Australian Government

Department of Veterans' Affairs

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CLINICAL DISCUSSION AND RECOMMENDATION PAPER – CLINICAL POSITION PAPER

CLINICAL POSITION STATEMENT

Title	*Tinnitus Severity Assessment and Tinnitus Rehabilitation outside of the Hearing Services Program, RAP and MBS*
Revision Number	*1.0*
Approval date name and position	*Approval 19 JUL 2024 Released 20 AUG 2024 AC DCHO*
Implementation Date	
Review Date	*20 AUG 2025 (12 months from approval for most scenarios, 6months for rapidly changing scenarios, 2 years for stable scenarios)*
Clinical Question	Under what criteria should DVA support tinnitus severity assessments and tinnitus rehabilitation for eligible people?
Clinical Recommendation	It is clinically reasonable to fund **tinnitus severity assessments** for eligible people if the following applies: 1. There is a referral *for a tinnitus assessment* from a GP, ENT, Neurologist or Psychiatrist to the audiologist making the prior approval request. (eg not a referral for hearing services) 2. If applicable, the referral should include information about the cause of tinnitus, and evidence that secondary tinnitus has been considered. Veterans with hearing loss may have other conditions such as brain tumours, vascular malformations or medication side effects that cause or worsen tinnitus. 3. The requested assessment includes gathering of audiology information, scientifically validated tinnitus questionnaire results, informational counselling, and, if needed, psychoacoustic testing, tinnitus goal-setting and referral to other professionals[3 10 20]. It is clinically reasonable to fund **tinnitus rehabilitation** for eligible people if the following applies: 1. The request has come from an audiologist or ENT specialist[1 3 10 11 20] 2. There is evidence that a tinnitus severity assessment has occurred. 3. There is evidence that a veteran has troublesome tinnitus, and treatment for any existing comorbid mental health conditions has not helped tinnitus[11] 4. Tinnitus devices, which include hearing aids with adaptive tinnitus settings through HSP and tinnitus items through RAP, have been trialled and do not help tinnitus, are not available, or are contraindicated.[22] If these have not been trialled, they must be included as part of the requested rehabilitation program. 5. The proposed rehabilitation is scientifically validated and follows standard clinical protocols[14]. Examples include Tinnitus Retraining Therapy[6 12 21], therapeutic counselling such as Cognitive Behaviour Therapy (CBT)[17 21], and sound enrichment therapy that includes therapeutic demystification and habituation techniques, such as Neuromonics[5]. It is <u>not</u> clinically reasonable to fund non-evidence-based treatments for tinnitus, such as herbal, pharmaceutical, non-therapeutic counselling or non-therapeutic sound-based

	interventions (such as CDs or Phone Apps)[16], or recurrent Transcranial Magnetic Stimulation (rTMS)[23].

SUPPORTING EVIDENCE

Current Clinical Guidance in Australia (and international where relevant)	Audiologists are at the centre of clinical assessment, including screening for secondary causes and rehabilitation for tinnitus[1 2 11]. Audiology Australia's Clinical Standards supports assessment, counselling and provision of hearing and/or tinnitus devices to treat tinnitus. Tinnitus assessment and rehabilitation aims to improve an eligible person's wellbeing by reducing the negative effects of troublesome tinnitus such as poor sleep, reduced concentration and increased stress[7]. Tinnitus severity assessment and rehabilitation is clinically indicated when tinnitus is of concern to the eligible person, and it wasn't helped with removal of possible secondary causes[20]. International evidence-based clinical best practice guidelines have been developed to help ensure practitioners offer a consistent approach in the clinical setting[10 20]. Clinical recommendations for tinnitus management are based on severity of impact on the person and include no further action, periodic reassessment and monitoring, standard audiology rehabilitation, specialised audiology rehabilitation, and referral to other medical, psychological and allied health professionals if indicated[3 4 11 15].
Additional Context	The Scope of Practice for Audiologists and Audiometrists in Australia states that audiologists, and not audiometrists, can assess tinnitus in adults[2]. Both audiologists and audiometrists can provide standard audiology assessments and help eligible people with tinnitus through education, hearing aids and tinnitus devices. Audiologists can provide tinnitus rehabilitation for eligible people with troublesome tinnitus[2]. Audiologists are allied health professionals with a Masters-level degree in clinical audiology who are full members of Audiology Australia and/or the Australian College of Audiology. Audiometrists are allied health professionals who must have completed a Diploma-level TAFE qualification in audiometry or a Bachelor of Audiometry[2]. Most people with mild, moderate or intermittent primary tinnitus as well as hearing loss, do well with standard audiology assessment and rehabilitation[3 10 20], which is provided for free through the Hearing Services Program. People with mild, moderate or intermittent primary tinnitus and no hearing loss who are not troubled by tinnitus often do not need to seek help, or are satisfied with general information about tinnitus[20].
Published Evidence	There is evidence for the importance of establishing tinnitus severity through assessment, to ensure

	results are credible and consistent, and to evaluate the potential need for rehabilitation[1 8 11 13 19]. There is no cure for primary tinnitus. However, research literature has established that hearing aids, hearing aids [9 18] with tinnitus settings[9 18], tinnitus retraining therapy[6 12], cognitive behaviour therapy[21], sound enrichment therapy[5] and tinnitus devices[23] are all potentially effective rehabilitation options for tinnitus. An eligible person with troublesome tinnitus may need a combination of these approaches for rehabilitation to be effective[10 20 21]. Secondary tinnitus may be due to a vascular lesion or tumour, and if suspected, medical imaging or specialist review (Ear Nose Throat – ENT) is warranted. These structural lesions require diagnosis, surveillance, management and possibly invasive procedures. Practitioners should be alert to the presence of troublesome tinnitus. There are potential risks of psychological injury from both lack of intervention[10 20] and over-intervention[24] when managing tinnitus. Eligible people with troublesome tinnitus and comorbid or undiagnosed mental health conditions should be referred to a medical and/or mental health provider[1 10 14 20]. Overtreatment of tinnitus can make people more aware of their tinnitus which then creates a cycle of distress that can make it have a greater impact on their life[24]. Potential benefits of effective treatment for troublesome tinnitus include improved wellbeing through improved sleep, a better understanding of how to manage emotional response to tinnitus, improved concentration, increased participation in life activities and improved mental health[3].
Assessment under the Treatment Principles	There are three applicable sections under the treatment principles for tinnitus. *TP 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.* Due to the risk of under and over treatment, it is suggested that the above clinical recommendations listed above are met to access tinnitus severity assessments and tinnitus rehabilitation services. *TP 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 (MBS) listed services; or (b) experimental and have not been demonstrated to be effective or safe by extensive clinical trials.* Tinnitus severity assessment and rehabilitation are unlisted services that can significantly improve eligible peoples' response to tinnitus. There are established clinical protocols to demonstrate tinnitus severity assessment and rehabilitation is effective and safe. *TP 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 war-caused to the extent that it is a necessary part of treatment for a war-caused injury or disease.*

Summary	The prior approval process can determine if tinnitus severity assessment and/or rehabilitation is a necessary part of treatment for tinnitus. Entitled people should attend emergency care or an ENT as soon as they can if the tinnitus has occurred from an injury or sudden hearing loss, or if they have symptoms of facial paralysis or muscle weakness. Entitled people who are experiencing severe mental health difficulties or suicidal ideation from their tinnitus should seek emergency care or mental health support immediately. Eligible people with troublesome tinnitus can receive safe and effective tinnitus severity assessment and rehabilitation if: they have consulted with a medical specialist (including a GP) who has referred them to an audiologist; the audiologist has followed clinical standards and best practice guidelines when assessing tinnitus; and tinnitus rehabilitation offered is validated and effective and appropriate to the level of severity.

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REFERENCES

References	1. American Academy of Audiology. (2000). Audiologic Guidelines for the Diagnosis and Management of Tinnitus Patients. Retrieved from https://www.audiology.org/publications-resources/document-library/audiologic-guidelines-diagnosis-management-tinnitus-patients. 2. Audiology Australia (2016). Scope of Practice for Audiologists and Audiometrists. Retrieved from https://audiology.asn.au/Tenant/C0000013/Position%20Papers/Other%20documents/Scope%20of%20Practice%20All-in-one%2020170119.pdf 3. Audiology Australia (2022). Professional Practice Standards for Audiologists. Retrieved from https://audiology.asn.au/standards-guidelines/professional-practice-guide/ 4. Carpenter-Thompson JR, Akrofi K, Schmidt S, Dolcos F, Husain F. Alterations of the emotional processing system may underlie preserved rapid reaction time in tinnitus. *Brain Research*, 2014; 1567: 28 5. Davis PB, Paki B & Hanley PJ. (2007). Neuromonics tinnitus treatment: third clinical trial. *Ear and Hearing*, *28*(2), 242-259. 6. Gold SL, Formby C, Scherer RW. (2021). The Tinnitus Retraining Therapy Counseling Protocol as Implemented in the Tinnitus Retraining Therapy Trial. American Journal of Audiology, Volume 30, Issue 1. 7. Hackenberg B (2023). Tinnitus and Its Relation to Depression, Anxiety, and Stress—A Population-Based Cohort Study. J Clin Med. 2023 Feb; 12(3): 1169. 8. Heller AJ (2003). Classification and epidemiology of tinnitus Otolaryngol Clin North Am,Volume 36, ISSUE 2, P239-248. 9. Henry JA, McMillan G, Dann S, Bennett K, Griest S, Theodoroff S, ... & Saunders G. (2017). Tinnitus management: Randomized controlled trial comparing extended-wear hearing aids, conventional hearing aids, and combination instruments. *Journal of the American Academy of Audiology*, *28*(6), 546-561. 10. Henry J, Zaugg T, Myers P, Schmidt C, Ribbe C, Edmonds K ... et al. (2015). Adult tinnitus management clinical practice recommendation. National Center for Rehabilitative Auditory Research, VA Portland Health Care System. 11. Henry JA, Zaugg TL, Myers P, & Kendall C. (2010). Progressive tinnitus management: Clinical Handbook for Audiologists. Plural Publishing Inc. San Diego, CA, USA. 12. Jastreboff PJ & Jastreboff MM. (2000). Tinnitus Retraining Therapy (TRT) as a method for treatment of tinnitus and hyperacusis patients. *Journal of the American Academy of Audiology*, 11, 162 – 177. 13. McCombe A, Baguley D, Coles R, McKenna L, McKinney C & Windle-Taylor P. (2001). Guidelines for the grading of tinnitus severity: The results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. *Clinical Otolaryngology*, 26, 388 – 393. 14. Makar SK, Mukundan G & Gore G. (2017). Treatment of Tinnitus: A Scoping Review. *The International Tinnitus Journal*, *21*(2), 144–156. 15. Norena AJ (2023).The Analogy between Tinnitus and Chronic Pain: A Phenomenological Approach Brain Sci. *Aug; 13(8): 1129.* 16. Nyenhuis N, Golm D & Kröner-Herwig B. (2013). A systematic review and meta-analysis on the efficacy of self-help interventions in tinnitus. *Cognitive Behaviour Therapy*, *42*(2), 159-169. 17. Philippot P, Nef F, Clauw L, de Romrée M & Segal Z. (2012). A randomized controlled trial of mindfulness-based cognitive therapy for treating tinnitus. *Clinical Psychology & Psychotherapy*, *19*(5), 411-419. 18. Searchfield GD & Tyler R. (2015). Hearing aids for tinnitus. *Tinnitus: Clinical and Research Perspectives, eds D. Baguley and M. Fagelson (San Diego, CA: Plural Publishing)*, 197-212. 19. Takehashi M, Kabaya K, Sekiya K et al (2018) An improved system for grading and treating tinnitus. Auris Nasus Larynx Volume 45, Issue 4, August 2018, Pages 711-717. 20. Tunkel DE, Bauer CA, Sun GH, Rosenfeld RM, Chandrasekhar SS, Cunningham Jr ER, ... & Henry JA. (2014). Clinical practice guideline: tinnitus. *Otolaryngology–Head and Neck Surgery*, 151(2_suppl), S1-S40.

21. Tyler RS. (2006). Neurophysiological models, psychological models, and treatments for tinnitus. *Tinnitus treatment: Clinical protocols,* 1 – 22.
22. Veterans' tinnitus support information https://www.dva.gov.au/get-support/health-support/health-services/hearing-services
23. Zhengrong Liang et al. (2020). Repetitive transcranial magnetic stimulation on chronic tinnitus: a systematic review and meta-analysis. *BMC Psychiatry*, 20, Article number: 547.
24. Vesterager, V (1997). Tinnitus – investigation and management. British Medical Journal, Vol 314, Issue 7082.

CONSULTATION/APPROVALS

Consultation	Name	Date	Signature
AS Health and Wellbeing Policy	Cath Haffner		
AS Health Programs and Services	Joumana El Hassan		
Approver	**Name**	**Date**	**Signature**
Deputy Chief Health Officer (DCHO)	Anna Colwell		

ASSOCIATED DOCUMENTS

HIMN is AH-05

Neuromonics 2013/07

CLINICAL
HEALTH INFORMATION AND MANAGEMENT NOTE (HIMN)

HIMN Number	AH-03
Date of Issue	03/12/2013
Review Date	07/01/2014
Last Approved By:	Tammy s 47F
Last Approval date	17/2/2022

NEUROMONICS TINNITUS TREATMENT UNDER DVA ARRANGEMENTS

Subject	Neuromonics tinnitus treatment under DVA arrangements
Purpose	To outline the circumstances in which DVA will approve funding of the Neuromonics Tinnitus Treatment Program to entitled persons
Service provider/s	Audiologists
Item Number	MT04 or MT06
Approvals **Prior financial authorisation**	s 47E
Retrospective approval	Funding of Neuromonics treatment should receive approval prior to treatment commencing as retrospective approval would not generally be granted.
MEPI reimbursement	Medical Expenses Privately Incurred (MEPI) reimbursements of Neuromonics treatment would not generally be granted.
Record keeping	Approved/declined items listed in this HIMN should be recorded by the delegate in the specified records management system. This information will assist in monitoring activity and expenditure.
Fee/Cost	s 47E
Delegation	s 47E
Authority	VEA Instrument 2013 No. R52 (as amended) [1]
Related HIMNs	Nil
Related BRs	N/A
Contact	s 47E

CLINICAL
HEALTH INFORMATION AND MANAGEMENT NOTE (HIMN)

HIMN Number	AH-03
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Last Approved By:	Tammy s 47F
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NEUROMONICS TINNITUS TREATMENT UNDER DVA ARRANGEMENTS

	s 47E
Enquiries	Any internal enquiries about the content of this HIMN should be referred to the following mailbox address: s 47E
Background	Due to the high number of veterans suffering from tinnitus, DVA undertook a study to review the success of the Neuromonics Treatment Program between 2007 – 2010. Results of the Neuromonics study indicated a high proportion of study participants reported clinically significant improvements in tinnitus related disturbance. Following consideration of the outcomes of the trial, the Commissions considered there was sufficient evidence of effectiveness and usability of the program for veterans to be reasonably confident that the program can deliver benefits to some veterans suffering from severe tinnitus.
Policy	**Accessing Neuromonics treatment under DVA arrangements** To access tinnitus treatment under DVA arrangements, DVA clients must visit their General Practitioner (GP) who can refer them to an Ear, Nose and Throat (ENT) specialist. The ENT can make a full assessment to rule out contributing clinical conditions and then refer client to an audiologist for treatment. The audiologist will assess suitability for the program and arrange access through DVA HA & HC. Eligibility criteria: • Have a Gold Card, or a White Card with tinnitus listed as an accepted disability (AD); and • Have been referred to an audiologist following an assessment by an ENT specialist to ensure they have been assessed appropriately, and all treatment options have been explored. • Requests for Neuromonics treatment are not to be processed unless there has been an assessment by an ENT specialist. Under DVA arrangements, the cost of this assessment will be covered up to the value of $200. **Hearing Aids for the treatment of tinnitus** Should the client's hearing provider determine that hearing aids may also assist in managing their hearing needs, veterans can obtain free to client hearing aids via the Australian Government Hearing Services program which is administered by the Department of Health. To access this program, DVA clients should visit their GP who can provide a referral to the program. **Requests for Neuromonics treatment**

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NEUROMONICS TINNITUS TREATMENT UNDER DVA ARRANGEMENTS

Providers should fax the treatment request to DVA including:

- Name and DVA file number of the entitled person who is to receive treatment;
- Provider number of the health care provider;
- Details outlining the client's assessment by their ENT;
- Breakdown of costs; and
- A copy of the patient's audiogram and clinical justification made by the audiologist.

Financial Authorisation

The guidelines set out in this HIMN are to be used by the HA & HC team to process requests for Neuromonics treatment.

Treatment requests outside DVA's Neuromonics policy guidelines outlined in this HIMN should be referred to s 47E (HE) for consideration under the non-MBS process.

CLINICAL
HEALTH INFORMATION AND MANAGEMENT NOTE (HIMN)

HIMN Number	AH-05
Date of Issue	16/05/2023
Review Date	14/12/2024
Last Approved By:	Chris s 47F
Last Approval date	14/12/2023

Allied Health Treatment

Subject	**Allied Health**
Purpose	To provide a schedule of Allied Health treatments, devices and diagnostic procedures which may be approved or declined by Health Approvals, RAP and Transport (HART) staff, as specified within this HIMN, without referral to s 47E s 47E
Allied Health Advice	Advice from Allied Health advisers is required for all requests that meet the circumstances described in this HIMN.
Service provider/s	Allied Health Service providers include • audiologists • chiropractors • diabetes educators • dietitians • exercise physiologists • occupational therapists • optometrists – Please see related HIMN OPT-01 - Optical Items • orthotists • osteopaths • physiotherapists • podiatrists – Please see related HIMN AH-01- Podiatry Services • psychologists • social workers • speech pathologists
Item Number	Any applicable item numbers.
Approvals	s 47E
Retrospective approvals	May be considered where: • treatment was provided in an emergency situation; • the Service Provider was unaware of the need to seek prior approval; and

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Allied Health Treatment

	• length of time following treatment, where date of services is not greater than 2 years. In these circumstances HART staff should make the provider aware of the process for future instances.
MEPI reimbursement	See HIMN PROG-01 Medical Expenses Privately Incurred
Record keeping	• Approved/declined items listed in this HIMN should be recorded by the delegate. This information will assist in monitoring activity and expenditure. • Approvals should be recorded in the Prior Approval and Referral System (PARS) under the appropriate treatment type using the relevant item numbers, including the maximum fee and/or number of consultations. • Advice of the decision should be provided in writing.
Fee/Cost	See ATTACHMENT A
Delegation	s 47E
Authority	s 47E
Related HIMNs	HIMN PROG-01 - Medical Expenses Privately Incurred HIMN OPT-01- Optical Items HIMN AH-01- Podiatry Services
Related BRs	N/A
Contact	Request for treatment outside of these guidelines should be referred to s 47E s 47E for consideration under the non-MBS process: s 47E
Enquiries	Any internal enquiries about the content of this HIMN should be referred to the following mailbox address: s 47E
Background	Many Allied Health services are frequently requested and could be approved as determined by HART staff.

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Allied Health Treatment

	This HIMN and associated Attachment A have been developed to streamline the approval process and list those services, which can be determined as clinically justified and approved, or not clinically justified and declined. The Attachment A: • lists treatments, diagnostic procedures and devices that are not listed on the Medicare Benefits Schedule (MBS), the DVA Allied Health Fee Schedules or included under the Rehabilitation Appliances Program (RAP); and • provides instructions for processing. Treatment outside the conditions listed in this HIMN should be referred on a template to s 47E for consideration. All requests for above RMFS rates, including retrospective MEPIs are to be escalated to s 47E for consideration.
Policy	**Financial Authorisation** The guidelines set out in this HIMN are to be used by HART to process the services outlined in the schedule of frequently requested allied health treatments, devices and diagnostic procedures provided in ATTACHMENT A. a) **Prior Approval** Allied health providers should seek prior approval in writing from DVA before delivering allied health services to members of the veteran community, which fall outside of DVA's usual arrangements. The request should preferably be on the relevant prior approval form. **Approvals** **Approval guidelines** All applications for the provision of allied health treatment or devices to Veteran White Card holders where eligibility and clinical justification for treatment is required to be established are to be forwarded to an Allied Health Adviser (AHA). Applications for the provision of allied health treatment or devices which are listed in the *Schedule of Allied Health Treatments* at Attachment A may be approved by HART staff following advice from an AHA in the following circumstances: • the request must have been reviewed and considered clinically justified; • the treatment has been requested by an appropriate allied health provider. o a treatment ordered or requested by a GP may be considered if, with advice from an AHA, the treatment/device was clinically justified, and is to be delivered by an appropriate allied health provider type;

Allied Health Treatment

- approval may be granted up to the maximum DVA limits set out in this HIMN; and
- all other items associated with this treatment, such as other consultation fees and travel, should be claimed against existing scheduled item numbers, and submitted to the Services Australia.

a) Non-MBS approval

The items listed in Attachment A no longer require approval from s 47E unless specified in this HIMN. If there are doubts or concerns regarding the clinical appropriateness of the request or the treatment falls outside of these guidelines, the request should be documented and submitted for assessment via a template to s 47E

b) Managing approvals

Advice of the decision should be provided in writing. Where approval is given the provider should use the item number as listed on *HIMN 01/2018 MT Item Numbers,* or profession specific item numbers as applicable, to claim and lodge the claim for payment with DHS in the usual way.

