to deliver treatment and meet the accountability requirements as set out in these Notes. Any breach of these Notes may lead to action in accordance with the *Treatment Principles*, such as non-payment of claims or recovery of monies from claims previously paid.

Amendment of the Notes

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

2. Treatment of entitled persons

Entitled persons

2.1 An "entitled person" means a person eligible for benefits or treatment from the Commonwealth as represented by the Commissions, in accordance with relevant legislation in the Veterans' Affairs portfolio. Entitled persons will hold a DVA Health Card issued by DVA, or have written authorisation on behalf of the Commissions.

The cards entitling treatment are the Gold Card and the White Card:

2.2 Entitled persons may be broadly described as:

(a) veterans;
(b) members and former members of the Australian Defence Force (ADF members);
(c) members of Peacekeeping Forces;
(d) Australian mariners;
(e) war widows and war widowers;
(f) children and other dependants of veterans or ADF members; or
(g) allied veterans - persons from overseas who are entitled to treatment under an arrangement with another country.

2.3 Gold Card holders are entitled to all clinically necessary treatment covered by DVA's health care arrangements.

2.4 White Card holders (excluding allied veterans) are entitled to clinically necessary treatment covered by DVA's health care arrangements for the following conditions:

(a) an 'accepted' disability, i.e. an injury or disease accepted by DVA as caused by war or service;

(b) malignant neoplasia (cancer);

(c) pulmonary tuberculosis;

(d) any mental health condition; or

(e) symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service).

2.5 Health care providers must check a White Card holders' eligibility for treatment before providing treatment. If a provider is unsure of the White Card holder's eligibility, they should contact DVA for information. [see Section 4 for contact details].

2.6 All DVA Health Cards must be current, as indicated by the expiry date, for the entitled person to be eligible for DVA funded treatment. Other cards issued by DVA such as a Pensioner Concession Card or the Repatriation Pharmaceutical Benefits (Orange) Card do not entitle the person to medical or allied health care services. Spouses and dependants of living entitled persons are not automatically eligible for treatment under DVA's health care arrangements.

** DVA card holders cover all age groups including young children and teens as well as seniors. GPs should be aware that a child or younger person may have an entitlement to DVA services through their own service or the service of a deceased parent.*

Allied veterans

2.7 DVA acts as an agent for certain other countries whose veterans reside in Australia. These allied veterans may hold a White Card with limited eligibility for treatment. Subject to decisions by the relevant governments of these countries, allied veterans may be treated for conditions accepted by their country as related to their war service.

2.8 Where allied veterans have authority to receive specified treatment, this will be conducted under DVA's health care arrangements. Allied veterans are not automatically eligible for treatment for non war-caused malignant neoplasia, pulmonary tuberculosis, PTSD or mental health conditions.

2.9 If a GP is unsure of an allied veteran's eligibility for treatment or what is covered for a White Card holder, they should contact DVA for information (see clause 14.1 for contact details).

Treatment thresholds/limits

2.10 Subject to the requirements in the Notes including the Treatment Cycle [see Section 3 Referrals], the health care provider determines the type, number and frequency of the treatments to be provided to the entitled person for all of the services that do not require prior financial authorisation from DVA. The determination must be based on the entitled person's assessed clinical needs and be part of a Patient Care Plan agreed with the entitled person, which includes the anticipated type

and frequency of treatments and the goals expected of the treatment.

2.11 Most services provided by the GP are listed in the Medicare Benefits Schedule (MBS) and/or the Repatriation Medical Fee Schedule (RMFS) [see clauses 7.1-7.6 for exceptions].

2.12 The treatment provided must be consistent with the fees and restrictions set out in the RMFS.

2.13 When treating an entitled person, the health care provider will treat the entitled person according to the following:

(a) they will be the centre of the treatment process;

(b) they will be assessed and provided treatment, according to assessed clinical needs and best practice; and

(c) care will be delivered in consultation with the entitled person and their usual GP[see clause 3.6].

2.14 An entitled person may ask for services that are not reasonably and clinically necessary. The Commissions do not accept financial responsibility for such services. Where it is found that such services have been paid for, the Commissions may take steps to recover payments.

Treatment Cycle

From 1 October 2019, new treatment cycle referral arrangements apply. Under these arrangements an allied health provider may treat a client for up to 12 sessions or one year, whichever ends first. At the end of the treatment cycle the allied health provider must report back to the client's usual GP. If further sessions are clinically necessary, the usual GP may provide the client with another referral for an additional 12 sessions.

Clients may have as many treatment cycles as their usual GP determines are clinically necessary. They may also have treatment cycles with multiple types of allied health providers at the same time.

In Australia's health care system, GPs are responsible for ensuring that patient care is well coordinated and that the care provided remains relevant to the clinical needs of the patient. DVA clients should see their usual GP for treatment cycle referrals.

Clients who are veterans in receipt of a Totally and Permanently Incapacitated payment (TPI veterans) will be exempt from the treatment cycle for exercise physiology and physiotherapy services. A client is identified as TPI on their DVA Gold Card. Services provided to these client must be clinically necessary.

Dental and optical services will not be affected by the treatment cycle as referrals are not needed to access these services.

3. Referrals for Allied Health Services

3.1 A referral is required for an entitled person to receive DVA funded allied health services, except for optical and dental treatment.

