Australian Government
Department of Health and Aged Care

Changes to allied health services for First Nations Australians

Last updated: 1 February 2024

- Streamlining First Nations Australians' access to allied health services.

What are the changes?

- Currently, to access 10 allied health services per calendar year, First Nations Australians need both:
    - A chronic disease management (CDM) plan that includes a GP Management Plan and Team Care Arrangements or for residents of an aged care facility, a multidisciplinary care plan; and
    - a health assessment.
- From **1 March 2024**, First Nations Australians only need to have either a CDM plan or a health assessment to access up to 10 allied health services per calendar year. There will be no requirement to have both services.

Individual allied health services items and claiming limits

Type of Health Service	Allied health services under CDM arrangements	Allied health services for First Nations Australians
Aboriginal and Torres Strait Islander	10950	81300
Diabetes Education	10951	81305
Audiology	10952	81310
Exercise Physiology	10953	81315
Dietetic	10954	81320
Mental Health Service	10956	81325
Occupational Therapy	10958	81330
Physiotherapy	10960	81335
Podiatry	10962	81340
Chiropractic	10964	81345
Osteopathy	10966	81350
Psychology	10968	81355
Speech pathology	10970	81360
Telehealth Video/telephone	93000/93013	93048/93061
No. of services PRIOR to changes	**5 services per calendar year**	**5 services per calendar year**
No. of services AFTER changes	**5 per calendar year**	**10 per calendar year**
Total capped services PRIOR to changes	**10 allied health services per calendar year**	
Total capped services AFTER to changes		

- A collective claiming cap of 10 services per calendar year will be applied to the allied health items in the groups specified below:
    - 81300 – 81360, 93048 and 93061 (allied health services for First Nations Australians).
    - 10950 – 10954, 10956, 10958, 10960 – 19070, 93000 and 93013 (CDM allied health services).
- The collective cap of 10 services can be made of any combination of up to 10 allied health services for First Nations Australians, and up to 5 CDM allied health services. Please refer to the example scenarios for further clarification.
- These changes do not affect the patient's entitlement to access both CDM and health assessment services where they are eligible and clinically appropriate.

Why are the changes being made?

This change is a result of a recommendation by the Medicare Benefit Schedule (MBS) Review Taskforce (Taskforce), which was informed by the Allied Health Reference Group. More information about the Taskforce and associated Committees is available on the Department of Health and Aged Care website. The clinical committee final reports can be found on the Department's website.

What does this mean for providers/referrers/other stakeholders?

- GPs/ Prescribed medical practitioners (a medical practitioner other than a GP, specialist, or consultant physician) will be able to refer for up to 10 individual MBS eligible health services per calendar year if the patient identifies as a First Nations Australian and has a CDM plan **OR** has had a health assessment.
- To refer for up to 10 allied health services, GPs/Prescribed medical practitioners should refer using the new '*Referral form for eligible allied health services under Medicare for people of Aboriginal or Torres Strait Islander descent*' or a document that contains all components of the form.
- Allied Health professionals will be able to provide up to 10 MBS eligible services per patient, per calendar year, with a valid referral.

Example Scenarios

Example One: A GP conducts a health assessment for a patient who identifies as being a First Nations Australian, and identifies the patient's need for both dietetic and exercise physiology services. The GP refers for 6 dietetic services and 4 exercise physiology services using the '*Referral form for eligible allied health services under Medicare for people of Aboriginal or Torres Strait Islander descent*'.

Example Two: The chronic condition of a patient who identifies as being a First Nations Australian is being managed by their GP under an existing CDM plan. They have claimed 5 physiotherapy services (10968) that calendar year. They were referred to these services using the '*Referral form for chronic disease allied health services under Medicare*' of which a maximum of 5 services can be referred. This referral form is not specific to patients who are First Nations Australians. To ensure that the patient can receive the full entitlement of up to 10 services per calendar year, the

GP refers for a further 5 physiotherapy services using the '*Referral form for eligible allied health services under Medicare for people of Aboriginal or Torres Strait Islander descent*'.

How will these changes affect patients?

The changes will streamline access for First Nation Australians needing individual MBS eligible health services. They will no longer need to have a CDM plan and a health assessment to access up to 10 referred individual eligible health MBS services.

Who was consulted on the changes?

Consultation was undertaken with stakeholders through the First Nations Implementation Liaison Group (ILG). Members of the ILG included the Australian Medical Association, Indigenous Allied Health Australia, Indigenous Urban Institute of Health, National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, Royal Australian College of General Practitioners, Services for Australian Rural and Remote Allied Health, and the Rural Doctors Association of Australia.

How will the changes be monitored and reviewed?

The Department regularly reviews the usage of new and amended MBS items in consultation with the profession. All MBS items are subject to compliance processes and activities, including random and targeted audits, which may require a provider to submit evidence about the services claimed.

Where can I find more information?

The full item descriptor(s) and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health and Aged Care provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the *Health Insurance Act 1973* and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Private health insurance information on the product tier arrangements is available at www.privatehealth.gov.au. Detailed information on the MBS item listing within clinical categories is available on the Department's website. Private health insurance minimum accommodation benefits information, including MBS item accommodation classification, is available in the latest version of the *Private Health Insurance (Benefit Requirements) Rules 2011* found on the Federal Register of Legislation. If you have a query in relation to private health insurance, you should email PHI@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact the Services Australia on the Provider Enquiry Line – 13 21 50.

The data file for software vendors when available can be accessed via the Downloads page.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation. This factsheet is current as of the Last updated date shown above and does not account for MBS changes since that date.