- Approved/declined items listed in this HIMN should be recorded by the delegate. This information will assist in monitoring activity and expenditure.

MEPI reimbursement

See **HIMN PROG-01 Medical Expenses Privately Incurred**

Enquiries

Any internal enquiries about the content of this HIMN should be referred to the following mailbox address: s 47E

Allied Health Treatment Cycle

A referral to an allied health provider will last either 12 sessions or 1 year, whichever ends first.

DVA clients who have a Totally and Permanently Incapacitated (TPI) Gold Card are exempt from the treatment cycle arrangements for exercise physiology and physiotherapy services.

In some cases, a client may benefit from the At Risk Client Framework which can be tailored to provide approval for 3, 6 or 12 months. Treatment outside of standard health card arrangements will still require prior approval.

DVA Requested Reports or Service

Requests from an allied health provider for approval of a DVA-requested report or service can be considered for funding up to a maximum fee as set out in the Fee By Negotiation (FBN) list – TRIM 231567147E.

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Allied Health Treatment

	• The report or service must have been requested by Departmental staff initially • Applies to FBN items: CD99, CH99, DT99, EP99, F990, OM99, OT99, PH99, SH99, SW99, US96. • Above maximum fee requests should be forwarded to s 47E • If approving at MT02 rate, please ensure to approve/record the requested report fee exclusive of GST Services Australia will add the GST to the items when they pay the invoice.

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Allied Health Treatment

ATTACHMENT A

Schedule of Allied Health Treatment – approvals with AHA recommendation

Items on this schedule can be approved by Health Approvals and Payments only **if they have been reviewed by an AHA** and considered clinically justified; and they meet the requirements set out in *HIMN AH-05Allied Health Treatment.*

Prior approval requests from allied health practitioners which meet these requirements can be approved or declined with AHA advice

Audiology

Hearing aids	• Hearing aids are generally not funded through DVA because they are funded through the Australian Government Hearing Services Program. Exceptions to this are veterans with White cards that list tinnitus but not hearing loss, veterans living overseas with Gold and White cards that list hearing loss conditions, and, if clinically indicated, veterans who are otherwise unable to access hearing aids through the Hearing Services Program. Prior approval requests for hearing aids should be escalated to Care and Assistance Programs s 47E when an audiology adviser has advised that the request is not clinically justified.
Hearing aid batteries	• Hearing aid batteries are normally covered under the maintenance payment arrangements with the Hearing Services Program (HSP) and do not need to be supplied separately. If a request is received from a veteran who has received a hearing aid outside HSP arrangements, the request should be documented for consideration under the non-MBS process.
Hearing aid drying kits/ dehumidifiers	• Standard drying kits suitable for standard perspiration issues are not funded by DVA when the client has hearing aids provided under the HSP. These inexpensive standard drying kits are generally covered under the HSP maintenance and battery agreement. Providers should be referred back to the HSP if they require guidance. • Specialist (sometimes electronic) drying kits may be considered for DVA funding in specific clinical circumstances e.g. the client lives in an excessively humid environment or has a sweating problem associated with a medical condition. • Approval for specialist drying kits should be determined in consultation with an audiology adviser up to $300 (usual cost is $120-$300).
Hearing aid remote controls	• Remote controls for hearing aids are not funded by DVA and are available through the HSP.
Hearing aid rechargers	• Rechargers and rechargeable hearing aids may be considered for funding if there is evidence of medical condition/s that prevent effective hearing aid battery

Allied Health Treatment

	changing
Hearing Assessments	Requests for hearing assessments should generally be declined as they are provided to Gold card holders and White card holders with accepted hearing loss conditions through the Australian Government Hearing Services Program, or through the MBS. • Exceptions to this are veterans with White cards that list tinnitus but not hearing loss, and veterans living overseas with Gold and White cards with accepted hearing loss conditions.
Hearing – cochlear implant assessment / switch on	From March 1 2023 cochlear implant switch on fees and ongoing rehabilitation support for cochlear implants is generally covered under MBS Items 82301, 82302 and 82304. An ENT referral is required. Audiologists may be granted approval for additional cochlear rehabilitation fees in some circumstances if there is a clearly documented clinical rationale. • See HIMN 2014-05 – Fees Associated with Cochlear Implants
Hearing – cochlear implant consumables and accessories	The following can be approved: • Cochlear dry bricks / aqua kits. • Parts and repairs to Cochlear implants. • Accessories such as battery chargers • Replacement of out of warranty processors. • Replacement of lost processors. Cochlear implant accessories listed below are supplied by RAP: • AA18 Streamers • AS22 Phone clips – AS22 one-offs • AA06 External Microphones • AA04 TV listeners
Cerumen removal	Approval may be granted for non-MBS requests for cerumen (earwax) removal from non-medical practitioners such as audiologists up to a maximum of $100 if there is a medical reason provided.
Custom earplugs	Earplugs can be considered for funding if there is evidence of medical need, for example recurrent ear infections that prevent effective use of hearing aids
Neuromonics tinnitus treatment	See HIMN 2014-05 – Neuromonics Tinnitus Treatment under DVA Arrangements
Tinnitus Assessments	Prior approval requests for tinnitus assessments may be funded up to a maximum of $300 for veterans with White cards that list tinnitus but not hearing loss.
Vestibular audiology	Vestibular audiology can be considered for funding up to a maximum of $750 when an audiologist provides the assessment following referral from an Ear Nose Throat (ENT)

assessments	specialist or General Practitioner for investigation of balance problems or as part of a cochlear implant assessment. • Must meet the conditions described in MT15.

Chiropractors

Same day services – same provider type	Approval can be considered for two chiropractic consultations on the same day (different service types / medical conditions) either by the same or different chiropractic provider. This can apply for either prior approval or retrospective payment requests.
Rejected payments	Funding can be considered for consultation item/s when a previous payment was rejected due to administrative error.
Same day services – different provider type	Approval can be considered for two musculoskeletal consultations on the same day when: • The service is to be delivered by chiropractic, exercise physiology, osteopathy, physiotherapy providers • The request for treatment is clinically justified • Any approval must be consistent with treatment cycle arrangements and cannot exceed approval of 12 treatments
Radiography	Radiography by chiropractors registered with DVA can be considered for approval only when one-and-two region spinal x-ray items are limited to one service for the same client, on the same day (as per fee schedule). • This applies to Items CH20, CH21, CH22, CH23. CH24, CH25, CH26, CH27 • Non-MBS items require s 47E decision
Public Hospital Items	Approval can be considered for chiropractic treatment in a public hospital. • This applies to Items CH31, CH32, CH33, CH34
Residential Aged Care	From 1 October 2022, access to allied health care services was expanded to eligible veterans, widows and widowers living in residential aged care facilities, regardless of the level of care they are receiving. Allied health care providers will no longer be required to seek prior approval to deliver services to DVA clients who were previously classified as high care.
Chiropractors - Small medical aids and appliances	Small medical aids and appliances provided by Chiropractors can be approved in line with PH94, plus postage (PH98).
Chiropractors - consumables	Clinically required consumables, provided by Chiropractors during or immediately after the consultation / treatment, can be approved in line with PH93. Provider claims the invoiced cost only, exclusive of GST, not exceeding the maximum fee. Services

Allied Health Treatment

	Australia will automatically add GST to the amount claimed.

Psychologists

Above schedule fee requests	As per HIMN 2021-03, all requests for above schedule fees require input from the Senior Mental Health Adviser and a decision by s 47E
Trauma Focused Therapy requests	Trauma Focused Therapy: After 8 sessions of trauma focussed therapy a Case Review (US07) must be provided to DVA and prior financial authorisation sought for any further treatments. Trauma focused exposure therapy and Eye Movement Desensitization and Reprocessing sessions when 50+ minutes is inadequate for effectively meeting the DVA client's therapeutic needs. While undertaking trauma assessment and general trauma treatment, standard item numbers are considered appropriate.
Neuropsychology Requests	Non-MBS or low-cost above fee services: • CL25 Neuropsychology Assessment (4 - to less than 6 hours) (Maximum Limit Applies) Fee By Negotiation GST-free • CL30 Neuropsychology Assessment (6 - to less than 8 hours) (Maximum Limit Applies) Fee By Negotiation GST-free • There must be a valid referral. • s 47E
ASD assessment request	Requests for Autism Spectrum assessments require a valid referral • Assessments over four hours require prior financial authorisation • For the purposes of ASD assessment, other psychologists, such as educational and developmental psychologists, who have completed an approved postgraduate qualification and supervised training in an area of practice and have endorsement in that area of practice, should also be paid at the same rate as for clinical psychologists for these assessments.

Dietetics

Enteral Nutrition Feeding Pumps/consumables and supplements	Requests for these items should be referred to RAP as they are available on the RAP National Schedule of Equipment.
Weight Management programs	DVA does not fund weight management programs outside of services provided by Accredited Practising Dietitians for eligible veterans

Exercise Physiologists

CLINICAL
HEALTH INFORMATION AND MANAGEMENT NOTE (HIMN)

HIMN Number	AH-05
Date of Issue	16/05/2023
Review Date	14/12/2024
Last Approved By:	Chris s 47F
Last Approval date	14/12/2023

Allied Health Treatment

Same day services – same provider type	Approval can be considered for two exercise physiology consultations on the same day (different service types) either by the same or different exercise physiology provider. This can apply for either prior approval or retrospective payment requests
Rejected payments	Approval can be considered for consultation item/s when a previous payment was rejected due to administrative error
Same day services – different provider type	Approval can be considered for two musculoskeletal consultations on the same day when. • The service is to be delivered by chiropractic, exercise physiology, osteopathy, physiotherapy providers • The request for treatment is clinically justified • Any approval must be consistent with treatment cycle arrangements and cannot exceed approval of 12 treatments.
Public Hospital Items	Approval can be considered for exercise physiology treatment in a public hospital • This applies to Items EP14, EP15, EP16, EP17
Residential Aged Care	From 1 October 2022, access to allied health care services was expanded to eligible veterans, widows and widowers living in residential aged care facilities, regardless of the level of care they are receiving. Allied health care providers will no longer be required to seek prior approval to deliver services to DVA clients who were previously classified as high care.
Non-liability Mental Health Care	Approval can be considered for exercise physiology consultations under NLMHC entitlement where the service is clinically relevant to the treatment of the veteran's mental health condition/s, and is part of a package of mental health treatment. Clinical advisers must refer to the current Protocol NLHC Funding when considering treatment under NLMHC arrangements.
Exercise Physiologists – Clinically required consumables	Clinically required consumables already provided by Exercise Physiologists to Veterans can be approved in line with PH93. Provider claims the invoiced cost only, exclusive of GST, not exceeding the maximum fee. Services Australia will automatically add GST to the amount claimed. • Exercise physiologists should use the RAP program to prescribe small exercise aids (AV10).

Occupational Therapy

Same day services – same provider type	Funding can be considered for two occupational therapy consultations on the same day (different service types) either by the same or different occupational therapy provider. This can apply for either prior approval or retrospective payment requests
Rejected	Funding can be considered for consultation item/s when a previous payment was

Allied Health Treatment

payments	rejected due to administrative error
Same day services – occupational therapy	Funding can be considered for two different types of occupational therapy services on the same day. • The provider must provide evidence of referral • May be the same or different occupational therapy provider • Any approval must be consistent with treatment cycle arrangements and cannot exceed 12 treatments per cycle
Public Hospital Items	Funding can be considered for occupational therapy treatment in a public hospital This applies to Items OT03, OT09, OT21, OT31 OT36, US33, US36
Residential Aged Care	From 1 October 2022, access to allied health care services was expanded to eligible veterans, widows and widowers living in residential aged care facilities, regardless of the level of care they are receiving. Allied health care providers will no longer be required to seek prior approval to deliver services to DVA clients who were previously classified as high care.
Lymphoedema Treatment	Approval of requests for Lymphoedema occupational therapy treatment by an Occupational therapist assigned Lymphoedema specialty code can be considered when the annual cap has been exceeded. • The number of additional services approved cannot exceed 12, per year. • This applies to Item OT26
Occupational Therapy - Small medical aids and appliances	Small medical aids and appliances provided by occupational therapists can be approved up to a maximum of $250 plus postage • This applies to Item OT75 Services Australia will add the GST to the items when they pay the invoice.

Orthotists / Prosthetics

Above fee items	For any orthotist/prosthetist requests where the requested fee exceeds the item fee as listed in the fee schedule, the item number can be replaced with either UT38 or UT39 which are the above schedule fee item numbers under the Orthotics schedule.
Two pairs of Orthoses	Orthotists requesting funding for two pairs of orthoses must provide clinical justification for the request to be considered.

Osteopathy

Same day services – same provider type	Approval can be considered for two osteopathy consultations on the same day (different service types) either by the same or different osteopathy provider. This can apply for either prior approval or retrospective payment requests.

CLINICAL
HEALTH INFORMATION AND MANAGEMENT NOTE (HIMN)

HIMN Number	AH-05
Date of Issue	16/05/2023
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Allied Health Treatment

Rejected payments	Approval can be considered for consultation item/s when a previous payment was rejected due to administrative error
Same day services – different provider type	Approval can be considered for two musculoskeletal consultations on the same day when. • The service is to be delivered by chiropractic, exercise physiology, osteopathy, physiotherapy providers and both providers have submitted a request for prior approval. • Any approval must be consistent with treatment cycle arrangements and cannot exceed approval of 12 treatments
Public Hospital Items	Approval can be considered for osteopathic treatment in a public hospital. • This applies to Items OM51, OM52, OM53, OM54
Residential Aged Care	From 1 October 2022, access to allied health care services was expanded to eligible veterans, widows and widowers living in residential aged care facilities, regardless of the level of care they are receiving. Allied health care providers will no longer be required to seek prior approval to deliver services to DVA clients who were previously classified as high care.
Osteopaths - Small medical aids and appliances	Small medical aids and appliances provided by Osteopaths can be approved in line with PH94, plus postage (PH98).
Osteopaths - consumables	Clinically required consumables, provided by Osteopaths during or immediately after the consultation / treatment, can be approved in line with PH93, exclusive of GST. Provider claims the invoice cost only, exclusive of GST, not exceeding the maximum fee. Services Australia will automatically add GST to the amount claimed.

Physiotherapy

Same day services – same provider type	Approval can be considered for two physiotherapy consultations on the same day (different service types) either by the same or different physiotherapy provider. This can apply for either prior approval or retrospective payment requests.
Rejected payments	Approval can be considered for consultation item/s when a previous payment was rejected due to administrative error.
Same day services – different provider type	Approval can be considered for two musculoskeletal consultations on the same day when • The service is to be delivered by chiropractic, exercise physiology, osteopathy, physiotherapy providers, and both providers have submitted a request for prior approval,

Allied Health Treatment

	• Any approval must be consistent with treatment cycle arrangements and cannot exceed approval of 12 treatments
Two consultations provided on the same day in Private Hospital	Approval can be considered for two physiotherapy consultations on the same day delivered in a Private Hospital. • The length of time for providing two consultations on the same day should not exceed five days; and • The treatment is for short term acute onset conditions. This applies to Items PH13, PH17, PH23, PH27.
Public Hospital Items	Approval can be considered for physiotherapy treatment in a public hospital • This applies to Items PH12, PH16, PH22, PH26
Residential Aged Care	From 1 October 2022, access to allied health care services was expanded to eligible veterans, widows and widowers living in residential aged care facilities, regardless of the level of care they are receiving. Allied health care providers will no longer be required to seek prior approval to deliver services to DVA clients who were previously classified as high care.
Physiotherapists - Small medical aids and appliances	Small medical aids and appliances provided by physiotherapists can be approved up to a maximum of $250 plus postage • This applies to Item PH94
Continence Physiotherapy	Approval of requests from a physiotherapist specialising in continence physiotherapy can be considered for up to five continence physiotherapy treatments, per calendar year. • This applies to item MT25
Vestibular Physiotherapy	Approval of requests from a physiotherapist specialising in vestibular physiotherapy can be considered for up to five vestibular physiotherapy treatments, per calendar year. • This applies to item MT26
Lymphoedema Treatment	Approval of requests for lymphoedema physiotherapy treatment by a Physiotherapist assigned Lymphoedema specialty code can be considered when the annual cap has been exceeded. • The number of additional services approved cannot exceed 12, per calendar year. • This applies to Item PH41
Non-liability Mental Health	Approval can be considered for physiotherapy consultations under NLMHC entitlement where the service is clinically relevant to the treatment of the veteran's

Allied Health Treatment

Care	mental health condition/s, and is part of a package of mental health treatment. Clinical advisers must refer to the current Protocol NLHC Funding when considering treatment under NLMHC arrangements.

Podiatry - Please see related HIMN 2008/04 - Podiatry Services

Social Workers/Mental Health Social Workers

Above fee requests	To be assessed by social work/psychology advisers

Speech Pathology

Notes for Speech Pathology requests	Requests from speech pathology providers generally include requests for assessment and treatment of communication and swallowing difficulties. Communication disorders include: dysphasia (oral language difficulties), dyspraxia (motor planning difficulties), dysarthria (speech difficulties), dysphonia (voice disorders), dysfluency (stuttering), written language difficulties (including dyslexia and dysgraphia) and cognitive language difficulties. Swallowing disorders include dysphagia (swallowing difficulties) and odynophagia (painful swallowing). Swallowing difficulties can be caused by difficulties with the oral mechanism (e.g. part of the tongue has been removed due to cancer, or the oral muscles are weak due to a stroke); and/or the pharyngeal mechanism (i.e. problems with the movement of the pharynx and throat when swallowing) e.g. The larynx may not raise up rapidly enough and the epiglottis may not close quickly enough over the airway to protect it when drinking or eating. Veterans with neurological disorders (e.g. Stroke, Parkinson's Disease, Motor Neurone Disease) are particularly at risk for swallowing disorders.
Non-RAP speech pathology items / procedures	Non-RAP items or low-cost procedures from speech pathology providers can be funded up to a maximum of $200
Specialised Assessments This applies to Items SH17, SH27	Requests for specialised assessments can be approved to a maximum of $200 such as • Modified Barium Swallow Study (MBSS), • Video-fluoroscopic Swallow Study (VFSS), • Fibreoptic Endoscopic Evaluation of Swallowing (FEES), and • Videostroboscopy
Group treatment	Group treatment such Stroke groups, LSVT-LOUD (SH28 / SH29) and Speak Out programs following rehabilitation may be approved up to a maximum of $200 • Must be facilitated by a speech pathologist

IMPORTANT

Australian Government
Department of Veterans' Affairs

Audiology Prior Financial Approval Request

Privacy notice – Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Go to www.dva.gov.au/privacy for more information about how DVA manages personal information.

Important information – Prior Approval is required for all implantable, tinnitus, hearing devices and other non-standard requests for items and services not available through the Australian Government Hearing Services Program or the Medical Benefits Scheme (MBS).

When completing this form, you must attach:

- a copy of the referral (except for hearing devices);
- a clinical report, including audiogram and clinical goals, describing why you believe this is an exceptional clinical case; and
- any other relevant evidence to support the request.

Incomplete forms and forms without these attachments will not be reviewed by DVA.

Do not provide the service until a funding decision is received from DVA. If the request is for hearing devices, do not proceed with a trial or fitting until you receive a funding decision from DVA.

For further information and support to complete this form, or if the request is URGENT, please contact the Provider Hotline on **1800 550 457** (option 3, option 1).

Do not complete this form if this request is:

- part of a compensation claim. Proceed as detailed with Transaction Reference Number (TRN) advice notice which can be provided by the entitled person.
- for a standard assistive listening device or tinnitus device. These devices are provided through the DVA Rehabilitation Appliances Program. Use Form D9376 instead.

Returning this form – You can print, scan and return this form, along with the referral and clinical report, by email to health.approval@dva.gov.au

Proposed date of service

Entitled person's details

1. **DVA File number**
2. **Surname**
3. **Given name(s)**
4. **Email address**

☐ I have confirmed with the entitled person that they would like to receive the outcome of the request via the email address provided above.