3.2 A referral to an allied health service is valid for one treatment cycle which is either:

(a) 12 sessions of treatment starting from the date of referral (which includes a consultation, treatment or assessment described within the Schedule of Fees. Diagnostic procedures, report writing, and ordering aids or equipment are excluded); or

(b) 1 year from the date of the referral where the year ends before the entitled person has received 12 sessions of treatment.

3.3 If an entitled person's usual GP determines that the treatment cycle arrangements will adversely impact on their health, the GP may apply through the Department's framework for at risk clients for an alternative referral arrangement for the entitled person. [see clause 14.2].

3.4 Referrals for entitled persons who are in receipt of a Totally and Permanently Incapacitated payment to physiotherapists and exercise physiologists are valid for:

(a) 12 months, or

(b) Indefinitely, where the referral is made by the entitled person's usual GP and clearly states that it is an indefinite referral for a chronic condition. Indefinite referrals must only be used where the entitled person's clinical condition is chronic and requires continuing care and management.

3.5 The entitled person's usual GP means:

(a) a GP who has provided the majority of care to the patient over the previous 12 months; or

(b) a GP who will be providing the majority of care to the patient over the next 12 months; or

(c) a GP who is located at a medical practice that provided the majority of services to the patient in the past 12 months or is likely to provide the majority of services in the next 12 months.

3.6 Initial referrals are valid if they are provided by:

(a) GPs;

(b) medical specialists; or

(c) a health professional as part of a hospital discharge.

3.7 Initial referrals are made when an entitled person is assessed as requiring allied health treatment by a GP, medical specialist or health professional as part of a hospital discharge.

3.8 Only the entitled person's usual GP can determine if a referral for subsequent treatment cycle is appropriate for the entitled person.

3.9 Referrals are not required to be sent with your accounts to the DHS however, all referrals must be kept with patient records and if required, made available for auditing purposes.

3.10 An entitled person must not receive treatment from more than one provider of the same provider type, for the same condition at the same time.

Referral information

3.11 The referral must include:

(a) name and DVA file number of the entitled person (as shown on the DVA Health Card);

(b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions, if known, for White Card);

(c) provider name and provider number of the referring health care provider;

(d) confirmation that the referring provider is the entitled person's usual GP, or a medical specialist or by a health care professional as the result of a hospital discharge;

(e) date of the referral;

(f) if the entitled person is resident in a Residential Aged Care Facility (RACF), the level of care that they are funded to receive and the date the funding began;

(g) entitled person's clinical details (including recent illnesses, injuries and current medication, if applicable);

(h) the condition(s) to be treated or reason(s) for referral (and not the service to be provided e.g. Osteoarthritis of right knee not Rehabilitation); and

(i) list other treating health care providers.

3.12 The referral may be written using either a 'DVA Request/Referral Form' (Form D904) or using the letterhead of the referring health care provider, but must include details as set out in clause 33.

3.13 Should an entitled person require treatment from more than one provider of the same provider type at any point in time for different conditions, both providers will require a separate referral.

During treatment*

3.14 Following the first consultation, the allied health provider must prepare a written Patient Care Plan (PCP) for the entitled person. Where there is an existing Patient Care Plan, it should be updated for each subsequent treatment cycle for the same condition.

3.15 The PCP should must be revised with any changes in the entitled person's clinical circumstances.

3.16 Consultation fees are not payable for the ongoing maintenance of PCPs.

3.17 PCPs must include:

(a) provider name and number of the referring health care provider;

(b) date of the referral and date of initial consultation;

(c) condition being managed/reason for referral

(d) patient goals

(e) the planned treatment regime, including treatment modality, the anticipated type, number and frequency of services

(f) where relevant list details of any aids and appliances the patient requires;

(g) the expected outcomes or results of the treatment regime for the entitled person plus proposed timelines;

(h) objective assessment results based on the use of validated outcome measurement and diagnosis of the condition(s); and

(i) the entitled person's written informed consent .

3.18 The PCP must be consistent with all relevant professional association and national board guidelines and standards.

3.19 The entitled person's usual GP, as the care coordinator, may request a copy of the PCP. DVA may also request a copy of the PCP. A copy must be given pursuant to any request within seven days from the date of that request. DVA may require the allied health provider to prepare the PCP in a specific format. Where specific DVA Programs stipulate requirements for PCPs, these requirements must be met in addition to the requirements in the Notes. If the entitled person's condition changes or the entitled person seeks treatment for a new condition, the health care provider may continue to provide treatment under the entitled person's current treatment cycle. For White Card holders, the new condition must be an accepted condition [See clause 14]. Allied health providers should inform the entitled person's usual GP of any changes of condition or new conditions.

**Other than optical providers, all allied health providers are required to keep patient care plans. This includes dental providers and other allied health treatment not subject to the treatment cycle. Optical providers are required to keep clinical notes as stipulated by law and/or by their association and are not required to provide this to the general practitioner.*

At the conclusion of the treatment cycle

3.20 DVA will not fund services provided after a referral has expired. It is the allied health provider's responsibility to monitor the number of sessions of treatment provided under the referral and the date of referral.

3.21 Where a referral has been made under Clause 3.2, the allied health provider must provide a report to the entitled person's usual GP at the end of the treatment cycle. Where the referral is made by a medical specialist, a hospital discharge planner or a general practitioner who is not the patient's usual GP, the allied health provider must send the report to the referring provider and the patient's usual GP.

