Procedural Guideline
Rehabilitation Plan Administration

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1. Overview

Procedural Guidelines outline DVA’s requirements and supporting guidance for Rehabilitation Providers (providers) and their Rehabilitation Consultants (consultants) working with DVA clients. Consultants are expected to follow this guideline throughout the administration of Rehabilitation Plans for DVA clients.

Rehabilitation Plan Administration (plan administration) incorporates all provider and consultant related management and administration activities necessary for the successful delivery of a client’s Rehabilitation Plan (plan) from plan approval through to plan closure. Plan administration excludes clinical treatment.

Close support and regular communications among all relevant stakeholders such as the client, the consultant, the Rehabilitation Delegate (the delegate), treating practitioners and other activity providers will ensure effective plan delivery. The aim is to:

- provide timely implementation of the plan to maximise the client’s outcomes
- minimise the potential development of chronic illness or injury
- establish a positive and supportive rehabilitation environment
- establish a professional relationship with the client, and
- monitor the client’s progress and continued engagement with rehabilitation.

1.1. Plan Administration Activities

Plan administration activities include:

- day-to-day management of the client’s plan, including maintaining regular contact with all relevant parties and monitoring plan progress and case conferencing
- submitting regular progress reports (i.e. three monthly or as otherwise agreed with the delegate) to DVA, and
- making amendments and variations to the client’s plan as needed.

Figure 1: Plan administration overview
2. **Plan administration requirements**

**Table 1: Initial rehabilitation plan administration requirements**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day-to-day management</td>
<td>Throughout a client’s plan, consultants must:</td>
</tr>
<tr>
<td></td>
<td>• maintain regular communication necessary to ensure all parties (client, delegate and treating medical practitioners) are fully informed including, but not limited to:</td>
</tr>
<tr>
<td></td>
<td>o letters, facsimiles, phone calls, emails, SMS or other indirect interactions</td>
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<tr>
<td></td>
<td>o video or face-to-face meetings</td>
</tr>
<tr>
<td></td>
<td>o case-conference calls or meeting attendances</td>
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<td></td>
<td>• notify DVA immediately if they become aware the client has urgent needs or is at risk</td>
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<tr>
<td></td>
<td>• ensure no activities commence prior to formal approval of the plan by all parties</td>
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<tr>
<td></td>
<td>• monitor the progress of the client in achieving plan objectives</td>
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<tr>
<td></td>
<td>• gather updates from other treatment providers as part of the monitoring of a plan</td>
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<tr>
<td></td>
<td>• ensure relevant documents, including invoices are uploaded via the Provider Upload Page in line with DVA required timeframes</td>
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<tr>
<td></td>
<td>• ensure that only goals, activities and assessments specified in the approved plan are undertaken, and</td>
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<tr>
<td></td>
<td>• ensure actual costs incurred throughout the plan are reasonable, reflect only the duration of work performed for the client and within the amount specified in the approved plan.</td>
</tr>
<tr>
<td>Progress Reporting</td>
<td>Progress reports must:</td>
</tr>
<tr>
<td></td>
<td>• be provided every three months, or as otherwise agreed with the delegate and specified in the plan</td>
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<tr>
<td></td>
<td>• be submitted by the due date</td>
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<tr>
<td></td>
<td>• use the <a href="#">D1330 Rehabilitation Plan Progress Report</a> template, ensuring that the progress report template is fully completed</td>
</tr>
<tr>
<td></td>
<td>• be accompanied by a completed <a href="#">D9230 Life Satisfaction Indicators</a> form. This form must be completed by the client</td>
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<tr>
<td></td>
<td>• be of a professional standard and a quality consistent with this guideline, and</td>
</tr>
<tr>
<td></td>
<td>• be uploaded using the Provider Upload Page.</td>
</tr>
<tr>
<td>Rehabilitation Plan Amendments</td>
<td>Plan amendments must:</td>
</tr>
<tr>
<td></td>
<td>• be discussed with the delegate before a client signs the rehabilitation amendment</td>
</tr>
</tbody>
</table>
Topic | Requirement
---|---
| **be completed using the [D1336 Rehabilitation Plan Amendment](#)** form |
| **be accompanied by a [D9230 Life Satisfaction Indicators](#) form, and** |
| **be uploaded using the Provider Upload Page.** |

**Rehabilitation Plan Variations**

Plan variations must:

- be discussed with the delegate before a client is asked to sign the new plan
- be completed using the [D1347 Rehabilitation Plan](#) form
- be accompanied by a [D9230 Life Satisfaction Indicators](#) form
- comply with the Rehabilitation Plan Development and Rehabilitation Plan Closure Procedural Guidelines, and
- be uploaded using the Provider Upload Page.

3. **Day-to-day plan management**

3.1. **Regular communication and monitoring**

Consultants play the critical role of case manager in the rehabilitation process, providing ongoing and proactive support to the client, management and implementation of recommended and approved goals and activities, and the close monitoring of the client’s responses and progress towards achieving objectives in their plan.