5. **Card type** Gold ☐ White ☐
6. **Condition being treated** Hearing loss ☐ Tinnitus ☐ Other ☐ ▶ Please provide details

Request details

7. Type of funding request

- ☐ Implantable (e.g. cochlear / bone-anchored assessments, processors, rehabilitation, accessories)
- ☐ Tinnitus (e.g. assessment, devices, rehabilitation, accessories)
- ☐ Hearing devices (e.g. hearing aids, accessories, non-standard Assistive Listening Devices)
- ☐ Other (e.g. non-MBS)

Servicing Provider's details

8. Practitioner type

☐ Audiologist ☐ Audiometrist **Note**: Audiometrists may only request funding for hearing devices and accessories.

9. Practitioner name

10. Practitioner Medicare number (if applicable)

11. Clinic name and address

Postcode

12. Telephone number (including area code if applicable)

13. Email address

Referring Provider's details

14. Referring provider type

- ☐ Specialist
  Note: Audiologists generally require a referral from an ENT for implant assessments, processors, switch on and rehabilitation, and certain non-MBS items such as tinnitus services or vestibular audiology.
- ☐ GP
- ☐ Allied Health Provider e.g. psychologist, OT, other audiologist (please describe)
- ☐ Other/Not applicable (please describe)

15. Name of referring provider (if same as Servicing Provider, write 'as above')

16. Referring provider Medicare number (if applicable)

17. Telephone number (including area code if applicable)

18. Email address

Details of treatment/service and clinical justification

19. Is this request for hearing devices only?

No ☐ ▶ *Continue to next question*

Yes ☐ ▶ ***Go to Hearing device requests on the next page***

20. Description of treatment/service requested

21. Clinical reason(s) for request

Attach relevant clinical information as required

22. Item number/treatment/service/accessory (if applicable)

Item number/treatment/service/accessory	Cost
	$
	$
	$
	$
	$

23. Are you requesting hearing devices?

No ☐ ▶ ***Go to Declaration***

Yes ☐ ▶ *Continue to next question*

Hearing device requests

There are many types of fully subsidised hearing devices available through the Australian Government Hearing Services Program at https://hearingservices.gov.au/. Fully subsidised hearing devices may include features such as adaptive noise reduction, adaptive directional microphones, multichannel compression, feedback cancellation, direct wireless streaming and connectivity, multiple listening programs, adaptive tinnitus programs and remote programming.

Use this form only if the range of features available in fully subsidised hearing devices through the Australian Government Hearing Services Program have been considered and there are specific reason(s) for requesting hearing devices with additional features.

DVA can consider funding for hearing devices in exceptional circumstances, such as when they cannot be supplied through the Hearing Services Program, or when the entitled person's health and/or personal circumstances and wellbeing are significantly affected by hearing loss and the entitled person is unable to access specialist hearing services.

Specialist hearing services are available at Hearing Australia. See https://hearingservices.gov.au/wps/portal/hso/site/eligibility/clientinfo/hearing_services_available_through_the%20program/specialist%20hearing%20services/ or go to https://hearingservices.gov.au/ and enter 'specialist hearing services' in the search bar. An entitled person may be eligible for specialist services with a three-frequency average hearing loss of 80dB or more in the better ear; or if an eligible person's hearing loss either prevents effective communication in their daily environment, or is caused or aggravated by significant physical, intellectual, mental, emotional or social disability. Some eligible people may have physical or mental health conditions in addition to hearing loss and/or tinnitus that may be relevant to your request.

24. Is the entitled person eligible to access specialist hearing services via Community Service Obligation (CSO) at Hearing Australia?
These services may include access to a greater range of hearing devices with more features and more services and supports.

No ☐ ▶ Please explain the reason(s) why the entitled person is not eligible to access specialist hearing services at Hearing Australia.

Yes ☐ ▶ currently accessing CSO – ***Stop completing this form and review what can be provided under CSO funding.***

Yes ☐ ▶ however are unable or have chosen not to receive CSO services
Please explain the reason(s) why

25. Proposed hearing device details

Hearing device	Cost after HSP subsidy
	$
	$

26. Previous hearing device details (if applicable)
Note: If you are recommending replacement of current devices please provide reason(s).

Hearing device requests continued...

27. Has the entitled person been given a choice from the range of fully subsidised hearing devices through the Australian Government Hearing Services Program which are appropriate for the entitled person's audiological needs, as required by Hearing Services Program (Voucher) Instrument 2019 clause 45(1)*?

* Includes hearing devices through the Australian Government Hearing Services Program.

No ☐
Yes ☐

28. Has the entitled person been supplied item(s) from the range of Assistive Listening Devices (ALDs) available through the DVA Rehabilitation Appliances Program (RAP) to help address specific listening and communication goals?

No ☐
Yes ☐

29. Please explain why the fully subsidised devices and/or ALDs would not meet the person's needs

30. Please explain why the item(s) are being requested. How will the item(s)' specific features help the client manage their hearing loss and meet their communication needs and goals? Provide supporting evidence as required

Declaration

31. Provider's declaration

I declare that:

- I am the servicing hearing practitioner named in this request and the information I have provided is true and correct to the best of my knowledge, and
- I have attached:
  - ☐ a referral specific to the requested service (except for hearing devices)
  - ☐ clinical report, and
  - ☐ other relevant information required to support this request.

Provider's signature

Date

Please send completed form, referral and clinical report to health.approval@dva.gov.au

For help and guidance call Provider Hotline on **1800 550 457** (option 3, option 1).

Save Print Clear

Treatment Principles

Instrument 2013 No. R52

made under subsection 90(4) of the

Veterans' Entitlements Act 1986

Compilation No. 31

Compilation date: 27 June 2024

Includes amendments: F2024L00785

Registered: 11 July 2024

Prepared by the Office of Parliamentary Counsel

About this compilation

This compilation

This is a compilation of the *Treatment Principles* that shows the text of the law as amended and in force on 27 June 2024 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on the Register (www.legislation.gov.au). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the Register for the compiled law.

Application, saving and transitional provisions for provisions and amendments

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. For more information on any modifications, see the Register for the compiled law.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

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Australian Government

REPATRIATION COMMISSION

Veterans' Entitlements Act 1986

Section 90

Treatment Principles

Instrument 2013 No. No. R52

PART 1 — INTRODUCTION/COMMENCEMENT

1.1.1 The *Treatment Principles*, prepared by the Repatriation Commission under section 90 of the Act, set out the circumstances in which, and conditions subject to which, treatment may be provided for eligible persons under Part V of the Act and are to be read subject to the Act.

1.1.2 The *Treatment Principles* state the rules under which the Repatriation Commission may arrange, or accept financial responsibility for the cost of, treatment for persons eligible for treatment under the Act.

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

1.2 Application of Repatriation Private Patient Principles

1.2.1 The Repatriation Private Patient Principles (the RPPPs), determined by the *Commission* under section 90A of the Act, apply in all States in which a Repatriation General Hospital has been integrated into the State health system and in those States and Territories in which the Commission has declared that they apply.

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

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

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 213 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 and/or Torres Strait Islander Primary Health Care worker" means a person who is qualified as an Aboriginal and/or Torres Strait primary health care worker after undertaking a course in Aboriginal and/or Torres Strait Islander Health, provided by an institution recognised by the *Aboriginal and Torres Strait Health Islander Practice Board of Australia* as suitable for providing a course of that nature, and who obtained a Certificate Level III (or higher) under the course.

"Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment" means treatment provided by an *Aboriginal and/or Torres Strait Islander Primary Health Care worker* to an *entitled person* under the *Coordinated Veterans' Care Program*, comprised of:

(a) implementing the *Comprehensive Care Plan* for the person under the Program — in particular co-ordinating treatment services under the *Comprehensive Care Plan*;
(b) liaising, in relation to the *Comprehensive Care Plan*, with the *general practitioner* who manages the *Comprehensive Care Plan* for the person;
(c) performing such other functions under the program that the *Aboriginal and/or Torres Strait Islander Primary Health Care worker* has under the *Fees for Coordinated Veterans' Care Program Providers*.

"ACPMH treatment" means action taken with a view to maintaining an *entitled veteran* in mental health and includes:

(a) training members of the Defence Force or staff made available under section 196 of the *Act*, or both, in the mental health care disciplines that could benefit the mental health of an *entitled veteran*; and

(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 veteran*; 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 196 of the *Act*; and

(iii) an *entitled veteran*; 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 veteran*.

Note (1): under subsection 80(1) of the *Act* treatment can be action taken with a view to maintaining a person in physical or mental health.

Note (2): the terms "member", "Defence Force", "member of the Defence Force", are defined in the *Act*.

"Act" means the *Veterans' Entitlements Act 1986*.

"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.

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

"**admitting general practitioner**", in relation to an *entitled person* in the *Coordinated Veterans' Care Program*, means the *general practitioner* 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", in relation to the *Veterans' Home Care Program* (Part 7.3A), means a State, Territory or Local Government, or incorporated organisation, or person, that has entered into an arrangement with the *Commission* or the *Department* 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 VHC-type service*;

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

"approved provider", in relation to *short-term restorative care*, has the meaning it has in the *Aged Care Act 1997*.

"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

"assistive communication device" means an object that enhances the ability of a person with complex communication needs to communicate and includes items such as:

- communication books or boards
- speech generating devices
- modified personal computers
- computerised devices, which may include a keyboard and screen display and which may incorporate synthetic speech, memory functions, and word prediction facilities
- devices commonly known as computer tablets and smart `phones.

"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*.

"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.

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

"Classification Principles 2014" means the legislative instrument of that name made under section 96-1 of the *Aged Care Act 1997*.

"**clinical psychologist**" means a *psychologist*:

(a) who has been given a *provider number* in respect of being a *psychologist*; and
(b) has appropriate qualifications in clinical psychology and practises as a clinical psychologist.

Note: an example of an appropriate qualification would be completion of 2 years of formal, post-graduate (Masters level) clinical training in an accredited, university based program and completion of 2 more years supervised clinical training as well as continuing education on an annual basis.

"Commission" means the Repatriation 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.

"Commonwealth Home Support Programme service" means a service provided to a person under the programme administered by the *Department of Social Services* called the "Commonwealth Home Support Programme" and includes any service provided under that programme as the name of the programme may change from time to time.

"community nurse" means a *registered nurse* or *enrolled nurse* who works in a community nursing setting and who is employed or engaged by a *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 *Comprehensive Care Plan* for the person under the Program — in particular co-ordinating treatment services under the *Comprehensive Care Plan*; and

(b) liaising, in relation to the *Comprehensive Care Plan*, with the *general practitioner* who manages the *Comprehensive Care Plan* for the person.

"community nursing provider" means a community nursing provider who has entered into an agreement with the *Commission* to provide *community nursing services* to *entitled persons*.

"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*.

"compensable patient" means a person who has established, or is likely to establish, an entitlement to damages or compensation from, or has commenced an action for damages against, another party that is not a registered health insurance organisation or a friendly society, for treatment of an injury, disease or other medical condition.

"**Comprehensive Care Plan**" means the care plan prepared by a *general practitioner*, in accordance with the *Notes for Coordinated Veterans' Care Program Providers*, for an *entitled person* participating in the *Coordinated Veterans' Care Program*.

Note: Fees for the preparation of a "Comprehensive Care Plan" are set out in the Schedule 8, Co-ordinated Veterans' Care (CVC) Program of the Department of Veterans' Affairs Fee Schedules for Medical Services (see: paragraph 3.5.1).

"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* 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*;
(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 eligible persons.

"convalescent care" means a period of medically prescribed convalescence for an *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* holders and eligible *White Card* holders of the veteran and defence force community and improve their social well-being. In particular the program has the following main features:

- assessment – a *general practitioner* (GP) 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 to participation in the program and the GP needs to record that consent. As treatment is being provided it is the GP'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 GP will prepare a *Comprehensive Care Plan* for a person the GP 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 GP's practice nurse (or a community nurse via a DVA-contracted community nursing

provider, or an Aboriginal and/or Torres Strait Islander Primary Health Care worker, if more appropriate) will implement the care plan and, in particular, co-ordinate services under the plan.

"Coordinated Veterans' Care Program treatment" means:

(a) *GP Care Leadership treatment*; or
(b) *Practice Nurse Care Co-ordination treatment*; or
(c) *Community Nurse Care Co-ordination treatment*; or
(d**)** *Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment*.

"co payment", in relation to the *Veterans' 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 Commission to be a country area under paragraph 80(2)(b) of the Act.

"daily care fee" means:

(a) in relation to an *entitled person* in 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

(b) in relation to an *entitled person* (including a former *prisoner of war* or a person awarded the Victoria Cross) who is receiving, or received, *residential care* — the maximum daily amount of resident fees worked out under section 52C-3 of the *Aged Care Act 1997*.

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

"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:

(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.

"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 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*.

"determined condition" means any injury, disease, condition, or symptom of a condition (whether the condition is identifiable or not) that may be treated under and subject to these Principles, pursuant to, and subject to, a determination under section 88A or 88B of the Act.

"determined residential care condition" means a determined condition in respect of which Commission-funded treatment is available solely by reason of section 6 of the *Veterans' Affairs (Extended Eligibility for Treatment) Instrument 2015* made under section 88A of the Act.

Note: Section 6 of the *Veterans' Affairs (Extended Eligibility for Treatment) Instrument 2015* extends Commission-funded residential care to a non-war caused etc condition of veterans with a White Card ("the determined condition"). Unless that determined condition attracts other Commission-funded treatment pursuant to another determination under section 88A of the Act, it may receive Commission-funded residential care only and not Commission-funded medical treatment or dental treatment etc.

"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 *Veterans' 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.

"DRCA" means the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

"**DRCA disability"** means an injury (within the meaning of the *Safety, Rehabilitation and Compensation (Defence-related Claims) 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 V of the *Act*.

Note 1: In the *Safety, Rehabilitation and Compensation (Defence-related Claims) 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 (Defence-related Claims) Act 1988*.

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

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

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

"eligible person" has the same meaning that it has in subsection 90(8) 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.

"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: emergency short term home relief is not relevant to the calculation of the *daily care fee* for *residential care* or *residential care (respite).*

"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.

"entitled person" means a person who is:

(a) an entitled veteran; or

(b) an entitled widow; or

(c) an entitled widower; or

(d) a child eligible for treatment under section 86 of the Act, but not a child who is eligible only under sub-section 86(5) of the Act; or

(e) subject to the terms of any determination under section 88A of the *Act*, a former child of a *veteran* who is eligible for treatment in accordance with a determination under section 88A of the *Act*; or

Note (1): "child" under the *Act* has a different meaning to its normal meaning and means a person who has not turned 16 or, in the case of a child receiving full-time education, has not turned 25. Accordingly a child of a veteran ceases to be a child of the veteran upon turning 16 or 25, as the case may be. The child is, therefore, a former child of the veteran.

Note (2): this paragraph is relevant to the provision of *limited VHC-type services* to former children of veterans receiving the Veterans' Home Care services of *Domestic Assistance* and *Home and Garden Maintenance*. See also Determination 7/2001.

(f) subject to the terms of any determination under section 88A of the *Act*, a dependant of a *veteran* who is the partner of the *veteran* or

Note: this paragraph is relevant to the provision of *limited VHC-type services* to partners of *entitled veterans* receiving the Veterans' Home Care services of *Domestic Assistance* and *Home and Garden Maintenance.* See also Determination 7/2001.

(g) a person with a *DRCA disability*.

"entitled veteran" means:

(a) a person who is eligible for treatment under section 85 of the Act, but not a person who is eligible only under subsection 85(9) of the Act; or

(b) subject to the terms of any determination under section 88A or 88B of the Act, a *veteran* who is eligible for treatment in accordance with a determination under section 88A or 88B of the Act.

Note 1: subsection 85(9) concerns Vietnam veterans requiring urgent treatment for any disease or injury, whether war-caused or not. See also principle 2.5.

Note 2: section 88A of the Act enables the Commission to determine a class of veterans to be eligible for specified treatment.

Note 3: section 88B of the Act enables the Commission to determine a class of persons to be eligible for treatment, being treatment that is the provision of services under the program established by the Commonwealth and known as the Veteran Suicide Prevention pilot.

(c) a person with a *SRCA disability*.

"entitled widow" or **"entitled widower"** means a person who is eligible for treatment under subsection 86(1) or 86(2) of the Act or, subject to the terms of any determination under section 88A of the ***Act***, a person who is a widow or widower who is eligible for treatment in accordance with a determination under section 88A of the ***Act***.

Note: section 88A of the *Act* enables the Commission to determine a class of veterans, or current or former dependants of veterans, to be eligible for specified treatment.

"**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

(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) a *HACC Review Agreement (National Partnership) service*; or
(b) a *Commonwealth Home Support Programme service*;

that is the same type of service that may be provided under the *Veterans' Home Care Program* as a *Home Care service (category A)* or *Home Care service (category C).*

Note : 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 child; or

Note: dependent child is defined in the ***Act*** as having the same meaning as in the Social Security Act. Note also that under the *Acts Interpretation Act 1901* the singular includes the plural meaning a person can have more than one dependent child.

(b) is a person to whom section 52Y of the *Act* applies**;** or

Note: the application of section 52Y to a person means the person avoids severe financial hardship.

(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; or

(d) in the opinion of the *Commission*, could suffer severe hardship if the person was to make a payment in respect of the service.

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 *Commission* or a member thereof, 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 practitioner" has the same meaning as "general practitioner" has in the *Health Insurance Act 1973*.

"Gold Card" means the identification card (also known as the Veteran Card) provided by the *Department* to a person who is eligible under the *Act* for treatment, subject to these *Principles*, for all injuries or diseases.

"GP Care Leadership treatment" means treatment provided by a *general practitioner* to an *entitled person*, under the *Coordinated Veterans' Care Program*, comprised of the following:

(a) preparing and managing the *Comprehensive Care Plan* for the person under the Program;

(b) overseeing a *practice nurse* in the implementation of the *Comprehensive Care Plan* — where a *practice nurse* and not a *community nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care worker* or the *general practitioner* co-ordinates treatment under the *Comprehensive Care Plan (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 and/or Torres Strait Islander Primary Health Care*

worker for *Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment*, if appropriate;

(d) performing such other functions under the program that the *general practitioner* has under the *Notes for Coordinated Veterans' Care Program Providers*.

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

(a) is in the form, if any, approved by the *Commission*; and

(b) is sent to the *VHC assessment agency*, including as a facsimile message.

"HACC Review Agreement (National Partnership) service" means a service of home or community care that could be, or could have been, provided to a person under an agreement between the Commonwealth and a State or the Northern Territory — being an agreement made under the *Home and Community Care Act 1985* but deemed to be a National Partnership Agreement in the context of the Intergovernmental Agreement on Federal Financial Relations of 2008, made under the *Federal Financial Relations Act 2009*.

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

"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 provided to a person under the auspices of the *Home and Community Care Act 1985* when that Act was in force.

Note: in 2015 there was a proposal to repeal the *Home and Community Care Act 1985* by the *Omnibus Repeal Day (Spring 2014) Act 2014*.

"**Home and Garden Maintenance**" means the service, under the *Veterans' 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 Veterans' 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 *Veterans' Home Care Program*.

"**Home Care service (category B)"** means:

(a) for an *entitled person* in Victoria or Western Australia at a time when the *Commonwealth Home Support Programme service* in Victoria or Western Australia, as the case may be, does not include a service that would satisfy the description of a *HACC Review Agreement (National Partnership) service* — the provision of treatment to the person pursuant to the *Veterans' Home Care Program* that would satisfy the description of:

(i) a *HACC Review Agreement (National Partnership) service* ;or
(ii) a *Commonwealth Home Support Programme service* other than such a service that would satisfy the description of a *HACC Review Agreement (National Partnership) service*; or
(ii) both services in (i) and (ii);

but does not mean the provision of treatment pursuant to the *Veterans' Home Care Program* that would satisfy the description of an *excluded service*; or

(b) for an *entitled person* in a State or Territory at a time when the *Commonwealth Home Support Programme service* in the State or Territory in which the person is in includes a service that would satisfy the description of a *HACC Review Agreement (National Partnership) service* — the provision of treatment to the person pursuant to the *Veterans' Home Care Program* that would satisfy the description of a *Commonwealth Home Support Programme service* but does not mean the provision of treatment pursuant to the *Veterans' Home Care Program* that would satisfy the description of an *excluded service*.