3.22 The DVA report template must be used. The report template can be downloaded from the DVA website at www.dva.gov.au, and all reports must include the following information:

(a) name and DVA file number of the entitled person (as shown on the DVA Health Card);

(b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions for White Card);

(c) provider name and number of the referring health care provider;

(d) date of the referral;

(e) the number and frequency of treatment sessions provided

(f) condition being managed/reason for referral

(g) patient goals and progress made to achieve the goals

(h) summary of the treatment provided

(i) objective assessment results based on the use of validated outcome measurement and diagnosis of the condition(s);

(j) recommendation to the general practitioner on further treatment required.

3.23 The report can be completed:

(a) when no further treatment is required;

(b) after the provider has provided 12 sessions of treatment;

(c) 1 year from the date of the referral where that date is reached before the entitled person has received 12 sessions of treatment; or

(d) after the eighth session and before the 12th session of treatment only where the allied health provider, the entitled person and the entitled person's GP agree this is required to maintain continuity of allied health treatment.

3.24 GPs must review the report provided by the allied health provider in consultation with the entitled person.

3.25 GPs may make a referral for a subsequent treatment cycles only if further treatment is clinically required. A subsequent referral must be made by the entitled person's usual GP.

4. Other Referrals

4.1 GPs may refer entitled persons to public community support services, medical specialists and to other health care providers for treatment at Commissions' expense.

4.2 GPs may refer entitled persons to either public or private health care providers. Please note private health care providers must be registered with the Department of Human Services (DHS) - also known as Medicare Australia - to provide services to the veteran and defence community.

4.3 The referral must be written on either a 'DVA Request/Referral Form' (Form D904 - provider forms are available from the DVA website: http://www.dva.gov.au/providers/forms-service-providers) or on the letterhead of the referring health care provider. All referrals must include the following information about an entitled person to ensure the provider understands the entitled person's medical history and to allow the provider to claim payment from DVA:

(a) Name and DVA file number of the entitled person (as shown on the DVA Health Card);

(b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions, if known, for white card);

(c) if the entitled person is residing in a Residential Aged Care Facility (RACF), the level of care they are funded to receive and the date the funding began;

(d) provider name and number of the referring health care provider;

(e) date of the referral;

(f) entitled person's clinical details (including recent illnesses, injuries and current medication, if applicable); and

(g) condition(s) to be treated.

4.4 GPs should ensure the information included in a referral enables the provider to gain an understanding of the entitled person's medical history. It is particularly important the GP informs the provider if an entitled person has a current illness or disability requiring specific attention and care during treatment.

4.5 When specifically requested by an entitled person, GPs (or practice staff) should make clinically approved appointments with medical specialists and other health care providers, and arrange transport with DVA if required by the entitled person as a result of his or her medical condition.

4.6 GPs are required to monitor treatment and treatment outcomes provided by a health care provider to whom the GP has referred an entitled person.

4.7 Copies of referrals must be kept with patient records. The health care provider must be aware of the dates of referrals as they are not able to claim for payment once a referral has expired.

Medical Specialists

4.8 When a GP refers an entitled person to a medical specialist, he or she should choose the closest practicable local specialist. The specialist should be willing to accept DVA's treatment arrangements and the RMFS schedule fees as full payment for their services, and not levy any additional fee on the entitled person. DVA will not accept financial responsibility for accounts from specialists who do not accept DVA's fee arrangements.

4.9 If an entitled person is likely to require hospitalisation, the GP should refer him/her to a specialist accredited at a local hospital covered by DVA's contractual arrangements (see section 5– Hospital Admissions). It would be desirable if the specialist has admitting rights to one or more local hospitals covered by DVA's contractual arrangements.

4.10 It is important for the GP to inform the specialist of the entitled person's treatment eligibility. The GP may send the referral directly to the specialist or the entitled person may take it to their first consultation.

4.11 In line with arrangements in the MBS, the GP should state the period of validity of the referral on the referral.

4.12 Country residents referred to metropolitan specialists must have prior DVA financial authorisation if they wish to claim travel assistance.

4.13 Providers must be willing to accept DVA's treatment arrangements and the schedule fees as full payment for services.

Pathology Services

4.14 GPs may refer entitled persons to private pathology providers without prior financial authorisation from DVA by using request forms supplied by the pathology providers. GPs should clearly show on the request that the patient is an entitled person. Pathology services are generally restricted to those services listed in the MBS or RMFS (see clauses 7.1-7.6 for exemptions).

4.15 Alternatively, a GP may use a DVA Treatment Service Voucher (D1216G) as the referral. The entitled person must sign the patient declaration box on this form. The GP may send the DVA and claimant copies of the D1216G directly to the pathologist with any other documentation.

Radiology Services

4.16 GPs may refer entitled persons to local radiologists without prior financial authorisation from DVA by using the DVA request/referral form (D904), or their usual referral arrangements. It is important the GP informs the radiologist of the entitled person's DVA eligibility and the radiologist agrees to treat the entitled person under DVA arrangements. Radiology services are generally restricted to those services listed in the MBS or RMFS (see clauses 7.1-7.6 for exemptions).

Transferring referrals

4.17 If a GP decides to cease treating entitled persons, move from an area, cease practice, or if an entitled person is moving away, the GP should refer the entitled person to another medical practitioner in their local area.

4.18 The GP must notify all entitled persons by telephone or in writing prior to transferring them. A separate referral is necessary for each entitled person.

4.19 If the GP transfers to another practice location within an area, they must ascertain whether the new practice continues to be the nearest suitable health care provider in that area for the entitled persons they are treating. If they are not, the GP will not be eligible to claim kilometre allowance to provide treatment (see section 10).