Client’s progress towards achieving their plan should be actively monitored by the consultant between progress reports to ensure that they are on track. The outcome of monitoring should be documented using case management notes, and formally reported to the delegate via Progress Reports in line with agreed reporting timeframes.

Consultants are expected to maintain regular contact with the client, the delegate and key service providers. The intensity of this contact will be determined by the complexity of the case or as discussed and agreed with the delegate.

3.2. **Case conferencing**

A case conference is a meeting held (usually via teleconference) between the consultant, the treating health practitioner/s, and when appropriate, the client and/or delegate, to jointly review and discuss the case in detail to keep matters progressing and resolve issues of concern. Regular case conferencing is considered to be best practice in rehabilitation case management; particularly in longer-term cases or cases of higher complexity.

Case conferencing can be beneficial early in the plan development stage where complexity exists in the case, or where it becomes apparent that mismatched expectations among key stakeholders are emerging.
When major barriers are identified (including but not limited to: treatment, client management or administrative matters) case conferencing involving relevant stakeholders can be an extremely useful and cost effective mechanism for reaching agreement on moving matters forward and confirming goals or objectives for all players.

### 3.2.1. Initiating a case conference

<table>
<thead>
<tr>
<th>Participant</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Consultant</td>
<td>To clarify and discuss the client’s current situation and facilitate conversation around possible options available to enable the client to positively progress with their plan.</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>To provide their professional judgement on the client’s current health status.</td>
</tr>
<tr>
<td>Other Medical Specialists</td>
<td>Other medical specialists or allied health professionals may be included but not limited to: physiotherapists, exercise physiologists, occupational therapists, dieticians, psychologists, psychiatrists and other mental health workers. They will typically be the client’s treating practitioner contributing</td>
</tr>
</tbody>
</table>
## Participant | Role
---|---
Client | their specialist knowledge in their medical speciality to the client’s condition and current symptoms.
Client family/support person | To discuss and clarify their wishes and any barriers or issues of concern they are experiencing in regards to any aspect of their rehabilitation.
Rehabilitation Delegate | To assist the client in the communication of the client’s wishes, current abilities and possible solutions to any part of their plan. This may be of particular importance if the client has difficulty in communicating these aspects themselves. This person is not a formal representative or advocate of the client but may communicate their wishes in the case conference.

The outcome/s of a case conference need not be pre-determined and may depend on the discussions that take place between all relevant parties. However, the outcomes of the case conference should be communicated in the next due report (assessment or progress).

### 3.3. Cost management and invoicing

Consultants should submit monthly invoices to DVA throughout the duration of the plan, where activities were delivered throughout the period. Consultants are required to use the invoicing template provided in Annex B of the Deed of Agreement for Rehabilitation Services. Invoicing for ongoing plan management activities should be done on a monthly basis once the relevant activity is completed and within five days of the end of the month to ensure payments by DVA can be made in a timely manner.

Consultants must ensure actual costs incurred throughout the plan are reasonable, reflect only the duration of work performed for the client and are within the amount specified in the approved plan. Where costs are expected to exceed the approved amount, the consultant must submit a plan amendment reflecting the revised costs. Costs cannot be incurred before delegate approval of a plan or plan amendment, and DVA cannot pay invoices that exceed the amount approved on the plan.

Costs approved in the plan are expected to be inclusive of all activities required to deliver the plan. This may include, but is not limited to:

- regular progress meetings and phone calls with the client throughout the duration of the plan through to plan closure to monitor plan progress and provide the client with support
- completion, collation and review of progress reports, life satisfaction indicators, plan amendments and plan variations using the DVA templates throughout the duration of the plan
- activities funded as part of the plan
- completion and review of the plan closure report using the DVA template at the conclusion of the plan
meetings, phone calls, letters, emails and messages with/to the client, treating practitioners, the delegate and other stakeholders throughout the duration of the plan, including case conferences.

- travel costs incurred in relation to plan administration and closure.
- provider administrative costs including invoice preparation, filing, uploading documents, distributing DVA promotional materials to clients and postage of letters, and.
- using DVA electronic resources (e.g. the Consolidated Library of Information and Knowledge (CLIK) and the DVA website) to guide clients through DVA requirements.

### 3.3.1. Provider Upload Page

It is mandatory that providers upload invoices via the Provider Upload Page (PUP). In the event that the PUP is offline, the consultant should wait several hours and try accessing the portal again. Where upload is still not possible, the consultant should contact the delegate before submitting the documentation via email.

DVA requests that a provider uploads an invoice for each client on a monthly basis where possible. An exception to this must be approved by DVA in writing. Invoices should be inclusive of administrative costs associated with delivering the plan for the client. Under no circumstances should providers be sending bulk invoices to DVA via email.