Note 1: as at 1 July 2015 some services under the *Commonwealth Home Support Programme* (CHSP) (generally speaking CHSP services are a Home Care service (category B)) were not provided in Victoria or Western Australia. The services in question are known as "HACC services". HACC services are home or community care services that were originally provided under agreements under the *Home and Community Care Act 1985* (the HACC Act) except in Victoria and Western Australia where similar services were provided under Bilateral Agreements with the Commonwealth Government. At or about 2008/2009 HACC services in States/Territories (except Victoria/Western Australia) were provided under agreements known as "National Partnership Agreements". The National Partnership Agreements were made under the auspices of the Intergovernmental Agreement on Federal Financial Relations of 2008 and the *Federal Financial Relations Act 2009*. In short, the original agreements under the HACC Act were deemed to be National Partnership Agreements and the HACC Act was rendered obsolete. On 1 July 2015, in all States/Territories except Victoria/Western Australia, HACC services ceased being provided under National Partnership Agreements and were provided under CHSP. However as at 1 July 2015 HACC-type services in Victoria/Western Australia continued to be provided under the Bilateral Agreements between those States and the Commonwealth.

Note 2: the intention of paragraph (a) of this definition is to enable the Department of Veterans' Affairs (DVA) to pay for HACC services for an entitled person in Victoria and Western Australia in addition to paying for services for the person under the Commonwealth Home Support Programme service until the Commonwealth Home Support Programme applies fully in those States and includes the HACC services. The intention in paragraph (b) of this definition is that where the Commonwealth Home Support Programme operates fully in Australia i.e. includes HACC services, DVA will only pay, under this definition, for services under the Commonwealth Home Support Programme. There is to be no potential for double-dipping.

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

(a) pursuant to a *GP Home Care service (category C) Referral* and allocated to the provider by a *VHC assessment agency*; and
(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*.

"Human Services Department" means a Department, or Executive Agency, administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

"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 *Act*.

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-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 the *daily care fee* for *residential care* or *residential care (respite).*

"inpatient" means a person formally admitted for treatment by a hospital.

"institution", in Part 11:

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

Note: retirement village is defined in section 5M of the *Act* and the intention is that the power of the *Commission* in subsection 5M(4) to determine premises have the same function as a retirement village, for the purposes of the Act, applies for the purposes of the Part 11 of the *Principles*.

"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.

"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*.

"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*.

"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.

"MRCA" means the *Military Rehabilitation and Compensation Act 2004*.

"MRCC" means the Military Rehabilitation and Compensation Commission established under the *MRCA*.

"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

"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-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 *Human ServicesDepartment*, has appropriate qualifications in clinical neuropsychology and practises as a neuropsychologist.

"Notes for Allied Health Providers" means the document approved by the Secretary to the *Department* entitled "Notes for Allied Health Providers", and referred to 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* or a member thereof, or by the Secretary to the *Department*, entitled "Notes for Coordinated Veterans' Care Program", and referred to in Schedule 1, that sets out the terms on which:

(a) a *general practitioner*;
(b) a *practice nurse*;
(c) a *community nurse (*via a *DVA-contracted community nursing provider)*; and
(d) an *Aboriginal and/or Torres Strait Islander Primary Health Care 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 General Practitioners" means the document that:

(a) is approved by the *Commission* or a member thereof, or by the Secretary to the *Department*, entitled "Notes for General Practitioners"; and

(b) is referred to in Schedule 1; and

(c) sets out the terms on which, and the conditions subject to which, a *general practitioner* 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 *general practitioner* and the *Commission* or the *Department*.

"Notes for Providers" means a *DVA document* approved by the Secretary to the *Department*, or by the *Commission* or a member thereof, with the word 'Notes' in its title, and referred to 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.

"**nursing-home-type care**" means the treatment described in paragraph 9.3 of the *Principles*.

"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 *Human ServicesDepartment*, 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.

"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:

(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*.

"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 *Veterans' Entitlements Act 1986*.

"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 a person eligible for the treatment under the *Principles*.

"outreach program counsellor" means:

(a) a *psychologist* who is registered as a psychologist with the Psychology Board of Australia; or

(b) a *social worker (mental health)* who is accredited as a Mental Health Social Worker with the Australian Association of Social Workers:

being a person approved by the *Department* or the *Commission* to provide *outreach program counselling* under Part 7.7A.

"**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) a *general practitioner*; or
(b) a *practice nurse*; or
(c) an *Aboriginal and/or Torres Strait Islander Primary Health Care 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 *general practitioner*, practice nurse, community nurse or *Aboriginal and/or Torres Strait Islander Primary Health Care worker*, provided that any *subsequent period of care* by the same *general practitioner* is approved by the *general practitioner* for the person.

"Personal Care" means the service under the *Veterans' 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.

"practice nurse" means a *registered nurse* or *enrolled nurse* employed or engaged by a *general practitioner* as a nurse in the practice of the *general practitioner*.

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

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

"Principles" means this instrument.

"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" includes a person who, as a civilian, was detained by the enemy during World War 2 - but being a civilian within the meaning of "eligible civilian" in the *Act*.

"private health insurer" has the meaning it has in the *Private Health Insurance Act 2007*.

"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 *Veterans' 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 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*;

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

(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.

"Quality of Care Principles 2014" means the legislative instrument of that name made under section 96-1 of the *Aged Care Act 1997*.

"RAP National Schedule of Equipment" means the document of that name approved by the *Commission* or a member thereof, or by the Secretary to the *Department*, and referred to 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.

"Rehabilitation Appliances Program (RAP) National Guidelines" means the document of that name approved by the *Commission* or a member thereof, or by the Secretary to the Department, and referred to 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*.

"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.

"Repatriation Pharmaceutical Benefits Card" means the identification card entitled 'Repatriation Pharmaceutical Benefits Card' which is provided to a person pursuant to a determination under section 93X of the *Act* and which entitles the person to pharmaceutical benefits in accordance with the *Repatriation Pharmaceutical Benefits Scheme*.

Note: Part VA of the Act extends pharmaceutical benefits to eligible Commonwealth veterans, eligible allied veterans and to eligible allied mariners.

"Repatriation Pharmaceutical Benefits Scheme" means Part I of the Scheme made under section 91 of the Act.

"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 facility" means a facility in which *residential care* is provided to a person.

"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 *Veterans' 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, .

"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 *Veterans' Home Care Program* consisting of *in-home respite, residential care (28 day respite)* or *emergency short term home relief*.

Note: by virtue of Determination 4/2001 made under section 88A of the ***Act, "Respite Care"*** may be applied in respect of all conditions of a white-card holder - not just for war-caused conditions.

"respite care in an institution" means care provided as *respite* to a person in an *institution*.

"revoked Treatment Principles" means the legislative instrument known as the *Treatment Principles* (2004 No. R8) made under section 90 of the *Act*.

"Rural Enhancement Scheme" means the scheme established by the *Commission* under subsection 84(1) of the *Act*, in consultation with the Australian Medical Association Ltd, and which has the following features:

(a) *general practitioners* 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 *general practitioners* 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.

(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.

"RPPPs" means the Repatriation Private Patient Principles determined by the Commission under section 90A of the Act.

"short-term restorative care" has the meaning it has in section 106A of the *Subsidy Principles 2014.*

"speech pathologist", for the purposes of the *Principles*, is a person who:

(a) has been trained to assess and treat people who have complex communication needs; and

(b) has a *provider number* (i.e. "registered" with the *Human ServicesDepartment*); and

(c) is not a disqualified *health care provider* in the terms mentioned in paragraph 7.1B of the *Principles*.

Note: under paragraph 7.1B a disqualified health care provider is a person whose services would not, under section 19B of the *Health Insurance Act 1973*, attract a *medicare benefit*.

"**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 *Human ServicesDepartment*, 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.

"**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.

"sub-contractor" means, in relation to the *Veterans' 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 a *general practitioner* to an *entitled person*, means a *period of care* that may be provided by the *general practitioner* after the expiry of a period of care that has already been provided by the *general practitioner* to the entitled person.

Note: a subsequent period of care must be approved by the *general practitioner* (see: 6A.3). A period of care by a *general practitioner* 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 *general practitioner* for the person i.e. where the person has changed *general practitioners*.

"Tier 1 Hospital" means a hospital in the category described as Tier 1 in 2.1 of the *RPPPs*.

"transition care" has the meaning it has in section 106 of the *Subsidy Principles 2014.*

"**Vertical Platform Lift"** means a lift installed adjacent to vertical walls, which travels up and down, with the platform finishing flat against the floor, and the user embarking/disembarking onto an even surface.

"veteran" has the same meaning as it has in sections 80 and 81 of the Act and includes a person with a *DRCA disability*.

Note: In sections 80 and 81 of the Act, "veteran" means a person:

(a) who is, because of section 7 of the Act, taken to have rendered eligible war service; or

(b) in respect of whom a pension is, or pensions are, payable under subsection 13(6) of the Act, other than a person who is a veteran under paragraph (a) by reason only that the person rendered service as a member of the Forces of a Commonwealth country of a kind described in paragraphs 6(1)(f) or (g) of the Act and was not domiciled in Australia or an external Territory immediately before the person's appointment or enlistment in those forces.

Section 81 of the Act provides that "veteran" is also to be read as a reference to a "member of the Forces" or a "member of a Peacekeeping Force" as defined in subsection 68(1) of the Act.

"Veterans' Access Payment" means the amount set out in the *DVA document* entitled "Department of Veterans' Affairs Fee Schedules for Medical Services" referred to in Schedule 1 and called the "Veterans' Access Payment" — being an additional amount payable by the *Department* to a *general practitioner* for a medical service provided by the *general practitioner* to an *entitled person* in accordance with these *Principles* and the *Notes for General Practitioners*.

Note: a Veterans' Access Payment is an amount additional to any amount otherwise payable by the *Department* to a *general practitioner* for a medical service provided by the *general practitioner* to an *entitled person* in accordance with these *Principles* and the *Notes for General Practitioners*.

"Veterans and Veterans Families Counselling Service" or **"VVCS"** means the service funded by the Department known as Open Arms – Veterans & Families Counselling.

"**Veterans' Home Care Program"** means:

(a) the treatment program under which the *Commission* ensures the provision of care and assistance services to *entitled 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 includes

section 7 of the *Veterans Affairs (Extended Eligibility for Treatment) Instrument 2015* and *Principles* made under section 90 of the *Act* and the arrangements in support thereof; and

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

"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): the *Subsidy Principles* 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.

"**VHC assessment agency**" means a person to whom the *Commission* has delegated its power to:

(a) assess whether a person is suitable for:

(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 *Veterans' Home Care Program*; and

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

"Victoria Cross" includes the Victoria Cross for Australia.

"Vietnam veteran" means a veteran who, while a member of the Defence Force, rendered continuous full-time service outside Australia in the area described in item 4 or 8 of Schedule 2 (in column 1) to the Act while that area was an operational area, whether or not the veteran rendered that service:

(a) as a member of a unit of the Defence Force that was allotted for duty; or

(b) as a person who was allotted for duty.

"VVCS OPC Provider Notes" means the document approved by the *Commission* or a member thereof, or by the Secretary to the *Department*, " Veterans and Veterans Families Counselling Services Outreach Program Counsellors Provider Notes", and referred to 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*.

"war-caused" is to be read as including "defence-caused" by force of section 81 of the *Act*; and in relation to a person with a *DRCA disability* means the person's injury (within the meaning of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*) was caused by, or arose out of, the person's employment in the Defence Force that is covered by the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*.

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

"week" means the period from Sunday to Saturday, inclusive.

"White Card" means the identification card (also known as the Veteran Card) provided by the *Department* to a person who is eligible under the *Act* for treatment, subject to these Principles and any determination under section 88A or 88B of the *Act*, for one or more of the following conditions:

(a) a *determined condition* (other than an unidentifiable condition);
(b) a *DRCA disability*;
(c) a mental health condition;
(d) malignant neoplasia;
(e) pulmonary tuberculosis;
(f) *war-caused* injury;
(g) *war-caused* 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 eligible under the *Act* for treatment, subject to these *Principles* and any determination under section 88A or 88B of the *Act*, of the following condition:

(h) unidentifiable condition.

Note 1: an "unidentifiable condition" is governed by the *Veterans' Affairs (Extended Eligibility for Treatment) Instrument 2015* (2015 No. R21), as in force from time to time.

Note 2: a "mental health condition" has the same meaning as in the *Veterans' Entitlements (Expanded Access to Non-Liability Health Care for Mental Health Treatment) Determination 2017* (Instrument 2017 No.R24), as in force from time to time, or in any subsequent legislative instrument, as in force from time to time, that repeals and replaces that determination.

1.4.2 In the *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.

PART 2 — ELIGIBILITY FOR TREATMENT

2.1 Treatment for eligible 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

(b) Vietnam veterans and their dependants, who are not otherwise eligible, and who are certified by a medical practitioner as requiring urgent hospital treatment for an injury or disease.

Note: See Principle 2.5 in relation to urgent treatment for Vietnam veterans and their dependants.

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 war-caused injuries or diseases only for:

(a) a veteran who is resident overseas; or

(b) a veteran 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 war-caused injury or disease while a veteran is temporarily absent from Australia unless, prior to departure, an office of the Department has been notified of the veteran’s intention to travel.

Financial Limits for Treatment Overseas

Treatment other than residential care/residential care (respite)

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:

(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 *veteran*, whether provided in an emergency or not — the lesser of:

(i) the amount charged the *veteran*; or
(ii) an amount equal to the amount of *residential care subsidy* that would be payable if the *veteran* was in Australia for the same period, plus any *daily care fee* that the *Commission* would have accepted responsibility for if the *veteran* was in Australia;

(b) in the case of *residential care (respite)* provided for a period to a *veteran*, whether provided in an emergency or not — the lesser of:

(i) the amount charged the veteran; or
(ii) an amount equal to the amount of *residential care subsidy* that would be payable if the *veteran* was in Australia for the same period (not exceeding 63 days in a financial year), plus any *daily care fee* that the *Commission* would have accepted responsibility for if the *veteran* was in Australia.

Note (1): the intention is that the *Commission* will not accept any further financial responsibility for *residential care (respite*) provided to a *veteran* in a financial year where in that year the *veteran* had already been provided *residential care (respite)* for 63 days.

Note (2): for the purpose of calculating the number of days for which a *veteran* was provided with *residential care (respite)* in a financial year, any day on which the *veteran* was provided *residential care (respite)* in Australia in that year is also to be taken into account.

Note (3): A "veteran" includes a former POW. In most, but not all cases, the *Commission* accepts liability for the *daily care fee* for former POWs receiving *residential care* or *residential care (respite)* but, in the case of *entitled persons* other than former POWs, who receive *residential care (respite)*, the *Commission* only accepts liability for the *daily care fee* for up to 28 days in a Financial year and in the case of *residential care* being provided to such persons, does not accept liability for any *daily care fee*.

Note (4): Subject to the *Principles*, the *Commission* will not accept financial responsibility for medical or allied-health treatment applied to the "non-war caused conditions" (i.e. non-accepted conditions) of the holder of a Gold Card or White Card residing or travelling overseas.

Note (5): 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 (6): the *daily care fee* is the amount worked out under s.52C-3 of the *Aged Care Act 1997*.

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.

2.2.6 Subject to these Principles, the Commission will accept financial responsibility for the treatment of an entitled widow who is resident overseas if her husband had been awarded the Victoria Cross.

2.2.7 Despite paragraph 2.2.1, the *Commission* will accept financial responsibility for the treatment of *entitled persons* for any injury or disease who were residing in Papua New Guinea at the date of independence (16 September 1975) and who have continued to reside there.

Note: Travelling to, or taking up, residence in Papua New Guinea after the date of independence is regarded as travelling to or residing in a foreign country.

No Overseas Veterans' Home Care

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

2.3 Treatment of associated non-war-caused 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

war-caused to the extent that it is a necessary part of treatment for a war-caused injury or disease.

2.4 Treatment of malignant neoplasia and pulmonary tuberculosis for veterans

2.4.1 The *Commission* will provide, or accept financial responsibility for, treatment of a *veteran* for malignant neoplasia or pulmonary tuberculosis (even if that injury or disease is not *war-caused*) on and from the date that is three months before the date on which an application to be provided with that treatment is received at an office of the *Department* in Australia.

2.4.2 The *Commission* will provide, or accept financial responsibility for, treatment of a veteran under paragraph 2.4.1 if the treating medical practitioner considers that a malignant neoplasm or pulmonary tuberculosis, as the case may be, is the actual or most likely diagnosis.

2.4.3 Continuing financial responsibility for treatment under paragraph 2.4.1 may be reviewed and may be withdrawn by the *Commission* if —

(a) the diagnosis is not confirmed to the satisfaction of the *Commission* within three months from the day on which an application to be provided with that treatment (referred to in subsection 85(2) of the Act) is received at an office of the Department in Australia; or

(b) the *Commission* is satisfied that the *veteran* does not suffer, or no longer suffers, any incapacity from a malignant neoplasm or pulmonary tuberculosis.

2.4.4 The *Commission* will provide or accept financial responsibility for the treatment of other conditions, symptoms, or sequelae resulting from the treatment of malignant neoplasia where it has provided treatment or accepted financial responsibility under paragraph 2.4.1.

2.5 Determination that specified person is eligible for specified kind of treatment

2.5.1 Subject to these *Principles*, the *Commission* will accept financial responsibility for treatment of a person eligible for that treatment pursuant to a determination under section 88A or 88B of the Act.

2.5A Treatment of mental health conditions for veterans and ADF members

2.5A.1 The *Commission* will provide, arrange, or accept financial responsibility for a person who is a *veteran or eligible ADF member* for the treatment of the person's *mental health condition* even if that condition is not a war-caused or service-related injury or disease.

2.5A.2 Continuing financial responsibility for treatment for a person under paragraph 2.5A.1 may be reviewed by the *Commission* at any time after 6 months from the date from which financial responsibility for the person's treatment is accepted and may be withdrawn by the *Commission* if —

(a) the person, following a request by the *Commission*, has failed to provide the *Commission* with a diagnosis from a psychiatrist, a *clinical psychologist* or *general practitioner* for the relevant *mental health condition*; or

(b) the *Commission* is otherwise satisfied that the person does not have, or no longer has, the relevant *mental health condition*.

2.5A.3 The *Commission* will provide, arrange, or accept financial responsibility for a *veteran or eligible ADF member* for the reasonable treatment of an injury or disease that is not war-caused or service-related to the extent that it is a necessary part of, and is directly associated with, the treatment of the person's *mental health condition* in respect of which financial responsibility was provided, arranged or accepted under paragraph 2.5A.1.

2.5A.4 In paragraph 2.5A:

"veteran or eligible ADF member" means a person who is within a class of persons specified in Part 2 of the *Veterans' Entitlements (Expanded Access to Non-Liability Health Care for Mental Health Treatment) Determination 2017* (Instrument 2017 No. R24), as in force from time to time; or in any subsequent legislative instrument, as in force from time to time, that repeals and replaces that determination; and

"**mental health condition**" has the same meaning as in the *Veterans' Entitlements (Expanded Access to Non-Liability Health Care for Mental Health Treatment) Determination 2017* (Instrument 2017 No. R24), as in

force from time to time, or in any subsequent legislative instrument, as in force from time to time, that repeals and replaces that determination.

Note: Other matters dealing with the treatment of mental health conditions on a non-liability basis for veterans and eligible ADF members are dealt with in the *Veterans' Entitlements (Expanded Access to Non-Liability Health Care for Mental Health Treatment) Determination 2017* (Instrument 2017 No. R24), as in force from time to time, or in any subsequent legislative instrument, as in force from time to time, that repeals and replaces that determination.

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 to other counselling services.

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—TRCP treatment (Training, Research, Communication-improvement, Policy Development for ADF-Veterans' etc Health Issues)

2.7A.1 The *Commission* may accept financial responsibility for *TRCP treatment* provided by a *TRCP provider*.

Note (1): under subsection 80(1) of the *Act* treatment is defined broadly and can include action taken with a view to maintaining a person in physical or mental health.

Note (2): *TRCP treatment* is defined in paragraph 1.4.1 and, generally speaking, is action taken by an education and research facility pursuant to an arrangement with the *Commission* to inquire into issues associated with the health of Defence Force members which could have a benefit for the health care of veterans and dependants of veterans, under the *Act*, and members and dependants of members or former members, under the MRCA.

Note (3): under s.88A(1)(d) of the *Veterans' Entitlements Act 1986* (VEA) a determination may be made granting eligibility for treatment under the VEA to "a person". A determination has been made granting eligibility for *TRCP treatment* under the VEA to a member or former member under MRCA and to a dependant of a member or former member.

Note (4): prior approval for *TRCP 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 veteran* who is eligible for such treatment by virtue of Determination no.R32/2007 made under section 88A of the *Act* and entitled *Veterans' Entitlements Treatment (Australian Centre for Posttraumatic Mental Health) Determination 2007.*

Note (1): under subsection 80(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 directly provided by the *Australian Centre for Posttraumatic Mental Health* but under its auspices.