5. Hospital admissions

5.1 GPs can make direct admissions to public and private hospitals.

5.2 Entitled persons may be eligible for hospital admission under DVA arrangements if they are:

(a) Gold Card holders; or

(b) White Card holders seeking treatment for accepted disabilities or for malignant neoplasia (cancer), pulmonary tuberculosis, PTSD, or mental health conditions.

Hospital admission of White Card holders

5.3 Before hospital admission is arranged for a White Card holder, the admitting GP should check with DVA to ensure DVA will accept financial responsibility for the treatment.

Repatriation Private Patient Scheme

5.4 Under the Repatriation Private Patient Scheme, DVA will fund the medical and surgical treatment of entitled persons as a private hospital patient in public hospitals, Tier 1 private hospitals and a large number of other contracted private mental health hospitals and day procedure centres.

5.5 A list of contracted Tier 1 private hospitals, mental health private hospitals and day procedure centres, for which admission requires no prior approval, can be found at: http://www.dva.gov.au/providers/hospitals-day-procedure-centres-and-mental-health-private-hospitals#private_hospitals

Order of preference for admitting entitled persons to hospital

5.6 The order of preference when admitting an entitled person to hospital is:

Tier 1

All public hospitals, former Repatriation Hospitals (former RHs) and veteran partnering (VP) private hospitals, contracted mental health hospitals and contracted day procedure centres. Services may be provided at these facilities without DVA's prior financial authorisation.

Tier 2

- DHS registered mental health contracted providers. No prior approval is required for DVA agreed range of mental health services. All other services require prior financial authorisation.
- Day procedure centres. No prior approval is required for DVA agreed range of day procedure services. All other services require prior financial authorisation.
- Contracted non-VP private hospitals which require DVA's prior financial authorisation for providing services at that facility.

Tier 3

Non-contracted private hospitals and non-contracted day procedure centres, which require DVA's prior financial authorisation for providing services at that facility.

5.7 If an entitled person requires hospitalisation the GP may admit the patient to a contracted hospital where he or she has appropriate visiting rights. The arrangements for visiting rights are between the GP and the hospital in each instance.

Admission to a Tier 3 non-contracted private hospital

5.8 As a last option, DVA may give financial authorisation for a GP to admit an entitled person to a Tier 3 non-contracted private hospital or day procedure centre. In such cases, DVA may only meet part of the costs associated with accommodation, pharmaceuticals, theatre fees and certain other incidentals. Payment of the balance of these costs, which may be significant, will be the responsibility of the entitled person.

5.9 In these circumstances, it is important the GP advises the entitled person to discuss the financial implications of his or her decision with DVA and their private health insurance fund, where applicable, prior to arranging admission.

A GP must obtain financial authorisation before admitting an entitled person to a Tier 3 hospital. DVA will not accept responsibility for any expenses incurred unless DVA has given financial authorisation for the admission (excluding emergencies, see clause 5.11).

Private insurance and the Repatriation Private Patient Scheme

5.10 DVA is not a 'gap' insurer. It is important to note an entitled person may not use private health insurance arrangements and then claim the gap fee from DVA.

Emergency admissions

5.11 DVA defines an emergency as a situation where an entitled person requires immediate treatment in circumstances where there is serious risk to their life or health. In emergency situations, patients may be admitted to the nearest hospital able to provide the required treatment.

5.12 If an ambulance has been called, an entitled person would usually be admitted through the casualty or accident and emergency department of the nearest suitable hospital. The entitled person should only be admitted to a non-contracted private hospital emergency department when:

(a) public hospital, former repatriation hospital or contracted facilities are not available; or

(b) the nature of the emergency is such that the entitled person requires access to hospital facilities that happen to be immediately available from a non-contracted private hospital than the nearest public hospital, repatriation hospital or contracted private hospital.

5.13 Whenever possible, a GP should confirm an entitled person's eligibility for treatment before arranging an emergency admission to a non-contracted private hospital. If this is not possible before the admission, the GP must notify DVA on the next working day following admission and obtain financial authorisation for the admission.

5.14 All Vietnam veterans and their dependants (who are not otherwise eligible for treatment at DVA expense) are, subject to conditions in the Acts, eligible for medically urgent in-patient treatment at former RHs, state country public hospitals and territory public hospitals.

Convalescent Care

5.15 A GP can refer an entitled person for convalescent care for a further period of recovery following a DVA funded hospital admission for an acute illness or operation. Convalescent care is to be provided in a facility that best suits the entitled person's needs. DVA will fund up to 21 days per financial year for each entitled person. Prior approval is required for all episodes of convalescent care in a private hospital or institution.

Transition Care

5.16 A GP can refer an entitled person aged 70+ for Aged Care Assessment Team (ACAT) assessment of their suitability for enrolment in a

Commonwealth/State funded transition care program immediately following a hospital admission. DVA will pay the daily co-payment fee for ex POWs and VC recipients enrolled in either a residential or community based program.

Country residents and travel assistance

5.17 If a country resident is to be referred to a metropolitan hospital (public or private) or day procedure centre, the GP should contact DVA in advance to establish the entitled person's eligibility for travel assistance, which is limited to travel to the closest practicable health care provider. While financial responsibility will be accepted for any clinically necessary treatment, DVA will not accept financial responsibility for travel not authorised by DVA.

