Australian Government
Department of Health, Disability and Ageing

Hearing Services Program

Compliance Update December 2025

5 December 2025

Provider Compliance

The Department of Health, Disability and Ageing administers the Australian Government Hearing Services Program. The program works with contracted service providers to support their compliance. The program monitors provider compliance under the Compliance Monitoring and Support Framework.

This Compliance Update includes:

- information on supports available.
- lessons learned during 2024-25.
- the focus for compliance in 2026.

Providers should review their processes to ensure they remain compliant with the program requirements.

Provider Compliance Support

The program works to ensure clients receive quality hearing services. The program has a range of supports available to help providers and their staff with compliance. These include:

- the program website – www.health.gov.au/hear
- Contact Information Centre – hearing@health.gov.au or 1800 500 726
- Schedule of Services Items and Fees
- Program Resources including Fact sheets, Provider Notices, Program Forms, User Guides etc
- Provider Handbook
- Compliance Information

The program also welcomes suggestions on how we can support providers to improve compliance. We are happy to work with individual providers or industry groups to support training, compliance processes and template reviews.

Provider Self-Assessment

All providers are required to complete the provider self-assessment (SAT) annually. The SAT is mandatory for all program providers and is an opportunity for providers to review their processes and ensure they are compliant with program requirements. In 2025, the SAT was released on 15 September 2025, and providers had six weeks to complete it. The department automatically audits any provider who does not submit their SAT.

2026 Compliance Priorities

The program continues to implement a robust risk-based compliance monitoring approach, which includes provider self-assessments, audits, and claim reviews. In 2026, our focus will include both service delivery integrity and digital transformation. Key priority areas are:

- Partially subsidised device supply
- Refitting
- Replacements
- Specialist Clients
- Large Provider Compliance Checks
- Provider Audits
- Claim Reviews
- Practitioner Approved Member Checks

Training and support will be provided to ensure a smooth transition to the new HSO Portal and service items and program standards. These changes will enhance efficiency, streamline provider interactions, claims, and compliance reporting.

Key Compliance Issues

Client Relocations and Client Records

Program clients have the right to choose where they receive hearing services and may transfer to another provider at any time.

Providers must:

- Send the complete client record promptly and securely within 7 business days.
- Use registered post or other secure methods to prevent loss of files.
- Avoid sending records via unencrypted email to protect client information.
- Ensure all files are complete before transfer.

Failure to comply may result in breaches of privacy obligations and program requirements and may require Notifiable Data Breach notifications.

Actions Required

1. If the client record is not received within the required timeframe:
   - First, follow up with the client's previous provider.
   - If you are still unable to obtain the file, contact the program immediately.
2. Do not send client files via express or general post.
   - It is a program requirement under the Schedule to send records by registered post or courier, ensuring delivery is trackable and signed for.
3. For digital records:
   - Use secure transfer methods outlined in the Schedule; options other than encrypted email are available.

4. Do not replace a digital record with a printed copy.
5. For any questions or concerns about relocations, follow the advice in the Schedule.

Client Goals and Rehabilitation Planning

Providers must ensure that client goals are documented and evaluated in accordance with the Schedule, with evidence retained in the client record.

- All rehabilitation plans must be based on the client's documented goals.
- Client records must include a review of goals for each Assessment and Client Review service.
- Goals must be evaluated during Client Review and/or Fitting follow-up services.
- Tick boxes or comments such as "goals are the same" are not acceptable as evidence.

Revalidated Services

There continues to be inappropriate requests and claims for revalidated services, including:

- Requests without sufficient evidence
- Requests submitted after the service was completed
- Claims without prior approval
- Missing required documentation

When applying for a revalidated service:

1. Provide comprehensive information about the client's situation and clinical needs.
2. Include a clear explanation of how the proposed device/s will address these needs.
3. Avoid vague descriptions such as updated technology, as these are insufficient and delay approval and client access to services.

For detailed guidance, refer to the information on revalidated services available on the program website.

Practitioner Management

While providers have made notable improvements in managing Qualified Practitioners (QPs), several compliance issues remain. These issues impact service delivery and claims processing under the program.

- QP numbers issued to non-qualified personnel.
- Failure to verify Practitioner Professional Body (PPB) membership renewal, resulting in ineligible practitioners delivering and claiming services.
- Inaccurate portal records, such as missing end dates for provider/QP links.
- Issuing duplicate QP numbers causes compliance and billing errors; always verify if a practitioner already has a QP number before creating a new one.

Compliance Reminder: Services can only be delivered and claimed when the QP has an active PPB membership in an approved category on or before the service date. Membership must be renewed annually after **1 July**; otherwise, services cannot proceed until renewal is complete.

Actions Required:

1. Confirm if a practitioner already holds a QP number before requesting a new one.
2. Link QPs to your business in the portal upon receiving their QP number.
3. After completion of work with an employer, the QP number must be unlinked from their business through the portal.

Refer to the Portal Quick Reference Guide and Practitioner Information on the program website for detailed instructions.