Note (3): The *Treatment Principles* establish the treatment called *ACPMH treatment* and the Determination entitled *Veterans' Entitlements Treatment (Australian Centre for Posttraumatic Mental Health) Determination 2007* (R32/2007), made under s.88A of the *Act,* establishes eligibility for that treatment.

Note (4): Unlike most of the eligibility provisions in Part V of the *Act*, eligibility for treatment under a "s.88A determination" need not relate to an injury or disease but can relate to a person's condition generally.

Note (5): prior approval for *ACPMH treatment* is not required.

2.8 Loss of eligibility for treatment

2.8.1 Unless the Commission makes a determination under subsection 85(8) of the Act, it will not provide, arrange, or accept financial responsibility for treatment for a person, as an entitled person, on or from:

(a) the date of notification that the person is no longer eligible under section 85, 86, 88A or 88B of the Act; or

(b) the effective date of reduction or cancellation of the qualifying pension;

whichever is the later.

Note: Subsection 85(8) provides, in effect, that where a service pension is suspended, the Commission may determine that, for the purposes of treatment eligibility, the person is deemed to be continuing to receive that pension during the period, or part of the period, of suspension.

2.8.2 Where a person's pension is reduced or cancelled because the person supplied false or misleading information, and that reduction or cancellation

results in a reduction or loss of eligibility for treatment, treatment benefits will be reduced or will terminate from the date of reduction or cancellation of the pension.

PART 3 — COMMISSION APPROVAL FOR TREATMENT

3.1 Approval for treatment

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

Note: Paragraph 1.5.1 provides that any approval given for treatment under the *Treatment Principles* revoked upon the commencement of these *Treatment Principles* is deemed to have been given for the purposes of, and under, these Principles.

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 *RPPPs*.

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) *convalescent care* in an *institution* — except where the institution is a *private hospital* or *public hospital*;

Note: for *convalescent care* in an institution that is a hospital see paragraph 9.5.2

(ha) *respite care in an institution* — except where the *institution* is a *private hospital* or *public hospital*;

Note: for *respite care in an institution* where the institution is a hospital see paragraph 10.7A.

(j) in-home respite care;

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

Note: the intention is that 3 days (the max ESTHR per emergency) should be sufficient time or 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”, referred to in Schedule 1; or

(ii) available to the *entitled person* under the *DVA document* entitled “Pricing Schedule for Visual Aids”, referred to 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;

(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 a *general practitioner* 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 RPPPs 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*;

(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 *community nurse* in accordance with paragraph 7.3.3 after the services have been provided;

Note:see principle 7.3.

(fa) treatment under the *Veterans' 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;

(ka) *convalescent care* at a *private hospital* or *public hospital;*

(kb) *respite care in an institution* — where the institution is a *private hospital* or *public hospital*.

(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

(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 war-caused injury or disease without prior approval only if approval is sought as soon as possible after the event.

Note: this Principle does not to 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

(b) the amount that an eligible 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 eligible 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", referred to 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 of Dental Services for Dentists and Dental Specialists", referred to 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", referred to 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", referred to 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", referred to 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", referred to 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));

(g) an exercise physiologist — the amount worked out under the *DVA document* entitled "Exercise Physiologists Schedule of Fees", referred to 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 *general practitioner* — the amount worked out under the *DVA document* entitled "Department of Veterans' Affairs Fee Schedules for Medical Services" referred to 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 General Practitioners;
General Practitioners Fee Schedule;
Guide to the Assessment of Rates of Veterans' Pensions (GARP) Fee;
Kilometre Allowance;
Medication Review Fees;
Pathology Fee Schedule;
Ready Reckoner for General Practitioners;
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 General Practitioners* ;.

(i) a *medical specialist* — the amount worked out under the *DVA document* entitled "Department of Veterans' Affairs Fee Schedules for Medical Services", referred to 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 GPs;
Guide to the Assessment of Rates of Veterans' Pensions (GARP) Fee;
Kilometre Allowance;
Medication Review Fees;
Pathology Fee Schedule;
Ready Reckoner for GPs
Relative Value Guide Fee Schedule;

Repatriation Medical Fee Schedule;

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

(ia) a neuropsychologist — the amount worked out under the *DVA document* entitled "Neuropsychologists Schedule of Fees", referred to in Schedule 1, on condition that the treatment was provided in accordance with the *Principles* and *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", referred to 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", referred to 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", referred to in Schedule 1, on condition that the treatment was provided in accordance with the *Principles* , the *DVA document* entitled "Pricing Schedule for Visual Aids", referred to 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", referred to 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 optometrists));

(m) an orthoptist — the amount worked out under the *DVA document* entitled "Orthoptists Schedule of Fees", referred to 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));

(ma) an orthotist — the amount worked out under the *DVA document* entitled "Orthotists Schedule of Fees" referred to 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(n) (Orthotists));

(n) an osteopath — the amount worked out under the *DVA document* entitled "Osteopaths Schedule of Fees", referred to 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));

(oa) an *outreach program counsellor* — the amount worked out under the *DVA document* entitled "Veterans and Veterans Families Counselling Service (VVCS) Outreach Program Counsellor Schedule of Fees", referred to 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", referred to 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", referred to 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", referred to 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", referred to 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", referred to 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", referred to 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 Fees", referred to 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(l)(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 eligible 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 2 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.

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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 2 years referred to in subparagraph 3.5.2(c).

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 Subject to paragraph 3.5.3A, 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.

3.5.3A Paragraph 3.5.3(a) does not apply to treatment that is private accommodation provided to an *entitled person* as a private patient in a hospital where a *private health insurer* of the person agrees to pay the difference between the cost of shared accommodation for the person at the hospital and the cost of the private accommodation for the person — the *RPPPs* covers such treatment.

Note 1: “private patient” is defined in s.90A(8) of the *Act*.

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Note 2: this provision ensures paragraph 3.5.3(a) does not prohibit the *Commission* from accepting responsibility for part of the cost of private accommodation in a hospital where a *private health insurer* pays for the remainder of the cost.

The *Commission's* responsibility in this area is regulated by the *RPPPs* i.e. cost-sharing between the *Commission* and the *entitled person* or a *private health insurer* is worked out under the *RPPPs*.

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

PART 4 — MEDICAL PRACTITIONER SERVICES

4.1 General Practitioners

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 two levels.

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

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

Unlike *general practitioners*, medical specialists (as at 1 April 2006) are not prepared to submit to the same level of regulation as *general practitioners* 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 a *general practitioner* 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 *general practitioner*; or

(b) a medical specialist.

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 *general practitioner*; 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 where a *general practitioner* or specialist provides or arranges for treatment of:

(a) an entitled person who has been issued with a Gold Card;or

(b) a veteran who has been issued with a White Card for any war-caused or other specifically listed injury or disease or for a *determined condition*; or

(c) a person who has been issued with a written authorisation on behalf of the Commission;

but the Commission will not accept financial responsibility for treatment costs where a *general practitioner* or specialist provides or arranges for treatment of a "*determined residential care condition*".

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 *general practitioner* 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 *general practitioner* 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 *general practitioner* 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 *general practitioner* or *medical specialist* had provided the service as a *practitioner* under that Act.

4.4 Referrals

4.4.1 A *general practitioner* 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 *general practitioner* 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 *general practitioner*;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 *general practitioner*.

4.7 Referrals: prior approval

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

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 *general practitioner* 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.

Note: Prior approval is not required in States or Territories where the RPPPs apply — see paragraph 1.2.2.

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 *general practitioner'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

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

(k) vaccination for an *entitled person* who proposes to travel outside Australia, unless:

(i) the person is the holder of a *Gold Card*; and

(ii) the person is in Australia at the time the vaccination is provided; and

(iii) the vaccination is provided to the person under the *Repatriation Pharmaceutical Benefits Scheme*.

Note 1: a vaccination is not treatment of an injury or disease. It is preventive treatment. Normally an *entitled person* under the *Act* is only eligible for treatment of an injury or disease. Eligibility for preventive treatment such as a vaccination is granted by a determination under s.88A of the Act – in this case the *Veterans' Entitlements (Vaccinations for Overseas Travel) Eligibility Determination 2010*.

Note 2: an approved medical practitioner is also a Community Pharmacist under the *Repatriation Pharmaceutical Benefits Scheme.*

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.

Note: paragraph 5.4.1 deals with emergency dental 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", referred to in Schedule 1, and comprised of Dental Schedules A, B and C, lists the dental services provided by *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", referred to 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) a war-caused injury or disease or a *determined condition* except a *determined residential care condition* of an entitled person receiving residential care; or

(b) a condition associated with malignant neoplasia; or

(c) a former prisoner of war.

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 eligible.

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.

5.3 Eligibility

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* and who is not a former *prisoner of war* will be provided with the following dental services:

(a) for treatment of an injury or disease that is not *war-caused*:

(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", referred to 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", referred to in Schedule 1 — on condition the services are provided in accordance with that Schedule.

(b) for treatment of a *war-caused* injury or *war-caused* disease or malignant neoplasia:

(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", referred to 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", referred to in Schedule 1 — on condition the services are provided in accordance with that Schedule.

5.3.3 A person who holds a *Gold Card* and who is a former *prisoner of war* will be provided with the following dental services:

(a) 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", referred to in Schedule 1 — on condition the services are provided in accordance with those Schedules (but without the annual monetary limit in the Schedule C);

(b) the dental services listed in the *DVA document* entitled "Fee Schedule of Dental Services for Dental Prosthetists", referred to in Schedule 1 — on condition the services are provided in accordance with that Schedule.

5.3.4 A person who holds a *White Card* is entitled to dental treatment of a *war-caused* injury or *war-caused* disease, a *determined condition* except a *determined residential care condition* of an *entitled person* receiving *residential care*, or of a dental condition associated with malignant neoplasia and will be provided with:

(a) the dental services listed in the *DVA document* entitled "Fee Schedule of Dental Services for Dentists and Dental Specialists", referred to 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", referred to 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", referred to in Schedule 1;
(c) the "Fee Schedule of Dental Services for Dental Prosthetists", referred to 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 *war-caused injury* or disease or of a condition associated with malignant neoplasia for which the person is receiving treatment under principle 2.4, or of a *determined condition* except a *determined residential care condition* of an entitled person receiving *residential care*.

5.5 Orthodontic treatment for children

5.5.1 Orthodontic treatment will continue to be provided for an entitled child of a deceased veteran if the child has ceased to be 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 child is still eligible; and

(b) the treatment is commenced while the child 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 *war-caused* injury or disease or other specifically listed condition or for a *determined condition* except a *determined residential care condition* of an entitled person receiving *residential care*, for *entitled persons* who hold a *White Card*; or

(b) for entitled persons who hold 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 war-caused injury or disease or other specifically listed condition or for a *determined condition* except a *determined residential care condition* of an entitled person receiving residential care, for persons who hold a *White Card*; or

(b) for persons who hold 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.

PART 6 — PHARMACEUTICAL BENEFITS

6.1 Repatriation Pharmaceutical Benefits Scheme

6.1.1 The Repatriation Pharmaceutical Benefits Scheme (Part I of the Scheme prepared under section 91 of the Act) relates to the supply of Pharmaceutical Benefits to entitled persons by community pharmacists as defined in that Scheme.

6.2 Eligibility under the Repatriation Pharmaceutical Benefits Scheme

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

(a) a “White Card" " for a war-caused injury or disease, or other specifically listed conditions or for a *determined condition* except a *determined residential care condition* of an entitled person receiving residential care; or

(b) a *Gold Card*; or

(c) a *Repatriation Pharmaceutical Benefits Card*.

PART 6A — COORDINATED VETERANS' CARE PROGRAM

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 health condition (set out in Principle 6A.5); and
- White Card holders with an accepted mental health condition with complex care needs due to the diagnosis of that mental health condition as a chronic health condition (set out in Principle 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 *general practitioner* and the *general practitioner’s practice nurse* (or a community nurse via a DVA-contracted community nursing provider) or an *Aboriginal and/or Torres Strait Islander Primary Health Care worker*, if more appropriate).

Essentially the *general practitioner* will prepare a comprehensive care plan for the entitled person and the *general practitioner’s practice nurse* (or a community nurse or *Aboriginal and/or Torres Strait Islander Primary Health Care worker*) will co-ordinate health care services under the plan. The *general practitioner* will provide oversight throughout. In cases where a *general practitioner* is unable to obtain the services of a nurse or *Aboriginal and/or Torres Strait Islander Primary Health Care worker* as a care co-ordinator, the *general practitioner* 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 *general practitioner* 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 *general practitioner* to a VHC assessment agency (an agency under the Veterans' Home Care Program) for an assessment as to the suitability of the person for a social support service under that Program.

Accordingly, two main treatments are provided under the program:

- GP Care Leadership treatment
- practice nurse/community nurse/ *Aboriginal and/or Torres Strait Islander Primary Health Care worker*/care co-ordination treatment

An ancillary treatment under the program is:

- GP 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 and are in addition to existing treatments available to the entitled person under the Medicare Benefits Schedule and the Treatment Principles.

The ancillary treatment may be provided by an approved provider of Veterans' Home Care services following a request for social support services from a VHC assessment agency. The *general practitioner* 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 VHC assessment agency will assess the person's suitability for a social support service.

6A.1A In this Part:

accepted mental health condition means that the *entitled person* has a mental health condition for which the person is entitled to be provided with treatment under Part V of the *Act* on the basis that the condition is due to a *war-caused* injury or *war-caused* disease.

Note: The paragraph 1.4.1 definition of "war-caused" includes a person with a *DRCA disability*.

Note 2: A *veteran or eligible ADF member* who receives treatment for a mental health condition as a member of a class of persons specified in Part 2 of the *Veterans' Entitlements (Expanded Access to Non-Liability Health Care for Mental Health Treatment) Determination 2017* (Instrument 2017 No. R24), as in force from time to time; will not be eligible for the Coordinated Veterans' Care Program.

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

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

6A.2.2 A *general practitioner* may, under the *Coordinated Veterans' Care Program*, provide:
(a) *GP Care Leadership treatment*; or
(b) a *GP Home Care service (category C) Referral*; or
(c) both (a) and (b);
for an *entitled person.*

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 and/or Torres Strait Islander Health Worker Care Co-ordination treatment

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

6A.3 GP Approval of Subsequent Period of Care

6A.3.1 Before any *subsequent period of care* of an *entitled person* by a *general practitioner* commences, being a *general practitioner* who is treating the person under the *Coordinated Veterans' Care Program*

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

Note 2: the period of care by a *general practitioner* 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 *general practitioner* is to:

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

(b) ascertain if the person is eligible for a subsequent period of care by the *general practitioner*.

Note: see 6A.6.2

6A.3.3. If the *general practitioner* 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 *general practitioner*, the *general practitioner* is to:

(a) approve a subsequent period of care by the *general practitioner* 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 *general practitioner* to the entitled person.

6A.3.4. Where a *general practitioner* approves a *subsequent period of care* by the *general practitioner* for an entitled person, before the expiry of a current period of care by the *general practitioner* 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 a *general practitioner* approves a *subsequent period of care* by the *general practitioner* for an entitled person (approval), after the expiry of a current period of care by the *general practitioner* for the person, the subsequent period of care commences on the date of the approval.

6A.3.6. If the *general practitioner* decides not to approve a *subsequent period of care* by the *general practitioner* 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 *general practitioner*, the *general practitioner* 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 *general practitioner*, of the decision;

(b) if the entitled person was receiving a *Home Care service (category C)* immediately before the potential subsequent period of care by the *general practitioner*, notify (including by telephone) the *VHC assessment agency* for the person, of the decision;

(c) notify the entitled person, in a manner the *general practitioner* 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) *GP Care Leadership treatment*;
(b) *Practice Nurse Care Co-ordination treatment;*
(c) *Community Nurse Care Co-ordination treatment*;
(d**)** *Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment*;

provided to an *entitled person,* during a *period of care* of the person by the *general practitioner*, the *practice nurse*, the *community nurse* or the ,

Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment 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 *general practitioner* under the *Coordinated Veterans' Care Program* (Program).

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

(a) *GP Care Leadership treatment*, *Practice Nurse Care Co-ordination treatment* and *Aboriginal and/or Torres Strait Islander Health Worker Care Co-ordination treatment* — are set out in the *DVA document* entitled: "Department of Veterans' Affairs Fee Schedules for Medical Services", referred to in Schedule 1;

(b) *Community Nurse Care Co-ordination treatment* — are set out in the *DVA document* entitled: "*DVA Community Nursing Schedule of Fees"*, referred to in Schedule 1.

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 a *general practitioner*, *practice nurse*, *community nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care worker* under the *Coordinated Veterans' Care Program* (Program) if any previous period of care provided by, respectively, a *general practitioner*, *practice nurse*, *community nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care 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 a *general practitioner*, *practice nurse*, *community nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care 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 *general practitioner* 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 and/or Torres Strait Islander Health Worker Care Co-ordination treatment* will be made by the *Department* to the *general practitioner* who employed or engaged the *practice nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care worker*, as the case may be, at the time the treatment was provided.

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 *general practitioner* 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 *general practitioners* and participants in the Program; or

(b) deliver training modules and resources in Chronic Disease Management to *general practitioners*, *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 a *general practitioner* treating the person:

(a) in the opinion of a general practitioner treating the person the entitled person has a chronic health condition (including an *accepted mental health 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.

(2) the *entitled person* is eligible for treatment under the *Act*:

(a) as a *Gold Card* holder; or

(b) as a *White Card* holder with an *accepted mental health condition*; 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 general practitioner* has recorded the consent (which may be an electronic record); and

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

(5) the *general practitioner* treating the person has prepared, in consultation with the person, a *Comprehensive Care Plan*; and

(6) the *general practitioner* 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 GP 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 a *general practitioner* 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 *general*

practitioner, 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 Department of Health Transition Care Program.

6A.6.2 An entitled person is not eligible for a subsequent period of care by a *general practitioner* 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 a *general practitioner* 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 a *general practitioner* to the entitled person under the program.

Note: treatment under the program provided by a *practice nurse*, *community nurse* or *Aboriginal and/or Torres Strait Islander Primary Health Care worker* can only occur during a period of care provided by a *general practitioner* under the program.

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

6A.8.1 A *general practitioner* 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 *VHC 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: GP Home Care service (category C) Referral.

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

6A.8.2 The *general practitioner* may provide a *GP 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 *general practitioner*:

(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 A *general practitioner* may medically assess an *entitled person* the *general practitioner* is treating to determine if the person would benefit from participation in the *Coordinated Veterans' Care Program* (Program).

6A.9.2 If the *general practitioner* decides the *entitled person* would benefit from participation in the program, and the person is entitled to participate in the program, then the *general practitioner* 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.

The *general practitioner* is to obtain the person's consent, if the person is to participate in the program, 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 *general practitioner* is to admit the person to the program. This takes the form of the *general practitioner* 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 *general practitioner* is to prepare, in consultation with the person, a *Comprehensive Care Plan* for the person.

6A.9.5 A *practice nurse* (nurse working for the *general practitioner*) or, if appropriate, a *community nurse* (nurse working for a *DVA-contracted community nursing provider*) or an *Aboriginal and/or Torres Strait Islander Primary Health Care worker* (working for the *general practitioner*) will co-ordinate care services under the *Comprehensive Care Plan* (care co-ordinator). The *general practitioner* may need to refer co-ordination of the *Comprehensive Care Plan* to a *DVA-contracted community nursing provider* if, for example, the *general practitioner* does not employ a *practice nurse*. In some cases the *general practitioner* 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 *general practitioner* is to provide oversight of the care co-ordination under the *Comprehensive Care Plan*.

6A.9.6 Part of the monitoring mechanism for the program involves the *general practitioner* assessing the progress an entitled person is making (progress assessment). This is to occur toward the end of a period of care by the *general practitioner* and before the *general practitioner* 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 *general practitioner* 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 *general practitioner* may refer the person to a *VHC assessment agency* for

an assessment as to the person's suitability for the service. The referral is called: GP Home Care service (category C) Referral

6A.9.8 The *VHC assessment agency* is to assess a person pursuant to a *GP 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 *Veterans' 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* a *general practitioner*, a *practice nurse*, a *DVA-contracted community nursing provider* (for a *community nurse*), and an *Aboriginal and/or Torres Strait Islander Primary Health Care 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.

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 *Veterans' 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 *Veterans' 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;

(c) chiropractic services;

(d) community nursing;

(dd) exercise physiology;

(e) occupational therapy;

(f) optometry;

(g) orthoptics;

(ga) orthotic services;

(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 a service listed in paragraph 7.1.2 for an *entitled person* receiving *residential care* if the *Commission* is satisfied that it is more appropriate that the service is provided by the owner or operator of the *residential care facility* because, due to assistance (financial or otherwise) received by the owner or operator of the *residential care facility* under Commonwealth, State or Territory legislation, it is fair for the owner or operator of the *residential care facility* to bear the cost of supplying the service.