5.18 Entitled persons are to be treated at local facilities and by the closest practicable specialist wherever possible. Those who choose to travel to other facilities or specialists, when appropriate local care is available, may be responsible for their own travel costs over and above the costs that would have been incurred had the entitled person travelled to the closest practicable health care provider.

6. Care plans

6.1 GPs should maintain a written care plan following the first consultation with each entitled person and keep it with the patient's records. The care plan should be revised with any changes in the entitled person's clinical circumstances.

6.2 As a minimum, any care plan should include:

(a) presenting condition(s);

(b) objective assessment results and diagnosis of the condition(s);

(c) the planned treatment regime, including the anticipated type, number and/or frequency of services;

(d) details of any aids and appliances required;

(e) the expected outcomes or results of the treatment regime for the entitled person; and

(f) written informed consent of the entitled person.

6.3 The GP, as the care coordinator, may request care plans developed by treating allied health providers. DVA may also request a copy of any care plan. A copy must be given pursuant to any request.

NOTE: Where specific DVA programs stipulate requirements for care plans, please adhere to the specific program requirements.

7. Non MBS items and above fee services

7.1 Some services not listed in the MBS and services where, due to clinical complexity, the normal fee is not suitable may be considered by DVA for provision to entitled persons, however prior financial authorisation (also called "prior approval") is required from DVA. GPs must contact DVA prior to administering these services to be able to claim for payment. In considering whether to approve these services, DVA will take into

consideration, among other things, whether there are alternatives already in the MBS and the efficacy of the treatment requested.

7.2 A GP can request prior financial authorisation from DVA by forwarding a written request by mail or facsimile on official letterhead (see clause 14.1 for contact details). If urgent, a GP may wish to advise DVA by phone, however a written request must follow as soon as practical.

7.3 The written request for authorisation must include:

(a) the name and DVA number of the entitled person;
(b) the treatment entitlement of the person, i.e. Gold Card or White Card;
(c) the provider number of the requesting health care provider;
(d) the provider number of the referrer (where applicable);
(e) the date of the referral (where applicable);
(f) the service requiring prior approval;
(g) clinical justification for the requested service or fee; and
(h) costs.

7.4 DVA will not automatically grant requests for prior financial authorisation. Each request is considered individually. Previous approval of an unrelated request for the same or another entitled person or for another health care provider does not exempt the health care provider from requesting prior approval in each circumstance.

7.5 DVA will advise the outcome of the request in writing.

7.6 Generally, DVA will not pay retrospectively for services where financial authorisation was required but not obtained unless the circumstances are exceptional. DVA reserves the right to recover monies paid to providers for services where financial authorisation was required from DVA but not obtained.

8. Services DVA will not pay for

8.1 DVA will not pay for any of the following services:

(a) services that have been paid for, wholly or partly, by Medicare or a private health insurance fund;
(b) services where the cost is otherwise recoverable, wholly or partly, by way of a legal claim;
(c) examination for employment purposes;
(d) examination for a medical certificate for membership of a friendly society;
(e) all alternative therapies including herbalist services, homeopathy, naturopathy and iridology;
(f) cosmetic surgery where there is no clinical need; and
(g) massage that is not performed as part of physiotherapy, chiropractic or osteopathic services claimable through DVA and performed by a physiotherapist, chiropractor or osteopath.

9. Rehabilitation Appliances Program

9.1 GPs are recognised prescribers of selected aids and appliances under the Department's Rehabilitation Appliances Program (RAP). RAP assists entitled persons to be as independent and self-reliant as possible in their own homes. The provision of aids and appliances is intended to minimise the impact of disabilities and maximise quality of life and independence. Items issued under RAP are generally designed specifically for people with an illness or disability.

9.2 When using RAP, assessing health prescribers must forward the RAP item order form to the appropriate DVA-contracted RAP supplier. For more information on RAP, including which providers are eligible to prescribe particular RAP items, see DVA Factsheet HIP72, on the DVA website or by contacting DVA (see clause 14.5). The RAP schedule of items can be found at:

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

10. Home visits and kilometre allowance for GPs

10.1 A GP may perform an assessment or treatment in an entitled person's place of residence, whether their home, a Residential Aged Care Facility (RACF) or a hospital. Where a genuine need to travel exists, for example, to conduct a home assessment or where the entitled person is physically unable to travel, kilometre allowance may be payable. If there is no evidence of a genuine need to travel, kilometre allowance will not be paid.

10.2 Kilometre allowance:

(a) applies to return travel from the nearest consulting rooms to visit an entitled person;

(b) is not payable for the first ten kilometres of each journey; and

(c) is not payable if a suitable GP is located closer to the entitled person.

10.3 The kilometre allowance is claimed by writing the entire distance travelled to visit the entitled person under the heading 'kilometres travelled' on the service voucher used to claim for the service or in the field in the online claiming system. Please see the "Notes for Allied Health Providers: Section One – General" for more information on kilometre allowance.

11. Coordinated Veterans' Care Program

11.1 The Coordinated Veterans' Care (CVC) Program is an initiative that uses a proactive approach to improve the management of participants' chronic conditions and quality of care. The program is for veterans with chronic conditions and complex care needs who are at risk of unplanned hospitalisation. Improved management and coordination of care, including community based social assistance, has been shown to reduce hospital admissions.