For further information about using the PUP, please consult the PUP user guide and frequently asked questions available through the [PUP home page](#).

### 4. Progress reporting

#### 4.1. The progress reporting process

Regular progress reporting is critical in documenting the client’s progress towards achieving the objectives of their plan and relaying this progress to all relevant parties, including the client, delegate, and treating practitioners. They help to identify any barriers to achieving objectives so that additional supports and strategies can be put in place as appropriate.

It is essential that if significant issues arise, such as deterioration in a client’s symptoms or conditions, or life changes that will impact on a client’s rehabilitation progress, that consultants are pro-active in contacting the delegate and informing them.

The standard progress reporting timeframe is three months, however an alternative timeframe may be agreed with the delegate and documented in the plan.

#### 4.2. Meaningful progress reporting

In order to ensure meaningful progress reports, DVA requires providers to fully and honestly complete the [D1330 Rehabilitation Plan Progress Report](#) form. The progress report should be succinct, but provide necessary information so that readers can determine progress since the last report. Consultants should not copy and paste progress updates from previous reports, rather, if
there has been limited or steady progress, this should be stated concisely in the report. Progress reports should:

- re-state the goals identified in the client’s plan or amendment
- reassess the client’s life satisfaction by the client completing D9230 Life Satisfaction Indicators and including these results on the progress report form. Note that whilst the consultant may assist the client in filling out their LSI, the ratings must be completed by the client
- document plan goals and activities in the plan details table provided, so that they progressively accumulate over time - this allows the reader to easily identify outcomes and status of interventions in chronological order
- document developments or activities undertaken during a set period of the plan
- be consecutively numbered
- be distributed by the consultant to all stakeholders, as identified by the delegate, and
- where appropriate, accompany the provider’s monthly invoice. It is essential that invoices are uploaded in a separate document to progress reports to ensure they are identified to be paid.

If the progress report is not completed to a satisfactory standard, the delegate may reject the report and send it back to the consultant for revision.

4.2.1. No surprises approach

Progress reports should not introduce new information that has not been previously discussed with the delegate or the client. It is important that major or significant developments are communicated to the delegate at the time of the incident or event.

5. Plan amendments and variations

There are two types of changes that can be made to a plan:

1. A plan amendment for minor changes, funding changes or a change in goals. This is completed using the D1336 Rehabilitation Plan Amendment form.

2. A plan variation for a change in plan focus i.e. a change from a non-return to work to a return to work plan or vice versa. This requires a new plan to be developed in line with the Rehabilitation Plan Development Procedural Guideline.

5.1. Situations giving rise to a plan amendment or variation

At times it may be necessary to amend a plan in response to changes to a client’s circumstances, or where the plan is not progressing as expected. Changes that would require a plan amendment may include:

- when any changes to the short or long term activities of a plan are required, but the overall focus or intent of plan are the same
- if the timeframes to complete activities of the plan need to be adjusted or extended
- if the goals in the plan are changing, but the focus or intent are the same
• if additional rehabilitation activities need to be included that do not change the overall focus of the plan, and/or
• where the approved funding for the plan activities requires an amendment.

Where there is a significant change in the focus of the plan, from a non-return to work to a return to work plan or vice versa, this will give rise to the need to develop a new plan.

5.2. Process for plan amendments and variations

Providers should discuss plan amendments and variations with the delegate before completing a plan amendment or new plan in line with a ‘no surprises’ approach. A client should never be asked to sign a plan amendment before the delegate has given their agreement to proceed.

A plan amendment is completed using the D1336 Rehabilitation Plan Amendment form. Once the amendment has been developed, it must be submitted to the delegate for approval PRIOR TO the client signing the amendment. This is to ensure that the delegate has the opportunity to review the plan amendment for appropriateness, cost-effectiveness and sustainability, and propose any revisions if necessary.

A plan variation requires the consultant to complete a new D1347 Rehabilitation Plan form. Please note, the requirement to do a plan variation may be due to a change in the client's circumstances, which may warrant a subsequent needs assessment to ensure that the relevant parties have an adequate understanding of the client’s current circumstances.

Where a plan variation occurs, a Rehabilitation Assessment will be required to be completed using the D1334 Rehabilitation Assessment form. Consultants should discuss and agree with the delegate whether a full Initial Rehabilitation Assessment or partial assessment is required. Where a partial assessment is required, consultants should agree with the delegate about what elements of the assessment should be completed. Providers are required to comply with the Rehabilitation Plan Development Procedural Guideline (and if applicable, the Initial Rehabilitation Assessment Procedural Guideline) when undertaking a plan variation.

When submitting the amendment or new plan to the delegate, they should be accompanied by a reassessment of the client’s life satisfaction by the client completing D9230 Life Satisfaction Indicators form. These documents should be submitted to DVA via the PUP.

The plan amendment or variation does not come into effect until approved by the delegate. Additional costs should not be incurred until after delegate approval has been given in writing.