Note: For example, if the *Commission* is taken to have accepted financial responsibility for amounts in respect of the *entitled person*'s *residential care* under Part 10 on the basis that those amounts are intended to cover services listed in paragraph 7.1.2, the *Commission* will not also accept financial responsibility for those services under paragraph 7.1.2.

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 *Veterans' Home Care Program*.

7.1A Notes for Providers

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 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 *outreach program counsellors*)	"	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
10A	Orthotists	"	Section 2(n) - Orthotists
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 *outreach program counsellors*)	"	Section 2(a) – Allied Mental Health Care Providers
15	Social Workers (General) (except where providing service as *outreach program counsellors*)	"	Section 2(a) – Allied Mental Health Care Providers
16	Social Workers (Mental Health) (except where providing service as *outreach program counsellors*)	"	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**	

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 provider*s is dealt with in the arrangements between the *Commission* and *DVA-contracted community nursing provider*s.

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 provider*s is dealt with in the arrangements between the *Commission* and *DVA-contracted community nursing providers*.

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*s is dealt with in the arrangements between the *Commission* and *DVA-contracted community nursing providers*.

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 *community nursing provider* by a *general practitioner*, a treating doctor in a hospital, a hospital discharge planner, an *authorised nurse practitioner*, or a *VHC assessment agency*; and

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

(b) a *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 *community nursing provider* shall be provided to the *Department* upon request by the *Department* to the *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 *community nursing provider* is to be made only to a *community nursing provider* that has entered into, and is bound by, an agreement 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 *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 *community nursing provider*.

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.

7.3AA Sustainability payments—community nursing

7.3AA.1 This subpart deals with a quarterly payment made to a *community nursing provider* (a ***sustainability payment***):

(a) for the costs incurred by the provider in delivering care coordination and management necessary for the provision of a *community nursing service* in a quarter taking place between 1 April 2024 and 31 March 2026 (the ***service period***); and

(b) that is to be paid:

(i) as soon as is reasonably practicable after the end of the quarter, within the service period, for the costs incurred in the quarter; and

(ii) between 1 July 2024 and 30 June 2026.

7.3AA.2 The *Commission* will, on its own initiative, pay a sustainability payment to a *community nursing provider*, for a quarter within the service period, if:

(a) the provider delivered a *community nursing service* to an *entitled person* in accordance with this Part at any time during the quarter; and

(b) the service was delivered under an agreement with the *Commission* that was in force at the time the eligibility for the payment is determined.

7.3AA.3 A sustainability payment for a quarter within the service period that is payable to a *community nursing provider* under paragraph 7.3AA.2 is worked out using the following steps:

(a) work out the number of *entitled people* who received a *community nursing service*:

(i) from the provider in each calendar month during the quarter; and

(ii) for which the *Commission* has accepted financial responsibility;

(b) multiply the number worked out under paragraph (a) by the amount determined, in writing, by the *Commission* for this paragraph.

7.3AA.4 To remove any doubt, for the purposes of paragraph 7.3AA.3(a), an *entitled person* is counted once for a calendar month even if the person received a *community nursing service* from a particular provider on more than one occasions in the calendar month.

7.3A Veterans' 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 *GP 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.

7.3A.3 (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.

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.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 VHC 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 VHC 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.

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 a *general practitioner* 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 *VHC assessment agency* pursuant to a *GP 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 *VHC assessment agency*; and

Note: it will be the VHC 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.

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 *Veterans' Home Care Program*, but for it being a proscribed amount, exceeds that charge; and

(b) a *Home Care service (category A)* or *Home Care service (category C)* is provided to the *entitled person* by an *approved provider* or a *sub-contractor;*

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:

(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.

Transitional

7.3A.14 For the purposes of paragraph 7.3A.15:

"former service", in relation to an *entitled person*, means any *Home and Community Care Program service* the person was receiving immediately before 1 January 2001 or after 1 January 2001 and immediately before the person seeks services under the *Veterans' Home Care Program*.

7.3A.15 (1) An *entitled person* who was receiving a former service is entitled to receive whichever of *Home Care service (category A)* services or of *Home Care service (category B)* services is the most similar to that former service if the *Commission* assesses the person as needing one of those services.

(2) Upon the *Commission* deciding a person in paragraph (1) is entitled to a *Home Care service (category A)* or a *Home Care service (category B)*, then the entitlement of that person to the service is subject to the *Principles*.

7.3A.16 Where a decision is made under paragraph 7.3A.15 (1), including a decision not to provide a service, the *Commission* shall make a record of the decision and give notice of the decision to the *entitled person*.

Note: a decision may be recorded in electronic form and notice of the decision may be given in electronic form.

7.3A.17 Upon the *Commission* making a decision under paragraph 7.3A.15 (1), the *entitled person's* entitlement, if any, to a *Home Care service (category A)*, or to a *Home Care service (category B)*, has effect subject to that decision.

Limited VHC-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 VHC-type service*.
widow(er) means a widow or a widower.

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

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

(a) an *entitled widow(er)* of a deceased *entitled veteran* in circumstances where the deceased *entitled veteran* was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; or

Note: Eligibility for a limited VHC-type service (treatment) is conferred on dependants by express provisions in Part V of the *Act* or by Determination 7/2001 made under paragraph 88A(1)(b) of the *Act*.

(b) an *entitled person* who is a child of a deceased *entitled veteran* in circumstances where the deceased *entitled veteran* or the deceased *entitled widow(er)* of the deceased *entitled veteran*, was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; or

Note: "child" under the *Act* has a different meaning to its normal meaning and means a person who has not turned 16 unless the person is undertaking full time education in which case the person is a child until turning 25.

(c) an *entitled person* who is a former child of a deceased *entitled veteran* in circumstances where the deceased *entitled veteran* or the deceased *entitled widow(er)* of the deceased *entitled veteran*, was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both and the former child is a person with a serious disability; or

Note: "child" under the *Act* has a different meaning to its normal meaning and means a person who has not turned 16 unless the person is undertaking full time education in which case the person is a child until turning 25. Accordingly a child of a veteran ceases to be a child of the veteran upon turning 16 or 25, as the case may be. The child is then a former child of the veteran.

(d) an *entitled person* who is a former child of a deceased *entitled veteran* in circumstances where the deceased *entitled veteran* or the deceased *entitled widow(er)* of the deceased *entitled veteran*, was, at or about the time of death, being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both and the former child was a full-time *carer* of the deceased *entitled veteran* or *entitled widow(er)* immediately prior to the death of the *entitled veteran* or the *entitled widow(er)*, as the case may be; or

Note: "child" under the *Act* has a different meaning to its normal meaning and means a person who has not turned 16 unless the person is undertaking full time education in which case the person is a

child until turning 25. Accordingly, a child of a veteran ceases to be a child of the veteran upon turning 16 or 25, as the case may be. The child is then a former child of the veteran.

(e) an *entitled person* who is the partner of an *entitled veteran* ("veteran") and who resided with that veteran immediately before the veteran needed to leave the *home* in order to receive treatment and at or about the time of the veteran's departure, the veteran was being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both.

(f) either: (i) a child of an *entitled veteran*; or
(ii) a former child of an *entitled veteran*;

who resided with the *entitled veteran* or with the *entitled widow(er)* of a deceased *entitled veteran* immediately before the *entitled veteran* or *entitled widow(er)* needed to leave the *home* in order to receive treatment and at or about the time of the departure of the *entitled veteran* or *entitled widow(er)*:

(iii) the *entitled veteran* or *entitled widow(er)* was being provided with *Domestic Assistance* or *Home and Garden Maintenance* or both; and

(iv) in the case of a former child of an *entitled veteran* residing with the veteran or the *entitled widow(er)* of the veteran, the former child was a person with a serious disability or was the full-time carer of the *entitled veteran* or of the *entitled widow(er)* of the veteran;

7.3A.21 The conditions on which the *Commission* will accept financial responsibility for the provision of a *limited VHC-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 veteran* died ("commencement day"), unless, within the period of 12 weeks commencing on the commencement day, the person claims a pension under Part II 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 *Department* notifies the *Commission* of the outcome of 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 VHC-type service*.

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

Note (3): notification can be orally or in writing including in electronic form.

(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 veteran or entitled widow(er),* as the case may be, 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 veteran* or *entitled widow(er)* 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 veteran* or *entitled widow(er)* 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 veteran* or relevant *entitled widow(er)* at the time of the death of the relevant *entitled veteran* or relevant *entitled widow(er)* or at the time the relevant *entitled veteran* or relevant *entitled widow(er)* departed from the *home* for treatment, as the case may be.

(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:

(a) the full-time carer of the *entitled veteran* immediately prior to the death of the veteran; or

(b) must have been the full-time carer of the *entitled widow(er)* of the deceased *entitled veteran* immediately prior to the death of the *widow(er)*;

at or about the time the service is required.

Note: the intention is to ensure that a former child satisfies eligibility criteria for a sevice by reference to his or her current situation and not to a previous one. For example, a former child

may, in the past, have been a full-time carer of a deceased entitled veteran who received a service. The former child then resided with the widow(er) of the deceased veteran and the widow(er) received a service. The widow(er) then dies or leaves the home for treatment but the former child is only eligible for a service if the child was the full-time carer of the widow(er). If not, and the former child cannot satisfy any other grounds of eligibility, then the former child is not eligible for a service.

7.3A.22 For the purposes of paragraph 7.3A.21, a particular veteran or widow(er) is a "relevant entitled veteran" or "relevant entitled widow(er)" in relation to a particular eligible person, where the eligible person was residing with that veteran or that widow(er) at the time of the death of the veteran or widow(er) or at the time of the departure of the veteran or widow(er) 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 child who resided with an entitled widow before her death is only entitled to the domestic-type assistance that widow was receiving and is not entitled to the domestic-type assistance some other widow was receiving. Similarly, the former child is not entitled to Home and Garden-type maintenance if the widow had not been receiving Home and Garden Maintenance. The entitlement of the eligible person is to reflect the entitlement of the primary beneficiary (entitled veteran, including deceased entitled veteran, or entitled widow(er)).

Note (2): in the case of a child or former child, it is that person's relationship with a veteran, as distinct from a relationship with a veteran's widow or widower, that establishes the eligibility of the child or former child to treatment.

7.3B Sustainability payments—Veterans' Home Care Program

7.3B.1 This subpart deals with a quarterly payment made to an *approved provider* for the *Veterans' Home Care Program* (a ***sustainability payment***):

(a) for the costs incurred by the provider in delivering care coordination and management necessary for the provision of a service under the program in a quarter taking place between 1 April 2024 and 31 March 2026 (the ***service period***); and

(b) that is to be paid:

(i) as soon as is reasonably practicable after the end of the quarter, within the service period, for the costs incurred in the quarter; and

(ii) between 1 July 2024 and 30 June 2026.

7.3B.2 The *Commission* will, on its own initiative, pay a sustainability payment to an *approved provider*, for a quarter within the service period, if:

(a) the provider delivered a service under the program to an *entitled person* in accordance with this Part at any time during the quarter; and

(b) the service was delivered under an agreement with the *Commission* that was in force at the time the eligibility for the payment is determined.

7.3B.3 A sustainability payment for a quarter within the service period that is payable to an *approved provider* under paragraph 7.3B.2 is worked out using the following steps:

(a) work out the number of *entitled people* who received a service under the program:

(i) from the provider in each calendar month during the quarter; and

(ii) for which the *Commission* has accepted financial responsibility;

(b) multiply the number worked out under paragraph (a) by the amount determined, in writing, by the *Commission* for this paragraph.

7.3B.4 To remove any doubt, for the purposes of paragraph 7.3B.3(a), an *entitled person* is counted once for a calendar month even if the person received a service under the program from a particular provider on more than one occasions in the calendar month.

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:

(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", referred to in Schedule 1.

7.4.3 Optometrical products are those referred to in the *DVA document* entitled "Pricing Schedule for Visual Aids", referred to in Schedule 1

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

7.4.4 An optometrist or 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 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 a *general practitioner* 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 *general practitioner's*, or medical specialist's, referral.

7.5.3 *Prior approval* is required for physiotherapy treatment 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.

7.6 Podiatry

7.6.1 Subject to paragraph 7.6.6, the *Commission* will accept financial responsibility for podiatry treatment where a *general practitioner* 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:

(b) where those services are to be provided in a public hospital; or

(c) involving providing an Electrodynographic Analysis and Report; or

(d) involving 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:

(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 *general practitioner*, *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 those services are to be provided to an *entitled person* in a public hospital.

7.7 Chiropractic and osteopathic services

7.7.1 The *Commission* will accept financial responsibility for chiropractic or osteopathic services where a *general practitioner* 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 person* in accordance with the *Principles*.

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

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

(a) the person is eligible for *VVCS* under the Act; and

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

(i) the 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

(ii) despite the 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 person by an *outreach program counsellor* pursuant to a referral from the *Veterans and Veterans Families Counselling Service*.

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.

PART 9 — TREATMENT OF ENTITLED PERSONS AT HOSPITALS AND INSTITUTIONS

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 as well as urgent treatment for Vietnam veterans**,** not otherwise entitled**,** and their dependants as indicated in principle 2.5, at a hospital or an institution.

Note: The Commission may raise a charge for treatment provided under paragraph 9.1.1 in accordance with section 93A of the Act.

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 eligible 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 *RPPPs*, only if prior approval for the admission is obtained.

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 *RPPPs.*

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;

(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;or

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;

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 *daily care fee*, unless:

(c) the Commission has granted an exemption under paragraph 10.3.1; or

(d) the *entitled person* is a former prisoner of war or an *entitled veteran* awarded the Victoria Cross;

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 *Veterans' Entitlements Act 1986* 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

Convalescent care in institutions other than hospitals

9.5.1 Subject to *prior approval* and subject to paragraph 9.2.5 (health insurance etc), the *Commission* will accept financial responsibility for the costs of *convalescent care* for an *entitled person* at an institution other than a *private hospital* or *public hospital* for a maximum of 21 days during any financial year.

Convalescent care in institutions that are private or public hospitals

9.5.2 Subject to paragraph 9.2.5 (health insurance etc), the *Commission* may accept financial responsibility for the costs of *convalescent care* for an *entitled person* at a *private hospital* or *public hospital*.

Note (1) *prior approval* is not a requirement in these circumstances.

Note (2) there is no express time limit in these circumstances but the Commission has a discretion to accept financial responsibility. It could exercise its discretion not to accept financial responsibility if it considered the length of *convalescent care* to be excessive.

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.

PART 10 — RESIDENTIAL CARE, HOME CARE AND TRANSITION CARE CO-PAYMENT

Part A — *residential care* not involving *residential care (respite)*

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 (1): this provision, in conjunction with a determination under section 88A of the Act, also enables the Commission to make a payment for residential care where that care is applied to a condition other than a war caused condition, malignant neoplasm, pulmonary tuberculosis, post traumatic stress disorder or an unidentifiable condition.

Note (2): an "unidentifiable condition" is governed by Determination 19/2000.

Note (3)'*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 *Veterans' Entitlements Act 1986* 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 Part V of the *Veterans' Entitlements Act 1986* 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 Repatriation Commission under the *Veterans' Entitlements Act 1986*.

10.1.4 Paragraph 10.1.3 does not permit payments to be made by the Commonwealth under both the *Veterans' Entitlements Act 1986* 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 *daily care fee*. Liability to pay that amount may be accepted by the *Commission* under the *Principles.*

10.2 Daily care fee for former prisoners of war

10.2.1 The *Commission* will accept financial responsibility for the *residential care subsidy* and the *daily care fee* for a former *prisoner of war* who is receiving:

(a) *residential care*; or

(b) care in a hospital, classified as nursing-home-type care under paragraph 9.3.1 or as care received as a nursing-home type patient under the *Health Insurance Act 1973*.

Note: If a former *prisoner of war* receives a standard of accommodation superior to that medically necessary, the *Commission* cannot accept financial responsibility for any amount additional to the *residential care subsidy* and *daily care fee* for that person.

10.2.2 Paragraph 10.2.1(a) applies to *residential care* provided on or after 1 January 2005 to a former *prisoner of war* – whether the person was receiving *residential care* immediately before 1 January 2005 or not.

Note: the intention is that the beneficial effects of Instrument 10/2004 (abolition of high/low residential care requirements), which commenced on 1 January 2005, also apply to residential care on/after 1 January 2005 for POWs who were in *low level residential care* under the less beneficial *Principles* in force prior to 1 January 2005.

10.3 Payment of daily care fee for certain veterans with dependants

10.3.1 The Commission may, in exceptional circumstances, accept financial responsibility for the *daily care fee* for a veteran who:

(a) has a dependant; and

(b) is receiving *residential care* in a *residential care facility* because of *war-caused* injury or *war-caused* disease, or both.

Payment of Residential Care Fees for Victoria Cross Veterans

10.4 The *Commission* may accept financial responsibility for the *daily care fee* and the *residential care subsidy* for an *entitled veteran* awarded the Victoria Cross and who is receiving, or has received, *residential care*.

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.

10.6 Residential care (respite) arrangements

10.6.1 *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 *Veterans' Home Care Program.*

10.6.2 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 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 *Subsidy Principles 2014*.

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 *daily care fee*) and *in-home respite* will be counted.
Note (2) in Part B *residential care (respite)* includes *residential care (28 day) respite.*

Note (3): by virtue of Determination 4/2001 *residential care* (*respite*) may be applied to the non-war caused (non-accepted) conditions of a white-card holder.

Note (4):the *Subsidy Principles 2014* (Principles) are made under subsection 96-1 of the *Aged Care Act 1997*. Under s.23 of the Principles the Secretary of the Department that administers the *Aged Care Act 1997* 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 REPATRIATION COMMISSION FOR RESIDENTIAL CARE (RESPITE)

category of patient	***type of care; max.period of care permitted; type of care costs accepted***	***type of care; max.period of care permitted; type of care costs accepted***
	residential care (28 day respite) up to 28 days (inclusive) in a Financial year	*residential care (respite)* other than *residential care (28 day respite*) upon an entitled person exhausting 28 days of *residential care (28 day respite)* in a Financial year — between and including 29 to 63 days* in that Financial year
POW	RCS + DCF	RCS + DCF
VC	RCS + DCF	RCS + DCF
Other person	RCS + DCF	RCS

For the purposes of this table:

'**POW**' means an *entitled veteran* who is a former *prisoner of war*.

'**VC**' means an *entitled veteran* awarded the Victoria Cross.

'**Other person**' means an *entitled person* other than a 'POW' or a 'VC'.

'RCS' means the *Commission* will accept financial responsibility for the *residential care subsidy* (including any *veterans' supplement*).

'DCF' means the Commission will accept financial responsibility for the *daily care fee*.

'RCS + DCF' means the Commission will accept financial responsibility for the *residential care subsidy* (including any *veterans' supplement*) and the *daily care fee*.

***** or for such further period permitted under the *Subsidy Principles 2014***.**

10.6.3 Where the *Commission* could accept financial liability for a *daily care fee* 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 provided with *residential care (respite)* for 63 days or such further period permitted under the *Subsidy Principles 2014*; 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.

10.6.4 Where the *Commission* accepts financial liability for a *daily care fee* 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.

10.6.5 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 provided with *residential care (respite)* for 63 days (or such further period permitted under the *Subsidy Principles 2014*).

10.6.6 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 provided with *residential care (respite)* for 63 days (or such further period permitted under the *Subsidy Principles 2014*) or if the person has received *in-home respite* for more than 28 days.

10.6.7 (1) For the purposes of paragraphs 10.6.1 to 10.6.6 (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 *daily care fee*, or for - in the case of *in-home respite*, the cost of *respite*

10.6.8 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 10.6.8 is to provide for payment to be made under the *Veterans' Entitlements Act 1986* 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 Part V of the *Veterans' Entitlements Act 1986* 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 Repatriation Commission under the *Veterans' Entitlements Act 1986*.

Note (2): the amount an *entitled person* could be liable to pay for *residential care (respite)* is the *daily care fee*, being a resident's contribution to his or her care.

10.6.9 Nothing in this Part is to be taken to permit payments to be made by the Commonwealth under both the *Veterans' Entitlements Act 1986* 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 care in an institution* not involving *residential care (respite)*

Note (1): this heading is intended to be an aid in interpretation.

Note (2): an example of *respite care in an institution* not involving *residential care (respite)* would be *respite* provided to a person in a hospital. The definition of *residential care* does not include hospital care.

respite care in an institution (other than a hospital)

10.7 The *Commission* may accept, in whole or in part, financial responsibility for *respite care in an institution* for an *entitled person* for a maximum period of 28 days in a financial year:

(a) being an institution (other than a *private hospital* or *public hospital*) in respect of which a *residential care subsidy* is not payable; and

(b) if, in the opinion of the *Commission*, it is a cost-effective and appropriate alternative to *residential care (respite)* under paragraph 10.6.1 and to *Respite Care* under the *Veterans' Home Care Program*.