11.2 For detailed information please refer to the CVC pages on the DVA website www.dva.gov.au/cvc

11.3 A key feature of the Program is the development and implementation of a comprehensive Care Plan, in consultation with the participant and their Care Team. The Care Plan enables an enhanced level of care and participant engagement, utilising a nurse coordinator who is either a practice nurse, DVA approved community nurse or Aboriginal health worker. Payments are made to GPs using CVC items which are claimed through the usual arrangements with DHS.

11.4 Potential candidates for CVC may be identified by the GP or individuals can self-nominate. The GP undertakes an assessment of the participant and determines whether they are eligible and will benefit from participating in the CVC Program. The GP is required to gain the participant's informed consent before enrolling them in the CVC Program.

11.5 In recognition of the impact social isolation has on veterans' health, additional resources are available for social assistance for participants most in need through CVC Social Assistance and Veterans' Home Care (VHC). For more information on both initiatives please refer to the DVA website. www.dva.gov.au/cvc and www.dva.gov.au/providers/provider-programs/veterans-home-care-provider-programs

12. DVA management requirements

Eligibility to provide DVA funded treatment

12.1 DVA Statutory Registration allows GPs who are eligible to claim for treatment services under the Medicare Scheme to provide treatment services to entitled persons under DVA's statutory provisions without having to enter into a contract with DVA. These provisions for statutory registration are covered by the relevant *Treatment Principles*. To apply for a Medicare provider number or amend details, please contact DHS (see clause14.9 for contact details).

12.2 To be eligible to provide treatment to entitled persons under the DVA health care scheme, the GP must have been a registered provider with DHS at the time the service was provided and a MBS benefit must have been claimable for the service (unless an exemption applies, see clauses 7.1-7.6).

12.3 In addition, the following conditions must be met to provide DVA funded treatment:

(a) where the health care provider is practising in a state or territory that has legislation requiring the registration of the occupation, the health care provider must be registered under that legislation; or

(b) if the health care provider is practising in a state or territory that does not have legislation concerning registration (occupational licensing legislation), the health care provider must, at a minimum, possess qualifications that would permit registration in another state or territory (if another state or territory has relevant occupational licensing legislation).

12.4 GPs must meet the professional and ethical standards set by their professional regulatory and/or representative body. DVA expects GPs to meet continuing education requirements set by their professional regulatory and/or representative body.

Insurance & indemnity

12.5 State or territory laws or provider registration bodies may require, as a condition of registration, that GPs carry a certain level of insurance and indemnity. This may vary across provider type and jurisdiction. For GPs covered under DVA's statutory registration scheme, DVA does not stipulate insurance requirements or level of coverage.

12.6 However, DVA does require that the provider shall at all times indemnify and hold harmless the Commonwealth, the Commissions, their officers, employees and agents (in this paragraph referred to as "those indemnified") from and against any loss (including legal costs and expenses on a solicitor/own client basis), or liability, incurred or suffered by any of those indemnified arising from any claim suit, demand, action, or proceeding by any person against any of those indemnified where such loss or liability was caused by any wilful unlawful or negligent act or omission by yourself, your officers, employees or agents in connection with DVA's statutory registration scheme or in the course of, or incidental to, performing the health services.

Privacy

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

Record keeping requirements and provision of information

12.8 The GP must create and maintain adequate and appropriate records relating to all administrative and clinical aspects of the provision of treatment to an entitled person.

12.9 All clinical records, including assessments, care plans, progress notes and clinical pathways, belong to the GP and must be retained and securely stored for the appropriate time period, if any, required under relevant State/Territory legislation.

12.10 GPs will comply with any reasonable request from DVA to supply information in relation to any entitled person. In relation to complaints, the GP must cooperate fully with DVA in investigating the matter, and must provide sufficient information to enable a response to the complaint within seven days of receiving an information request from DVA.

Advertising

12.11 GPs must not refer to DVA in any promotional material unless they observe the following conditions:

(a) the only permissible words providers can use to indicate the availability of allied health services to the veteran community are 'DVA Health Cards (Gold and White) are accepted as

payment upon a GP referral', noting these services should not be advertised as free to DVA clients.

(b) the Australian Government logo must not be used in the advertisements;

(c) the advertisement must not imply endorsement as DVA's preferred health care provider, or that the health care provider is an employee or agent of DVA. The advertisement may only advise that the health care provider will treat DVA entitled persons;

(d) no false or misleading information is to be included in the advertisement; and

(e) advertisements referring to DVA will not be permitted if state/territory regulations for each provider type prohibit advertising; and

(f) no inducements or other offers are to be made to DVA clients or their spouses.

12.12 If a GP has been informed of these guidelines and breaches them, DVA can take appropriate and necessary action which could include action under the *Competition and Consumer Act 2010*.

Use of locums, students and/or assistants

12.13 DVA will accept financial responsibility for the services of a locum if the locum GP is eligible to provide services under statutory registration and is willing to treat entitled persons under the DVA health care scheme.

12.14 DVA will not accept financial responsibility for health care services provided fully or in part to an entitled person by a fieldwork student or an assistant.

Benchmarking and monitoring and the audit process

12.15 DVA has systems in place to monitor the servicing and claiming patterns of GPs. DVA uses this information, in addition to best practice guidelines from professional regulatory or representative bodies, to establish internal benchmarks for the future delivery of services and to identify possible instances of overpayment resulting from administrative error, inappropriate-servicing or fraud.

12.16 DVA conducts audits of GPs. The audits will examine whether a health care provider is complying with:

(a) DVA's administrative arrangements; and

(b) DVA's treatment guidelines.