Other Issues

1. **Voucher Checking and Service Availability:** Before delivering any services, verify the client's voucher status. Clients must be informed whether a service is covered by the program. Providers should confirm available services by reviewing the client's record in the portal.
2. **Record Keeping:** Recent complaint investigations and compliance reviews have highlighted ongoing issues with inadequate record keeping.
   - Tick boxes alone are not acceptable as evidence of an activity and do not support continuity of care.
   - Providers must maintain detailed notes of discussions and information provided to clients.
   - This is especially critical when there is no other supporting evidence, such as audiograms or COSI goals.
3. **Assessment and Client Reviews on the Same Day:** If assessments and client reviews occur on the same day, ensure the client record shows all required activities for both services. Refer to the Schedule for more information.
4. **Specialist Clients:** Clients who meet the specialist criteria must be offered services under the Community Services Obligations (CSO) component of the program. Refer to the Schedule (Section 38) for detailed requirements.

If a client meets any specialist criteria:

- Tick the Complex Client box in the client record within the portal.
- Ensure CSO services are offered in line with program requirements.

1. **Device Option Discussions:** Ensure clients are offered a fully subsidised device and feel no pressure to choose partially subsidised options, as this has been a recurring concern.
2. **Eligibility Criteria for Refitting:** Clients are not automatically eligible for refitting every five years. Providers must confirm clinical necessity and demonstrate that the current device is no longer suitable before offering a new device. The client record must document the assessment of the previous devices, the reason they are no longer suitable and the evidence meeting the specific ECR requirements.
3. **Returned Devices:** If a client returns devices within the returns period, providers must recover the original fitting claim. When no further fitting will occur, providers may claim Item 1 (monaural) or Item 2 (binaural) to cover the initial fitting time.

4. **Teleaudiology:** Providers must document in the client record whenever a service is delivered via teleaudiology.
5. **Provider Details in the Portal:** Providers must update any changes to contact details, site information, or QP details in the portal within 5 days of the change.

Evidence Requirements

Follow the Schedule for evidence requirements.

Fully document every service in the client record; lack of evidence means services cannot be verified.

Common compliance gaps:

- No record of client goals or evaluation at follow-up/review.
- No check of current device suitability or eligibility criteria before refitting.
- Insufficient evidence when assessment and review occur on the same date.
- No proof that fully subsidised devices were offered.
- Client must personally date signed forms; prepopulated dates are prohibited.
- Detailed notes are mandatory—tick boxes alone are not acceptable evidence.

Common Claiming errors identified during audits.

During our Claim Review audits, we identify errors in submitted claims. The claim requirements must be met prior to claiming for an item. If any discrepancies are found, recovery and reimbursement to the program will be required. Some of the most common errors observed include:

- **Maintenance Date of Service within 12 months of fitting item Date of Fitting** - where a fitting takes place a maintenance item cannot be claimed with a Date of Service on or within 12 months after the Date of Fitting.
- **Different replacement device when previous device was still on approved Device Schedule at time of replacement** – if a lost/DBR (damaged beyond repair) device is still on the approved Device Schedule it cannot be replaced with a different device (code), it must be replaced with the same device (code) as the lost/DBR device (code), unless the requirements of section 76(8) of the Schedule are met.
- **Binaural item claimed when client is monaurally fitted** – where a client Fitting Configuration changes from binaural to monaural, binaural service items 710, 722, 940 etc cannot be claimed.
- **Replacement Date of Service does not match replacement Date of Fitting** – replacements do not require a follow-up, the Date of Service must match the Date of fitting of the item 840 or 850.
- **Incomplete update of or missing private aid device details recorded against the Service History table in the portal** – where a private aid is being maintained through the program, the Device Type, Device Code to one or both ears must be recorded on the Service History table, the Fitting Configuration must be updated to reflect monaural or binaural and the private device must be on the approved Device Schedule.
- **Refits where Date of Fitting within previous voucher period and Date of Service within current voucher period, however a fitting already exists on the previous**

voucher – if a fitting has already been claimed against the previous voucher a second Date of Fitting within that same voucher period cannot take place.

- **Refits provided when a replacement has taken place since the last fitting** – refits must be assessed and based on the device a client is currently wearing, which could be a device that was fitted or a device that was replaced. The current device must be assessed and found to be no longer suitable before a new device is offered.

Claiming

Rejected claims increase provider workload and delay payments for completed services.

To avoid rejections, ensure the following before submitting a claim:

- Verify the service has not already been delivered or claimed (avoid duplicates).
- Confirm the correct voucher is active on the date of service.
- Ensure the practitioner is linked to the provider for the service date and the correct QP number is used.
- Do not claim maintenance before the current maintenance period expires.
- Select the correct service item (e.g., refitting vs. subsequent initial fitting).
- Check all dates for accuracy – fitting dates must not be after the date of service.
- Validate QP numbers and site IDs before submission.
- Include all required details, such as 3FAHL values for assessments, fittings, and reviews, and ensure these values are correct.
- Confirm Cost to Client amounts are accurate, including Partially Subsidised amounts and Total cost to client.

Program Reimbursements

Providers must reimburse any claims that do not meet legislative and contractual requirements. This includes services delivered by practitioners who were not financial, approved PPB members on the date of service or date of fitting. Compliance must be verified at the time of service and before submitting a claim, providers cannot rely solely on the hearing services online portal for compliance checks.

As required under the Service Provider Contract:

- Verify the client has a valid voucher and the service is eligible.
- Ensure all conditions for claiming are met prior to submission.
- Confirm claim details are complete, accurate, and correct.

Providers are reminded that they should be confirming the client has a valid voucher and that the service to be delivered is available on the voucher before providing services. A client can only be charged for private services if they have been provided with all required information prior to the service being delivered. Providers cannot charge a client for services if a claim is rejected or recovered.