This guide is designed to be a quick reference tool to assist in processing claims under DVA’s Community Nursing Program.

**Helpful Definitions and Descriptions**

| **CLAIM PERIOD** | The claiming period is 28 days and starts from the date the entitled person enters the Program. You submit your claim for payment for services delivered to Medicare at the end of the 28-day claim period. |
| **MAJORITY OF CARE** | You can work out the majority of care for each person by comparing the number of clinical services you delivered to the number of personal care services you delivered in a 28-day claim period. Whichever has the most visits is the majority of care and becomes the core item for claiming. If there is the same number of visits, the majority of care is clinical. |
| **VISIT TYPE** | There are three categories of visit:  
- **Clinical care** – nursing care required to treat medical conditions  
- **Personal care** – support activities including hygiene, aids and appliances, assessment and monitoring, nutrition, medication prompting and administration of non-prescription medication  
- **Other care** – including palliative, overnight and bereavement follow-up. |
| **VISIT LENGTH** | In the Community Nursing Schedule of Fees, visits are categorised by the time spent at each visit:  
- **Clinical care** – Short (20 mins or less) and Long (21 mins or more)  
- **Personal care** – Short (15–30 mins), Medium (31–45 mins) and Long (46 mins or more)  
- **Other care** – Length of visits are different for services delivered:  
  o three times a day – Short (less than 30 mins) and Long (31-60 mins), and  
  o overnight care – see the Clinical and Personal Care Overnight tables in the Schedule of Fees. |
| **TDS** | This refers to where services are provided to an entitled person three times a day. It can be claimed for either clinical or personal care. |

**Key Contacts**

DVA’s Nursing Advice and Approvals Centre (NAAC)  
1800 636 428  
for all general claiming enquiries (not rejected claims)  

Medicare 1300 550 017 (option 2)  
for claims that have been rejected
How do I determine the CORE ITEM?
To determine whether to use the clinical or personal care core schedule, add up how many clinical visits and how many personal care visits you did in the 28-day claim period.

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

How do I determine the VISIT LENGTH?

Total minutes ÷ number of visits = average visit length

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

CLINICAL
450 ÷ 10
Average 45 minutes per visit = 10 long visits

PERSONAL
240 ÷ 8
Average 30 minutes per visit = 8 short visits

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

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

ADD-ONs*
Personal Care
8 short visits (Item No. NT02)

OTHER ITEMS/CONSUMABLES
(if applicable)

SUBMIT CLAIM TO MEDICARE

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