Australian Government
Department of Veterans' Affairs

CVC
Coordinated Veterans' Care Program

Coordinated Veterans' Care (CVC) Program FAQs for GPs

What is the Coordinated Veterans' Care (CVC) Program?

The Coordinated Veterans' Care (CVC) Program is for eligible veterans with chronic conditions and complex care needs who are at risk of unplanned hospitalisation. The program uses a proactive approach to improve participant health, wellbeing and quality of care, and reduce unplanned hospitalisations.

The participant works with their GP and care coordinator (usually a practice nurse) to develop an individualised comprehensive care plan, with ongoing care coordination occurring as outlined in the care plan. Participants may have a broader care team, based on their individual needs, which can include allied health providers, pharmacists, ex-service organisations (ESOs) and carers as required.

As each participant's needs are different, their care plan and the extent of care coordination will be unique to their situation. The CVC Program is about genuine, ongoing engagement with the participant and collaboration between the members of the care team. Participants will remain enrolled in the program for as long as they continue to benefit from enrolment.

Who is eligible to participate?

Veteran Gold Card holders with one or more chronic health conditions may be eligible.

Veteran White Card holders who have a chronic DVA accepted mental health condition (a condition that has been accepted by DVA as being related to service) may also be eligible.

In addition, patients must be living in the community, have complex care needs, and be at risk of unplanned hospitalisation.

GPs are encouraged to assess each patient against the program eligibility criteria. The CVC Toolbox has an eligibility tool that can assist GPs with this process.

How is the CVC Program delivered?

Once a participant has been identified and they have consented to participate in the CVC Program, the GP and care coordinator are required to meet with the participant to undertake an individual assessment. The assessment process will form the basis of the care plan.

There are no specific assessment tools or tests to be completed for this step. The assessment must take into account the individual needs of the participant including health needs, personal preferences, and level of engagement at the outset of the program. Assessment is intended to be undertaken as required, with an ongoing review process built into the delivery of the program.

The GP and care coordinator work with the participant and the other members of the care team, on an ongoing basis, to deliver services outlined in the care plan. The care coordinator will ensure effective and regular communication with the participant and other members of the care team. It is anticipated the care coordinator will visit the participant in their home at least once over a 12 month period, if the practice has capacity to undertake this visit and a home visit is of benefit to the participant. The GP is required to provide regular feedback and guidance to the care coordinator.

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What is a period of care?

A period of care refers to the 90 day blocks during which services are delivered as per the care plan. At the end of each period of care, the care plan will be reviewed to confirm eligibility for continued enrolment. This review must occur prior to the commencement of the next period of care, and ahead of claiming.

When and how can I make a claim?

Claims can be made at specific times based upon the service dates.

1. *Initial assessment and program enrolment items*
   These items can only be claimed once in the lifetime of a client, following the assessment process and development of the care plan.
   - UP01 – GP with practice nurse
   - UP02 – GP without practice nurse
2. *Completion of 90 day period of care – review of care plan and eligibility items*
   The **first date of service** is day 1 of the 90 day period of care. Claims for each period of care can be made once a 90 day period has completed.
   - UP03 – GP with practice nurse
   - UP04 – GP without practice nurse

The CVC Program fee items can be claimed in addition to existing Repatriation Medical Fee Schedule (RMFS) fee items.

The CVC Toolbox provides a claim calculator which can assist providers to determine the dates that claims can be made for each 90 day period of care from the **first date of service**.

All claims are processed directly through Medicare. If there is an error with a claim it will be rejected by Medicare and will need to be resubmitted.

If you have a query about claims, please contact Medicare on 1300 550 017.

Contacting DVA

Should you have questions about the program, including in relation to program eligibility or claiming enquiries after contacting Medicare, you can phone 1800 550 457 or email cvcprogram@dva.gov.au.

Further information is available on the Coordinated Veterans' Care Program pages of the DVA website.