12.17 The key objectives of the audit process are to:

(a) ensure compliance with DVA's management requirements;

(b) provide an opportunity for DVA to educate GPs of their responsibilities when treating entitled persons;

(c) monitor the quality of health care being provided;

(d) monitor the achievement of health care outcomes for entitled persons;

(e) minimise the risk of overpayment as a result of administrative error, inappropriate-servicing and fraud; and

(f) address cases of individual non-compliance, in a manner consistent with the range of remedies contained in the DHS compliance model.

12.18 The compliance audits will be conducted at the provider's location, or at a DVA office at DVA's discretion. The health care provider will be given reasonable advance written notification of the audit.

Inappropriate claiming

12.19 The Commissions reserve the right to broadly determine the level of servicing for entitled persons for which they will accept financial responsibility.

12.20 Should it appear a GP may be supplying inappropriate levels or types of health care services, or has been submitting incorrect claims, DVA may contact the GP by telephone or in writing to discuss and clarify DVA's concerns.

12.21 A reasonable period of time will be given to the GP either to:

(a) demonstrate the health care services supplied were appropriate to meet the entitled person's treatment needs; and/or

(b) implement an agreed remedial action plan with DVA.

Financial matters

GST and ABNs

12.22 It is the GP's responsibility to notify DHS of all changes to GST registration status. DHS must have this information to ensure correct GST processing of claims for payment. Failure to notify DHS could result in failure to comply with GST law.

12.23 DVA requires GPs treating entitled persons to enter into a Recipient Created Tax Invoice (RCTI) Agreement with DVA if they are registered for GST. The RCTI Agreement and instructions on how to complete it are located on the DVA website (see also clause 14.10).

12.24 The RCTI Agreement permits DHS to automatically add GST to claimed taxable items. It also allows DHS to issue the GP with a RCTI to comply with GST law.

12.25 If a GP does not complete DVA's RCTI Agreement, DHS will reject claims for payment.

12.26 All GPs who receive DVA payments under DVA's health care arrangements are required to have an ABN. Having an ABN does not automatically mean a business is registered for GST.

Financial responsibilities

12.27 The Commissions will accept financial responsibility for the provision of health care services to meet the clinically assessed needs of entitled persons. The health care services must be delivered in accordance with these Notes and the *Treatment Principles*.

12.28 Generally, the Commissions will not accept financial responsibility for the cost of a service provided to an entitled person by a GP if, at the time the service was provided, a MBS benefit would not have been payable (see clauses 7.1-7.6 for exemptions).

12.29 Subject to clause 12.28, by accepting an entitled person's Gold or White Card and billing DHS, the GP agrees to accept the DVA fee as full payment for health care services without making any additional charges to the entitled person, unless advised to the contrary in the Schedule of Fees (see clause 13.3), by legislation, or as described in these Notes. The Commissions' financial responsibility for health care services provided to entitled persons is limited to the actual fees set out in the Schedule of Fees.

12.30 The Commissions do not accept financial responsibility for the payment of health service appointments missed by entitled persons. If it is standard practice to charge a fee for missed appointments, the entitled person must pay that fee.

12.31 DHS undertakes the processing of DVA claims. DHS operates a computerised claims processing system to pay GPs who treat entitled persons. Payment can be delayed or rejected if GPs submit claims containing incomplete, inaccurate or illegible information.

Right of the Australian Government to recover money

12.32 Without limiting the Australian Government's rights under any provision of these Notes, the *Treatment Principles*, any other legislation or under the Common Law, any payment or debt owed by the GP to the Australian Government under these Notes may be recovered by the Australian Government. The Australian Government can recover the amount of payment from any claim or from any other monies payable to the GP for any debt owed.

12.33 Recovery of monies paid to GPs by DVA can also be pursued via the civil recovery process through the Australian Government Solicitor.

13. Claiming Procedures

13.1 The GP can send the claim forms to DHS for processing, or use the online claiming system.

13.2 For health care services requiring prior financial authorisation from DVA, please ensure prior financial authorisation is granted by DVA at least one week before any associated claims are lodged with DHS.

Schedule of fees

13.3 Payment for health care services is based on DVA's Schedule of Fees relevant to the profession. An entitled person must first be assessed as requiring treatment by a GP and be issued a referral before seeing a specialist or allied health care provider.

13.4 The Schedule of Fees for each health care provider type is an integral part of DVA's "Notes for Providers". Each Schedule of Fees is available on the DVA website at:

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

Indexation of fees

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

Online Claiming

13.6 Online claiming allows GPs to submit electronic claims for processing without the need to send any paperwork to DHS (see clause 14.8(b)).

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

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

13.9 When using online claiming, the GP must adhere to the following principles, as is required when filling out Form D1217:

(a) the services were rendered by the GP or on the GP's behalf and, to the best of the GP's knowledge and belief, all information in the claim is true; and

(b) none of the amounts claimed are for a service which is not payable by DVA (see clause 12.27-12.31 for details).

DVA Webclaim

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

(a) access to DVA Webclaim is available via the Department of Human Services (DHS) Health Professional Online Services (HPOS) portal;

(b) Health professionals need a Medicare provider number and an individual Public Key Infrastructure (PKI) certificate to access DVA Webclaim;

(c) If you have a current Medicare provider number you can apply for your individual PKI Key through DHS; and

(d) For more information on DVA Webclaim, see the DVA Website provider information.