Note (1): *prior approval* is required (see paragraph 3.2.1(h)).
Note (2): an institution here would include a residential care facility not covered by the *Aged Care Act 1997*.

respite care in an institution (being a private or public hospital)

10.7A The *Commission* may accept, in whole or in part, financial responsibility for *respite care in an institution* for an *entitled person* where the institution is a *private hospital* or *public hospital*.

Note (1) prior approval is not a requirement in these circumstances.
Note (2) there is no express time limit in these circumstances but the *Commission* has a discretion to accept financial responsibility. It could exercise its discretion not to accept financial responsibility if it considered the length of *respite care in an institution* to be excessive.

Part D – HOME CARE CO-PAYMENT

Definition:

"co-payment", in this Part, 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*.

10.8 The *Commission* may accept financial responsibility for the *co-payment* a former *prisoner of war*, or an *entitled veteran* awarded the Victoria Cross (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*.

10.9 In deciding whether to accept financial responsibility for a *co-payment* for *home care* provided to a former *prisoner of war* or VC veteran 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;

(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 veteran is receiving under other provisions of the *Principles* (double-dipping).

10.10 Billing

10.10.1 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 veteran (client) but if the client is billed, the *Commission* may, subject to paragraphs 10.8 and 10.9, accept financial responsibility for the *co-payment*.

Part E – TRANSITION CARE CO-PAYMENT

Definition:

"co-payment", in this Part, 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*.

10.11 Financial Responsibility for Co-Payment

10.11.1 The *Commission* may accept financial responsibility for the *co-payment* a former *prisoner of war* (POW), or an *entitled veteran* awarded the Victoria Cross (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 *Subsidy Principles 2014*, 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.

(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 paragraph 111(3)(a) of the *Subsidy Principles 2014.*

10.11.2 In deciding whether to accept financial responsibility for the *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 *Subsidy Principles 2014* 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 paragraph 111(3)(a) of the *Subsidy Principles 2014*; and

(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).

10.12 Billing

10.12.1 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 10.11.1 and 10.11.2, accept financial responsibility for the amount.

Part F – SHORT-TERM RESTORATIVE CARE CO-PAYMENT

Definition:

"co-payment", in this Part, means an amount a person must pay for *short-term restorative care* but does not include an amount payable to the *approved provider* of the *short-term restorative care* as subsidy under the *Aged Care Act 1997*.

10.13 Financial Responsibility for Co-Payment

10.13.1 The *Commission* may accept financial responsibility for the *co-payment* a former *prisoner of war* (POW), or an *entitled veteran* awarded the Victoria Cross (VC recipient), paid, or is to pay, to an *approved provider* for *short-term restorative care* (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 *Subsidy Principles 2014*, in force from time to time; and

Note (1): The maximum number of days for which flexible care subsidy is payable for an episode of short-term restorative care by an *approved provider* for a care recipient is 56 days. *See* section 111A of the *Subsidy Principles 2014*.

(b) to the extent 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*.

Note (2): The maximum co-payment amount an *approved provider* is permitted to charge is set out in section 23AB of the *User Rights Principles 2014* made for paragraph 56-3(a) of the *Aged Care Act 1997*.

10.13.2 In deciding whether to accept financial responsibility for the *co-payment* for *short-term restorative 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 "agreed care plan" (within the meaning of section 111A of the *Subsidy Principles 2014*) in place between the *approved provider* and the POW or VC recipient;

(b) whether the care was otherwise provided in accordance with the relevant provisions of the *Aged Care Act 1997* and relevant instruments under that Act; and

Note (1): Part 3.3 of Chapter 3 of the *Aged Care Act 1997* deals with flexible care.

Note (2): The *Approval of Care Recipients Principles 2014*, the *Subsidy Principles 2014*, the *Quality of Care Principles 2014*, *the Accountability Principles 2014* and the *User Rights Principles 2014* are relevant to *short-term restorative care* – a form of flexible care.

(c) whether the care essentially duplicates treatment the POW or VC recipient is receiving under other provisions of these *Principles* (double-dipping).

10.14 Billing

10.14.1 An *approved provider* is to bill the *Department of Human Services* (via Medicare) for the *co-payment* for *short-term restorative care*, rather than the POW or VC recipient (client) but if the client is billed, the *Commission* may, subject to 10.13.1 and 10.13.2, accept financial responsibility for the amount.

PART 11 — THE PROVISION OF REHABILITATION APPLIANCES

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:

(c) the *Commission* could provide the appliance to the person, for that injury or disease, under a part of the *Act* other than Part V; or
(d) the *MRCC* could provide the appliance to the person, for that injury or disease, under *DRCA* or *MRCA*.

Note (1): an appliance could be provided to a person under Part VIA of the *Act* (Rehabilitation).

Note (2): an appliance could be provided to a person under Part III or s.148 of DRCA (but not under s.16(1) by virtue of 144B(5)DRCA) and under Chapters 3 or 4 of MRCA or under MRCA Treatment Principle 11.1.1.

Note (3): 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 (4): 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

(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;

and likely to facilitate the independence and/or self-reliance of the *entitled person* based on an assessment of clinical need by an appropriately qualified health professional.

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” referred to in Schedule 1 and the "Rehabilitation Appliances Program (RAP) National Guidelines" referred to 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.

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 aids or appliances only to veterans who have a medically assessed need for these items due to a war-caused injury or disease or a ***determined condition*** other than a ***determined residential care condition***:

(b) the supply of a guide dog, mobility dog or hearing dog;

(c) the supply of special vehicle driving controls and devices, if the *veteran* owns the vehicle and is licensed under relevant State or Territory law to drive a modified vehicle;

(d) a *Vertical Platform Lift*.

Note: an example of a Vertical Platform Lift may be seen at:
http://www.prking.com.au/pdf/VerticalWC-Shaftway.pdf

Assistive Communication Devices

11.3.2 Subject to paragraph 11.1.3 (clinical need, cost effective etc), the *Commission* may accept financial responsibility for the provision to an *entitled person* of an *assistive communication device*.

11.3.3 Where the *assistive communication device* is a computer tablet or smart `phone, the *Commission* may only accept financial responsibility for the device if:

(a) the *entitled person* has been clinically assessed by a *speech pathologist* as having complex communication needs that would be significantly met by a computer tablet or smart `phone; and

(b) in the case of a smart `phone — the *entitled person's* communication needs:

(i) could not be reasonably satisfied by the provision of a computer tablet; or

(ii) are not being reasonably satisfied by the use of a computer tablet; and

(c) the computer tablet or smart `phone has been preloaded with a speech pathology application; and

(d) the *entitled person* is:

(i) a *Gold Card* holder; or
(ii) a *White Card* holder whose communication needs are *war-caused* or arise from a *determined condition* (other than a *determined residential care condition*); and

(e) the *Commission* considers all relevant guidelines in relation to the provision of an *assistive communication device* that is a computer tablet or a `smart phone as set out in the *RAP National Schedule of Equipment* and the *Rehabilitation Appliances Program (RAP) National Guidelines*.

Note 1: the repair and replacement of rehabilitation appliances is covered by Treatment Principle 11.7.

Note 2: the holder of a *Gold Card* is a *veteran*, or dependant of a *veteran*, eligible under the *Act* for treatment for any injury suffered, or disease contracted.

Note 3: the holder of a *White Card* is a *veteran* eligible under the *Act* for treatment for a *war-caused* injury or *war-caused* disease or for a *determined condition*.

Note 4: "dependant" is defined in s.11 of the *Act*; and eligibility of dependants for treatment is set out in s.86 of the *Act.*

Electric Mobility Aids

11.3.4.1 Subject to this Part, the *Commission* may provide or accept financial responsibility for the supply of an electric wheelchair, electric scooter or a *power-assist device* to:

(a) an *entitled veteran* who has a medically assessed need for the item due to a war-caused injury or disease or a *determined condition* other than a *determined residential care condition*; or

(b) an *entitled veteran* who has a medically assessed need for the item and is eligible to be provided with treatment under the Act, subject to these Principles, for all injuries or diseases; or

(c) an *entitled veteran* who has a medically assessed need for the item due to malignant neoplasm, and in respect of whom the Commission has accepted financial responsibility under paragraph 2.4 for treatment of that condition.

11.3.4.2 For paragraph 11.3.4.1:

power-assist device means an electrically-powered device that can be mounted on to a manual wheelchair to provide additional mobility assistance and support independent operation.

Assistance Dogs

11.3.5.1 Subject to this Part, the *Commission* may accept financial responsibility for the supply of a psychiatric assistance dog to a person if the *Commission* is satisfied:

(a) the person is an *entitled veteran*; and

(b) the person has an accepted condition of post-traumatic stress disorder or a diagnosis of post-traumatic stress disorder from a *psychiatrist*; and

(c) the person is undergoing treatment by a *psychiatrist* or a *psychologist* for post-traumatic stress disorder and has been undergoing such treatment for at least 3 months; and

(d) the person has been assessed as suitable for the supply of a psychiatric assistance dog by a *mental health professional* having regard to the factors in the *RAP Guidelines* for this assessment; and

(e) the person is suitable for the supply of a psychiatric assistance dog having regard to the factors in the *RAP Guidelines* relating to living arrangements, current life circumstances, support networks, and ability to properly care for the dog.

11.3.5.2 In making a decision about the supply of a guide dog, mobility dog or hearing dog for a veteran under paragraph 11.3.1, the *Commission* is to have regard to the factors in the *RAP Guidelines* relating to the supply of a guide dog, mobility dog or hearing dog, as the case requires.

11.3.5.3 If the Commission has accepted financial responsibility for the supply of an *assistance dog* the *Commission* will also be responsible for the reasonable costs associated with keeping the dog while the dog remains in the care of the veteran.

11.3.5.3A The *Commission* may accept financial responsibility for the reasonable costs, incurred on or after 1 July 2022, associated with a person keeping a psychiatric assistance dog while the dog remains in the care of the person if:

(a) the person is an *entitled veteran*; and

(b) the person has an accepted condition of post-traumatic stress disorder or a diagnosis of post-traumatic stress disorder from a *psychiatrist*; and

(c) the person has undergone treatment, or is undergoing treatment, by a *psychiatrist* or a *psychologist* for post-traumatic stress disorder and has accessed such treatment for at least 3 months; and

(d) the *Commission* is satisfied that:

(i) the dog was supplied to the person before 27 September 2019; or

(ii) the dog was supplied to the person on or after 27 September 2019 in connection with the person commencing training with the dog, or another psychiatric assistance dog, before 27 September 2019; and

(e) the person satisfies any other criteria determined by the *RAP Guidelines* for the purposes of this subparagraph.

11.3.5.4 For paragraphs 11.3.5.1 to 11.3.5.4:

AHPRA means the Australian Health Practitioner Regulation Agency;

assistance dog means a guide dog, a mobility dog, a hearing dog or a psychiatric assistance dog;

mental health professional means:

(a) a *psychiatrist*; or

(b) a *psychologist*; or

(c) a *mental health occupational therapist*; or

(d) a *mental health social worker*;

mental health occupational therapist means a person who is registered with AHPRA to practise as an occupational therapist and eligible to provide focussed psychological strategies under Medicare;

mental health social worker means a social worker who is a member of the Australian Association of Social Workers and certified by that association as eligible to provide focussed psychological strategies under Medicare;

psychiatrist means a medical practitioner who is registered with AHPRA and holds specialist registration as a psychiatrist;

psychologist means a person who is registered with AHPRA to practise as a psychologist;

RAP Guidelines means the Rehabilitation Appliances Program (RAP) National Guidelines defined in paragraph 1.4.1 of these Principles.

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:

https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule

(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.

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:

https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule

(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 unit.
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:

https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule

(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
(iv) 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:

https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule

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 a veteran who has a medically assessed need for these items because of a war-caused injury or disease.

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) 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”, referred to in Schedule 1.

11.4.2 Visual aids may be prescribed from the *DVA document* entitled “Pricing Schedule for Visual Aids”, referred to 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”, referred to 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

(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", referred to 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 of:

(a) all injuries or diseases; or

(b) war-caused deafness or deafness that is a *determined condition* other than a *determined residential care condition*; or

(c) war-caused visual defect or a visual defect that is a *determined condition* other than a *determined residential care condition* 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 war-caused hearing defect or a hearing defect that is a *determined condition* other than a *determined residential care condition* 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 hearing aid is unable to be supplied to the eligible 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 war-caused injury or disease or as a result of a malignant neoplasm or as a result of treatment of one of these conditions or as a result of a *determined condition* other than a *determined residential care condition* or as a result of the treatment of a *determined condition* other than the treatment of a *determined residential care condition*; 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.

11.6.4 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 *Repatriation Pharmaceutical Benefits Scheme*.

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 war-caused 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

(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.

PART 12 — OTHER TREATMENT MATTERS

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.

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.

12.3 Compensable patients

12.3.1 Unless otherwise indicated in these Principles, the Commission will not accept financial responsibility for the cost of treating a compensable patient.

Note: Where expenses have been incurred in relation to the treatment of a compensable patient, costs will be recovered from the patient or the person or authority responsible for compensation in accordance with section 93 or 93A of 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 eligible 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.

12.5 Veterans' Home Services program

12.5.1 For the duration of an entitled person's episode of need, and subject to the availability of funds, the Commission may operate the Veterans' Home Services program for that person if he or she:

(a) had been assessed as being in need of home-help services at 15 September 1987;and

(b) had been in receipt of those services at that date; and

(c) has continuously needed and received those services since that date.

12.5.2 The services provided under paragraph 12.5.1 may supplement, but may not duplicate for the entitled person, home-help services provided by State, Territory and local government authorities and community agencies.

12.5.3 Assessment of continuing need for home-help services provided in accordance with paragraph 12.5.1 is carried out by the Commission's Aged and Extended Care Departments or by other bodies authorised by the Commission.

12.5.4 In making these assessments, continuing need for services provided in accordance with paragraph 12.5.1 will be considered to have been established

if these have enabled an entitled person to be maintained at home, rather than entering a hospital or institution.

12.5.5 The Commission will not accept financial responsibility for the cost of home-help services not provided in accordance with principle 12.5.1 or at a level of service in excess of that which existed at 15 September 1987.

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

(c) 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. Treatment Principles No. R52 of 2013

(a) any arrangement entered into, or taken to have been entered into, by the *Commission* or the *Department* with a *health provider*, under the *revoked 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 decision made, or action commenced, by the *Commission*, the *Department*, a health provider or an *entitled person*, under the *revoked Treatment Principles* being a decision or action that, immediately before the commencement of these *Principles*, was still in force or uncompleted, as the case may be, is taken, respectively, to have been made or instigated under these *Principles*.

(c) a Scheme (eg Local Medical Officer Scheme, Local Dental Officer Scheme) prepared by the *Commission* under the *revoked Treatment Principles*, 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 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*.

(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 Treatment Principles* (former qualification) in the state the *revoked Treatment Principles* existed immediately before the commencement of these *Principles* under 1.1.3, is satisfied where a person holds a former qualification.

Note: under the *revoked Treatment Principles* an aboriginal health worker *Aboriginal and/or Torres Strait Islander Primary Health Care 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 *Aboriginal and Torres Strait Health Islander Practice Board of Australia*. 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 *Aboriginal and Torres Strait Health Islander Practice Board of Australia*.

SCHEDULE 1 DATES FOR INCORPORATED DOCUMENTS

The following documents are incorporated-by-reference into the *Treatment Principles* in the form in which they exist from time to time:

1. Notes for General Practitioners (paragraph 1.4.1)
   https://www.dva.gov.au/providers/notes-providers
2. Department of Veterans' Affairs Fee Schedules for Medical Services (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules
3. Notes for Allied Health Providers (paragraphs 3.5.1 and 7.1A.1)
   https://www.dva.gov.au/providers/allied-health-professionals
4. Optometrist Fees for Consultation (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
5. Orthoptists Schedule of Fees (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
6. Pricing Schedule for visual aids (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
7. Fee Schedule of Dental Services for Dentists and Dental Specialists (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
8. Fee Schedule of Dental Services for Dental Prosthetists (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
9. Chiropractors Schedule of Fees (paragraph 3.5.1)
   https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
10. Diabetes Educators Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
11. Dietitians Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
12. Exercise Physiologists Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
13. Occupational Therapists Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
14. Osteopaths Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
15. Physiotherapists Schedule of Fees (paragraph 3.5.1)
    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules
16. Psychologists Schedule of Fees (paragraph 3.5.1)

https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

17. Podiatrists Schedule of Fees (paragraph 3.5.1)

    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

18. Social Workers Schedule of Fees (paragraph 3.5.1)

    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

19. Clinical Psychologists Schedule of Fees (paragraph 3.5.1)

    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

20. Speech Pathologists Schedule of Fees (paragraph 3.5.1)

    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

21. DVA Community Nursing Schedule of Fees (paragraph 6A.4.2(b))

    https://www.dva.gov.au/providers/community-nursing

22. Notes for Coordinated Veterans' Care Program Providers (Part 6A)

    https://www.dva.gov.au/providers/provider-programs/coordinated-veterans-care

23. Rehabilitation Appliances Program (RAP) National Guidelines (paragraph 11.2A.1)

    https://www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap

24. RAP National Schedule of Equipment (paragraph 11.2A.1)

    https://www.dva.gov.au/providers/provider-programs/rehabilitation-appliances-program-rap

25. Veterans and Veterans Families Counselling Services Outreach Program Counsellors Provider Notes (paragraph 1.4.1 and 7.1A.1)

    https://www.openarms.gov.au/resources/provider-resources

26. Veterans and Veterans Families Counselling Service (VVCS) Outreach Program Counsellor Schedule of Fees (paragraph 3.5.1)

    https://www.openarms.gov.au/resources/provider-resources

29. Orthotists Schedule of Fees (paragraph 3.5.1)

    https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe how an amendment is to be made. If, despite the misdescription, the amendment can be given effect as intended, then the misdescribed amendment can be incorporated through an editorial change made under section 15V of the *Legislation Act 2003*.

If a misdescribed amendment cannot be given effect as intended, the amendment is not incorporated and “(md not incorp)” is added to the amendment history.