Manual Claiming

13.11 DVA health care claim forms and vouchers can be accessed from the DVA website (see clause 14.7).

13.12 An accounts claim is made up of a '*General Practitioner Treatment Services Voucher*' (Form D1216G) and a '*Claim for Treatment Services Voucher*' (Form D1217).

13.13 The information below is required in the following circumstances for a claim to be considered as correctly submitted:

(a) if the patient is the holder of a DVA White Card, the name of the condition being treated (e.g. osteoarthritis), not the description of the treatment provided;

(b) if the patient has been referred to you, for the first consultation in the referral period, the referring health care provider's name, provider number and the date of the referral; or

(c) if treatment was provided in a hospital or aged care facility, the name of that institution.

13.14 The process when making a paper-based claim for payment is as follows:

(a) submit the original copies of D1216G and D1217 to DHS (see clause 14.8(a));

(b) give the entitled person the patient copy of D1216G; and

(c) keep the claimant copies of D1216G and D1217 on record.

13.15 Recording the patient's entitlement number exactly as it appears on their card when filling out DVA forms, will minimises errors when processing accounts.

13.16 All health care services in an account submitted by an individual GP must have been rendered by the same GP. All health care services in an account submitted by an incorporated business entity or Government body must have been rendered at the same practice location.

13.17 The claim may contain service vouchers of several clients, as long as there are no more than 50 vouchers and no more than 99 services.

13.18 Claims for payment should be forwarded to DHS within two years of the date of service delivery, however the period may be extended in special cases.

Payment to different names and addresses

13.19 Provider numbers are location specific. The provider number used for claiming purposes must correspond to the provider number of the location at which the treatment was provided.

13.20 DHS has a group link facility, which allows payments to a name or address different from the name or address of the treating provider. When a group link is established, the payment name and address is linked to the GP provider number in the DHS system to ensure correct payment. To establish a group link, contact DHS (see clause 14.9 for contact details).

Non-payment of claims and resubmitting claims

13.21 DHS will process manual claims within 20 business days of receiving a complete and correct claim. Do not contact DHS with queries relating to unpaid claims until at least 25 business days after posting a manual claim. It may take up to an additional two business days (if paid by Electronic Funds Transfer (EFT) or an additional five business days (if paid by cheque) for payable benefits to be received by the provider.

13.22 DHS will process online claims within two business days. It may take up to an additional two business days (if paid by EFT) or an additional five business days (if paid by cheque) for payable benefits to be received by the provider. If your claim has not been paid within this time you should request an electronic remittance report.

13.23 If a claim is not paid by DHS because of errors on the form, the entire claim or a number of service vouchers will be returned to the GP with an explanation of non-acceptance.

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

Adjustments

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

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

13.26 The GP should not submit a Form D1216G or a Form D1217 to make an adjustment.

14. Contact list

14.1 Prior financial authorisation or eligibility checking

Metro	1300 550 457
Non-metro	1800 550 457
Fax:	(08) 8290 0422
Postal address	GPO Box 9998
	In your capital city

14.2 General information about DVA

General enquiries	133 254
Country callers	1800 555 254
Interstate Dial-in	1300 131 945
Email:	GeneralEnquiries@dva.gov.au

14.3 Veterans' Affairs Pharmacy Advisory Centre (VAPAC)

Advice about prescriptions accessible under the Repatriation Pharmaceutical Benefits Scheme (RPBS) and approval for Authority Prescriptions:

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

14.4 Repatriation Transport Unit

To make a transport booking for an entitled person or for information about DVA transport arrangements:

Metro 1300 550 455
Non-metro 1800 550 455

14.5 Rehabilitation Appliances Program (RAP)

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

Phone: 1300 550 457 (option 1)

14.6 Coordinated Veterans' Care (CVC)

Website:

www.dva.gov.au/cvcPhone: 1800 555 254

14.7 DVA Stationery

DVA Provider health care claim forms and vouchers are now available directly from the DVA website at:

http://www.dva.gov.au/providers/forms-service-providers

14.8 Payments and Claims

(a) DVA Medical paper-based claims can be sent to the following locations for processing:

GPs in QLD, TAS and VIC:

Veterans' Affairs Processing (VAP) - Medical
Department of Human Services
GPO Box 9869
MELBOURNE VIC 3001

GPs in ACT, NSW, NT, SA and WA:

Veterans' Affairs Processing (VAP) - Medical
Department of Human Services
GPO Box 9869
PERTH WA 6848

(b) Information about online claiming

Phone: 1800 700 199

Email: onlineclaiming@dva.gov.au

(c) Telephone queries about payments should be directed to Department of Human Services on

Phone: 1300 550 017 (Select Option 1)

14.9 Provider Registration

Applications for provider registration should be directed to Department of Human Services as follows:
http://www.medicareaustralia.gov.au/provider/pubs/medicare-forms/provider-number.jsp

Phone: 132 150

GP enquiries and changes to provider details should be directed to the Department of Veterans' Affairs Phone: 1300 550 457.

14.10 Recipient Created Tax Invoice (RCTI) Agreement

Download the RCTI Agreement from:

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

Phone: 1800 653 629

Send completed RCTI Agreements to:

Fax: 1800 069 288

Email (scanned copy): ABN.RCTI.NOTIFICATIONS@humanservices.gov.au

Mail: GST Program
GPO Box 2956
ADELAIDE SA 5001

14.11 Reporting Fraud

Send allegations of fraud to the DVA Business Compliance Section:

Email: fraudallegation@dva.gov.au or
Phone: 03 9284 6402

15. DVA Factsheets

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