Endnote 2—Abbreviation key

ad = added or inserted
am = amended
amdt = amendment
c = clause(s)
C[x] = Compilation No. x
Ch = Chapter(s)
def = definition(s)
Dict = Dictionary
disallowed = disallowed by Parliament
Div = Division(s)
ed = editorial change
exp = expires/expired or ceases/ceased to have effect
F = Federal Register of Legislation
gaz = gazette
LA = *Legislation Act 2003*
LIA = *Legislative Instruments Act 2003*
(md not incorp) = misdescribed amendment cannot be given effect
mod = modified/modification
No. = Number(s)
o = order(s)
Ord = Ordinance
orig = original
par = paragraph(s)/subparagraph(s) /sub-subparagraph(s)
pres = present
prev = previous
(prev…) = previously
Pt = Part(s)
r = regulation(s)/rule(s)
reloc = relocated
renum = renumbered
rep = repealed
rs = repealed and substituted
s = section(s)/subsection(s)
Sch = Schedule(s)
Sdiv = Subdivision(s)
Sub-Ch = Sub-Chapter(s)
SubPt = Subpart(s)
underlining = whole or part not commenced or to be commenced

Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Treatment Principles *2013 No. R52*	2 December 2013 (*see* F2013L02029)	3 December 2013 (except references to "SRCA disability" in para.1.4.1) 10 December 2013 (for references to "SRCA disability" in para.1.4.1)	Paragraph 1.2
Veterans' Entitlements (Treatment Principles – Rehabilitation Appliance Program) Amendment Instrument 2014 *2014 No. R1*	2 May 2014 (*see* F2014L00493)	3 May 2014	Paragraph [3]
Veterans' Entitlements (Treatment Principles – Residential Care Classification) Amendment Instrument 2014 *2014 No. R24*	28 June 2014 (*see* F2014L00877)	1 July 2014	
Veterans' Affairs (Treatment Principles – Private Accommodation in Hospital Surcharge) Amendment Instrument 2014 *2014 No. R78/MRCC78*	14 October 2014 (*see* F2014L01348)	15 October 2014	Paragraph [3]
Veterans' Entitlements (Treatment Principles – Mental Health Disorders – Diagnostic Protocols) Amendment Instrument 2014 *2014 No. R113*	2 January 2015 (*see* F2015L00012)	3 January 2015	
Veterans' Affairs (Treatment Principles – Provision of Falls Prevention Items) Amendment Instrument 2014 *2014 No.R107/MRCC107*	19 January 2015 (*see* F2015L00055)	6 February 2015	Paragraph [3]
Veterans' Affairs (Treatment Principles – TRCP Treatment and Updating of RAP Schedules) Amendment Instrument 2015 *2015 No.R29/MRCC29*	21 May 2015 (*see* F2015L00713)	22 May 2015	
Veterans' Affairs (Treatment Principles – Updating Home and Community Care (HACC) References and other References) Amendment Instrument 2015 *2015 No. R46/MRCC46*	17 September 2015 (*see* F2015L01446)	1 July 2015	

Endnotes

Name	Registration	Commencement	Application, saving and transitional provisions
Veterans' Affairs (Treatment Principles – Removal of Prior Approval Requirement and Time Limits for Convalescent and Respite Care in Hospital) Amendment Instrument 2015 *2015 No.R32/MRCC32*	27 August 2015 (*see* F2015L01342)	28 August 2015	
Veterans' Affairs (Treatment Principles – Updating of Rehabilitation Appliance Schedule/VVCS Outreach Program Counsellors Fees Schedule) Amendment Instrument 2015 *2015 No.R73/MRCC73*	7 December 2015 (see F2015L01941)	8 December 2015	
Veterans' Affairs (Treatment Principles – Lodgment of Claims by Providers) Amendment Instrument 2016 *2016 No.R3/MRCC3*	8 March 2016 (*see* F2016L00256)	31 March 2016	Section 4
Veterans' Entitlements (Treatment Principles – Streamlining Access to Non-Liability Health Care) Amendment Instrument 2016 2016 No.R16	10 May 2016 (*see* F2016L00765)	11 May 2016	
Veterans' Affairs (Treatment Principles – Updating of RAP National Schedule of Equipment) Amendment Instrument 2016 2016 No. R31/MRCC31	12 May 2016 (*see* F2016L00781)	1 June 2016	
Veterans' Affairs (Treatment Principles – Community Nursing) Amendment Instrument 2016 2016 No.R30/MRCC30	17 May 2016 (*see* F2016L00805)	1 July 2016	
Veterans' Entitlements (Treatment Principles – Extension of Non-Liability Health Care for Mental Health Treatment) Amendment Instrument 2016 2016 No. R36	16 August 2016 (*see* F2016L01288)	1 July 2016	
Veterans' Affairs Treatment Principles (Short-term Restorative Care) Amendment Instrument 2016 2016 No. R46MRCC46	6 December 2016 (*see* F2016L01869)	1 January 2017	

Endnotes

Name	Registration	Commencement	Application, saving and transitional provisions
Veterans' Affairs (Treatment Principles – Updating of RAP National Schedule of Equipment) Amendment Instrument 2017 2017 No. R1/MRCC1	20 March 2017 (*see* F2017L00260)	1 April 2017	
Veterans' Affairs (Treatment Principles – Updating of Fee Schedules for Medical Services and Other Matters) Amendment Instrument 2017 2017 No. R21/MRCC21	21 June 2017 (*see* F2017L00711)	1 July 2017	
Veterans' Affairs (Treatment Principles – Incorporated Documents) Amendment Instrument 2018 2018 No. R12/MRCC12	13 Mar 2018 (*see* F2018L00242)	Sch 1: 1 Apr 2018 (s 2)	
Veterans' Entitlements (Treatment Principles–Veteran Suicide Prevention Pilot) Amendment Instrument 2018 2018 No. R72	9 July 2018 (*see* F2018L01015)	10 July 2018 (s 2)	
Veterans' Affairs (Treatment Principles – Orthotists) Amendment Instrument 2018 2018 No. R88/MRCC88	21 Jan 2019 (*see* F2019L00049)	Sch 1: 1 Feb 2019 (s 2)	
Veterans' Affairs (Treatment Principles – Electric Mobility Aids and Other Measures) Amendment Instrument 2019 2019 No. R13/MRCC13	16 May 2019 (F2019L00678)	Sch 1: 25 Apr 2019 (s 2)	
Veterans' Affairs (Treatment Principles – Local Medical Officer) Amendment Instrument 2019 2019 No. R41/M42	10 Sept 2019 (F2019L01171)	Sch 1: 1 Oct 2019 (s 2)	
Veterans' Affairs (Treatment Principles – Rehabilitation in the Home and Other Amendments) Determination 2020 2020 No. R3/MRCC3	18 Aug 2020 (F2020L01028)	Sch 1: 18 Aug 2020 (s 2)	

Endnotes

Name	Registration	Commencement	Application, saving and transitional provisions
Veterans' Affairs (Treatment Principles – Extend Eligibility for Allied Health Treatment to Residential Care Recipients) Determination 2020 2020 No.R42/MRCC42	22 Dec 2020 (F2020L01674)	Sch 1: 10 Dec 2020(s. 2)	
Veterans' Affairs (Treatment Principles – Rehabilitation in the Home and Other Amendments) Revocation Determination 2021 2021 No. R7/MRCC7	12 February 2021 (F2021L00116)	13 February 2021	
Veterans' Affairs (Treatment Principles – Removal of References to Rehabilitation in the Home) Amendment Determination 2021 2021 No. R8/MRCC8	2 Mar 2021 (F2021L00177)	Sch 2: 3 Mar 2021	
Veterans' Affairs (Treatment Principles – Extend Eligibility for Coordinated Veterans' Care to Eligible White Card Holders) Amendment Determination 2021 2021 No, R14/MRCC14	18 June 2021 (F2021L00782)	Sch 1: 1 July 2021	
Veterans' Affairs (Treatment Principles – Extend Support Provided Under the Psychiatric Assistance Dog Program) Amendment Determination 2022 2022 No. R16/MRCC16	30 June 2022 (F2022L00921)	Sch 1: 1 July 2022	
Veterans' Affairs (Treatment Principles - Extend Eligibility for Treatment by Allied Health Providers for Entitled Persons Receiving Residential Care) Amendment Determination 2022 2022 No. R29/MRCC29	30 June 2022 (F2022L00922)	Sch 1: 1 July 2022	

Endnotes

Name	Registration	Commencement	Application, saving and transitional provisions
Veterans' Affairs (Treatment Principles—Extending Access to Allied Health and Rehabilitation Appliances for Residential Care Recipients) Amendment Determination 2022 2022 No. R36/MRCC36	30 Sept 2022 (F2022L01287)	Sch 1 (items 18–35): 1 Oct 2022 (s 2(1) item 1)	
Veterans' Entitlements Treatment Principles Amendment (Outreach Program Counselling) Determination 2024 R1/2024	2 Apr 2024 (F2024L00427)	3 Apr 2024 (s 2)	
Veterans' Entitlements Treatment Principles Amendment (Sustainability Payments) Determination 2024	26 June 2024 (F2024L00785)	27 June 2024 (s 2)	

Endnote 4—Amendment history

Provision affected	How affected
1.1.3	rep LA s 48D
1.1.4	rep LA s 48D
1.3.1 (Note)	am 2017 No.R21/MRCC21
1.4.1	am.2014 No. R1; am.2014 No. R24; am.2014 No. R78/MRCC78; am.2014 No.R113; am. 2015 No. R29/MRCC29; am. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32; am 2016 No. R16; am 2016 No. R30/MRCC30; am 2016 No. 46/MRCC46; am 2017 No. R21/MRCC21; am 2018 No. R72; am 2018 No. R88/MRCC88; am 2019 No. R13/MRCC13; ed C22; am 2019 No.R41/M42; ed C23; am 2020 No. R3/MRCC3; am 2021 No. R8/MRCC8; am 2021 No. R14/MRCC14; am 2022 No. R36/MRCC36; am R1/2024; ed C30; am F2024L00785
2.2.4	am. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32; am 2022 No. R36/MRCC36
2.2.8 (including heading and note)	rs. 2014 No.R107/MRCC107
2.4 (heading)	rs. 2014 No.R113; rs 2016 No. R16; rs 2016 No. R36
2.4.1	rs. 2014 No.R113; am 2016 No. R36
2.4.2A	rs. 2014 No.R113; rep 2016 No. R36
2.4.2B	rs. 2014 No.R113; rep 2016 No. R36
2.4.3(b)	rs. 2014 No.R113; am 2016 No. R36
2.4.5	rs.2014 No.R113; rep 2016 No. R36
2.5 (heading)	rs 2016 No. R36
2.5.1	am 2016 No. R16; am 2016 No. R36; am 2017 No.R21/MRCC21; am 2018 No. R72
2.5A (including heading)	ad 2016 No. R16; rs 2016 No. R36
2.5A.1	ad 2016 No. R16; rs 2016 No. R36; am 2017 No.R21/MRCC21
2.5A.2	ad 2016 No. R16; rs 2016 No. R36; am 2017 R21/MRCC21
2.5A.3	ad 2016 No. R16; rs 2016 No. R36
2.5A.4	ad 2016 No. R16; rs 2016 No. R36; rs 2017 R21/MRCC21
2.7A (heading)	rs. 2015 No. R29/MRCC29
2.7A.1	rs. 2015 No. R29/MRCC29
2.8.1	am 2018 No. R72

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Provision affected	How affected
3.2.1	am 2015 No.R32/MRCC32; am 2018 No. R88/MRCC88
3.3.2(a)	am 2019 No.R41/M42
3.3.2(f)	am 2016 No.R30/MRCC30
3.3.2(k)	rs. 2015 No.R32/MRCC32
3.3.2(ka)	ad. 2015 No.R32/MRCC32
3.3.2(kb)	ad. 2015 No.R32/MRCC32
3.4.4(b)	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
3.4.5(b)	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
3.5.1(1)	am 2017 No.R21/MRCC21; am 2018 No. R88/MRCC88; am 2019 No.R41/M42
3.5.2 (Note 2)	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
3.5.2(c)(iii)	am 2016 No.R3/MRCC3
3.5.2A	am 2016 No.R3/MRCC3
3.5.2C	rep 2016 No.R3/MRCC3
3.5.3	am. 2014 No.R78/MRCC78; am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
3.5.3A	ad. 2014 No.R78/MRCC78
4.1 (heading)	am 2019 No.R41/M42
4.1.3	rs 2019 No.R41/M42
4.1.4	am 2019 No.R41/M42
4.2.2	am 2019 No.R41/M42
4.2.5	am 2019 No.R41/M42
4.3.1	am 2019 No.R41/M42
4.3.2	am 2019 No.R41/M42; am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
4.3.4	am 2019 No.R41/M42
4.3A.1	am 2019 No.R41/M42
4.4.1	am 2019 No.R41/M42
4.5.1	am 2019 No.R41/M42
4.7.3	am 2019 No.R41/M42; am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7

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Provision affected	How affected
4.8.1	am 2019 No.R41/M42; am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
5.2.1	am 2018 No. R88/MRCC88
5.2.2	am 2018 No. R88/MRCC88
5.3.2	am 2018 No. R88/MRCC88
5.3.3	am 2018 No. R88/MRCC88
5.3.4	am 2018 No. R88/MRCC88
5.4.1	am 2018 No. R88/MRCC88
6A.1	am 2019 No.R41/M42; ed C23; am 2021 No. R14/MRCC14
6A.1A	ad 2021 No. R14/MRCC14
6A.2.1	am 2019 No.R41/M42
6A.2.2	rs 2019 No.R41/M42
6A.2.7	am 2021 No. R14/MRCC14
6A.2.8	am 2021 No. R14/MRCC14
6A.3 (heading)	am 2019 No.R41/M42
6A.3.1	am 2019 No.R41/M42
6A.3.2	am 2019 No.R41/M42
6A.3.3	am 2019 No.R41/M42
6A.3.4	am 2019 No.R41/M42
6A.3.5	am 2019 No.R41/M42
6A.3.6	am 2019 No.R41/M42
6A.4.1	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.4.2	am 2016 No.R30/MRCC30; am 2018 No. R88/MRCC88; am 2019 No.R41/M42; am 2021 No. R7/MRCC7; am 2021 No. R14/MRCC14
6A.4.2 (Note)	am 2020 No. R3/MRCC3
6A.4.3	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.4.4	am 2019 No.R41/M42
6A.4.5	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.4A.1	am 2019 No.R41/M42

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Provision affected	How affected
6A.5.1	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.6 (heading)	am 2019 No.R41/M42
6A.6.1	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.6.2	am 2019 No.R41/M42
6A.7.1	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.8 (heading)	am 2019 No.R41/M42
6A.8.1	am 2019 No.R41/M42; ed C23
6A.8.2	am 2019 No.R41/M42
6A.9.1	am 2019 No.R41/M42
6A.9.2	am 2019 No.R41/M42; am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
6A.9.3	am 2019 No.R41/M42
6A.9.4	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
6A.9.5	am 2019 No.R41/M42; ed C23; am 2021 No. R14/MRCC14
6A.9.6	am 2019 No.R41/M42
6A.9.7	am 2019 No.R41/M42
6A.9.8	am 2019 No.R41/M42
6A.9.9	am 2019 No.R41/M42; am 2021 No. R14/MRCC14
Part 6B	rep 2019 No.R41/M42
6B.1 (heading)	rep 2019 No.R41/M42
6B.1.1	rep 2019 No.R41/M42
6B.1.2	rep 2019 No.R41/M42
6B.2 (heading)	rep 2019 No.R41/M42
6B.2.1	rep 2019 No.R41/M42
6B.2.2	rep 2019 No.R41/M42
6B.2.3	rep 2019 No.R41/M42
6B.2.4	rep 2019 No.R41/M42
6B.2.5	rep 2019 No.R41/M42
6B.2.6	rep 2019 No.R41/M42

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Provision affected	How affected
6B.3 (heading)	rep 2019 No.R41/M42
6B.3.1	rep 2019 No.R41/M42
6B.4 (heading)	rep 2019 No.R41/M42
6B.4.1	rep 2019 No.R41/M42
6B.4.2	rep 2019 No.R41/M42
6B.4.3	rep 2019 No.R41/M42
6B.4.4	rep 2019 No.R41/M42
6B.4.5	rep 2019 No.R41/M42
6B.5 (heading)	rep 2019 No.R41/M42
6B.5.1	rep 2019 No.R41/M42
6B.5.2	rep 2019 No.R41/M42
6B.6 (heading)	rep 2019 No.R41/M42
6B.6.1	rep 2019 No.R41/M42
7.1.2	am 2018 No. R88/MRCC88
7.1.3	rs. 2014 No.R24; am 2020 No. R42/MRCC42; rs 2022 No. R36/MRCC36
7.1A.1	am 2018 No. R88/MRCC88
7.1C	ad 2020 No. R42/MRCC42; rep 2022 No. R36/MRCC36
7.1C.1	am 2022 No. R29/MRCC29
7.3.3	am 2016 No.R30/MRCC30; am 2019 No.R41/M42
7.3.4	am 2016 No.R30/MRCC30
7.3.6	am 2016 No.R30/MRCC30
7.3.6A	am 2016 No.R30/MRCC30
7.3AA	ad F2024L00785
7.3AA.1	ad F2024L00785
7.3AA.2	ad F2024L00785
7.3AA.3	ad F2024L00785
7.3AA.4	ad F2024L00785
7.3A.1	am 2019 No.R41/M42

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Provision affected	How affected
7.3A.6B	am 2019 No.R41/M42
7.3B	ad F2024L00785
7.3B.1	ad F2024L00785
7.3B.2	ad F2024L00785
7.3B.3	ad F2024L00785
7.3B.4	ad F2024L00785
7.4.2	am 2018 No. R88/MRCC88
7.4.3	am 2018 No. R88/MRCC88
7.4.4	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
7.4.5	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
7.5.1	am 2019 No.R41/M42; ed C23
7.5.2	am 2019 No.R41/M42
7.5.3	am. 2014 No.R24; am 2020 No. R42/MRCC42; rs 2022 No. R36/MRCC36
7.6.1	am 2019 No.R41/M42
7.6.2	rs. 2014 No.R1; am. 2014 No.R24; am 2020 No. R42/MRCC42; am 2022 No. R36/MRCC36
7.6A.1	am 2019 No.R41/M42
7.6A.2	am. 2014 No.R24; am 2020 No. R42/MRCC42; rs 2022 No. R36/MRCC36
7.7.1	am 2019 No.R41/M42
7.7A.1	rs R1/2024
7.7A.2	rs R1/2024
7.7A.3	rep R1/2024
Principle 7.7B	ad 2020 No. R3/MRCC3; rep 2021 No. R8/MRCC8
9.3.2	am. 2015 No. R46/MRCC46
9.5.1	rs. 2015 No.R32/MRCC32
9.5.2	add. 2015 No.R32/MRCC32
10.1.5	am. 2015 No. R46/MRCC46
10.2 (heading)	rs. 2015 No. R46/MRCC46

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Provision affected	How affected
10.2.1	am. 2015 No. R46/MRCC46
10.3 (heading)	am. 2015 No. R46/MRCC46
10.3.1	am. 2015 No. R46/MRCC46; am 2022 No. R36/MRCC36
10.4	am. 2015 No. R46/MRCC46
10.6.2	am. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32
10.6.2 (Table)	rs. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32
10.6.3	am. 2015 No. R46/MRCC46
10.6.3(a)	am. 2015 No.R32/MRCC32
10.6.4	am. 2015 No. R46/MRCC46
10.6.5	am. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32
10.6.6	am. 2015 No. R46/MRCC46; am. 2015 No.R32/MRCC32
10.6.7(2)	am. 2015 No. R46/MRCC46
10.6.8	am. 2015 No. R46/MRCC46
Part C (Heading and Notes)	rs. 2015 No.R32/MRCC32
10.7	rs. 2015 No.R32/MRCC32; am 2016 No. 46/MRCC46
10.7A	ad. 2015 No.R32/MRCC32
10.10.1	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
10.11.1(a)	am. 2015 No. R46/MRCC46
10.11.1(b)(ii)	am. 2015 No. R46/MRCC46
10.11.2(a)	am. 2015 No. R46/MRCC46
10.11.2(b)(i)	am. 2015 No. R46/MRCC46
10.12.1	am 2020 No. R3/MRCC3; am 2021 No. R7/MRCC7
Part F	ad 2016 No. 46/MRCC46
10.13	ad 2016 No. 46/MRCC46
10.14	ad 2016 No. 46/MRCC46
11.1.1	am 2021 No. R14/MRCC14; am 2022 No. R36/MRCC36
11.1.4	am. 2014 No.R1

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Provision affected	How affected
11.2A.1	am 2018 No. R88/MRCC88
11.3.1	am. 2014 No. R1; am. 2014 No.R24
11.3.1(a)	rep 2019 No. R13/MRCC13
11.3.1(b)	rs. 2014 No. R1; rs 2019 No. R13/MRCC13
11.3.1(c)	rs. 2014 No. R1
11.3.2	rs. 2014 No. R1
11.3.3	rep. 2014 No. R1
11.3.4	rep. 2014 No. R1
11.3.4.1	ad 2019 No. R13/MRCC13
11.3.4.2	ad 2019 No. R13/MRCC13
11.3.5	rep 2019 No. R13/MRCC13
11.3.5.1	ad 2019 No. R13/MRCC13
11.3.5.2	ad 2019 No. R13/MRCC13
11.3.5.3	ad 2019 No. R13/MRCC13
11.3.5.3A	Ad 2022 No. R16/MRCC16
11.3.5.4	ad 2019 No. R13/MRCC13
11.3.6	am 2022 No. R36/MRCC36
11.4.1	am 2018 No. R88/MRCC88
11.4.2	am 2018 No. R88/MRCC88
11.4.3	am 2018 No. R88/MRCC88
11.4.6	am 2018 No. R88/MRCC88
11.6.3	rep. 2014 No.R1
11.9	rep. 2014 No.R107/MRCC107
11.9.1	rep. 2014 No.R107/MRCC107
11.9.1A	rep. 2014 No.R107/MRCC107
11.9.1B	rep. 2014 No.R107/MRCC107
11.9.2	rep. 2014 No.R107/MRCC107
11.9.3	rep. 2014 No.R107/MRCC107

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Provision affected	How affected
11.9.4	rep. 2014 No.R107/MRCC107
11.9.5	rep. 2014 No.R107/MRCC107
11.9.7	rep. 2014 No.R107/MRCC107
11.9.8	rep. 2014 No.R107/MRCC107
Transitional Provisions	am 2021 No. R14/MRCC14
Schedule 1	rs. 2014 No.R1; rs. 2014 No.R24; rs. 2014 No.R107/MRCC107; rs. 2015 No. R29/MRCC29; rs. 2015 No. R46/MRCC46; rs. 2015 No. R73/MRCC73; rs 2016 No. R31/MRCC31; rs 2016 No. R30/MRCC30; rs 2017 No.R1/MRCC1; rs 2017 No.R21/MRCC21; rs 2018 No.R12/MRCC12; am 2018 No. R88/MRCC88; am 2019 No.R41/M42; am R1/2024