Frequently asked questions for patients and guardians: Medicare services for eligible disabilities

Patient Eligibility

Who can seek a diagnosis of a disability through Medicare?

Any person under 25 years of age who is suspected of having one of the Medicare-eligible disabilities can seek a diagnosis through Medicare.

What is an eligible disability?

If a person is suspected of having or has been diagnosed with one of the following disabilities, they can access certain Medicare benefits.

- Angelman syndrome
- cerebral palsy
- CHARGE syndrome
- Cri du Chat syndrome
- Cornelia de Lange syndrome
- deafblindness
- Down syndrome
- fetal alcohol spectrum disorder (FASD)
- Fragile X syndrome
- hearing impairment that results in:
  - a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or permanent conductive hearing loss and auditory neuropathy
- Kabuki syndrome
- Lesch-Nyhan syndrome
- microcephaly if a child has:
  - a head circumference less than the third percentile for age and sex
  - and a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence*
- Prader-Willi syndrome
- sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
- Rett syndrome (previously Rett's disorder)
- Smith-Magenis syndrome
- Williams syndrome
- 22q deletion syndrome
- stuttering
- speech sound disorders, including:

    - articulation disorder
    - phonological disorder
    - childhood apraxia of speech (also known as dyspraxia, developmental verbal dyspraxia, or speech apraxia), and
    - dysarthria
- cleft lip and/or palate

Can disabilities other than those on the list of eligible disabilities be considered for the assessment and treatment services?
No, Medicare benefits for these services are limited to these disabilities.

Diagnosis

Do I need a referral for a diagnosis through Medicare?
This depends on who is making the diagnosis. If the GP makes the diagnosis, you do not need a referral. Where a specialist or consultant physician makes the diagnosis, then the GP will write a referral to the specialist or consultant physician.

Are allied health assessments required for a diagnosis?
No, an allied health assessment is not required for a diagnosis. If the GP, specialist or consultant physician determines that an allied health assessment is needed, they can make a referral.

Are there any types of testing/assessments that allied health professionals need to undertake to assist with the formulation of a diagnosis?
It is up to the allied health professional to determine which tests are clinically appropriate.

Does a referral to an allied health practitioner for assessment need to specify the number of assessment services?
No. The number of assessment services does not need to be on the referral. Eligible allied health practitioners can provide up to four assessment services per patient from one referral.

If a patient needs more than four assessment services from the same allied health provider, the doctor must agree. It is up to the allied health provider to consult with the doctor to get their agreement.

A maximum of eight Medicare allied health assessment services (82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041) can be claimed per patient up to the age of 25 years.

Can I only get one diagnosis of an eligible disability through Medicare?
You can get more than one diagnosis of an eligible disability in your lifetime. However, only one of the four Medicare diagnosis items (137, 139, 92141 or 92142) can be used in your lifetime.

These items are used if there is a diagnosis (or previous diagnosis) of an eligible disability and the doctor develops a treatment and management plan.

If these Medicare items have already been claimed, then a general attendance item can be used instead.

Example: a doctor diagnoses a patient with an eligible disability and uses item 139 for the consultation in which they confirm a diagnosis, write a treatment and management plan, and refer the patient for allied health treatment. If a doctor conducts an additional diagnosis for

another condition on the eligible disability list with the same patient at a later stage, they will not be able to use any of the items 137, 139, 92141 or 92142, but may wish to consider using a clinically appropriate general attendance item for the consultation.

Treatment

How do I know if I am eligible for treatment?

You are eligible for the allied health treatment services (82010, 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044) if you are under 25 years and have a confirmed diagnosis of an eligible disability. Your doctor will need to develop a treatment and management plan and provide a referral for allied health treatment services.

What treatments will be provided by an allied health professional?

The treatment must be consistent with the treatment and management plan. The plan is prepared by the referring doctor in keeping with commonly established interventions as practised by the health professionals and appropriate for the age and needs of the patient being treated. Allied health professionals may contribute to the patient's treatment plan where appropriate.

Do I need a referral for allied health treatment?

Yes. Medicare benefit eligibility for allied health treatment requires a diagnosis of an eligible disability, a treatment and management plan, and a referral from a doctor.

A separate referral is required for each allied health practitioner providing treatment services.

When do I need a new referral for treatment?

The referring doctor will put the number of treatment services (up to 10 services per referral) on your referral. There is a maximum of 20 treatment services available per patient lifetime for the treatment items under Medicare (82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044).

After the referral services are used, the allied health professionals must provide your referring doctor with a written report. When reviewing the report, the doctor will decide if a new referral is needed for more treatment services.

Claiming Requirements

Where can the services be provided?

The services can be provided in consulting rooms, or elsewhere (such as at the patient's home or school).

How long is a referred allied health assessment or treatment service?

A service for an assessment or contribution to a treatment and management plan must be at least 50 minutes in duration.

A service for treatment must be at least 30 minutes in duration.

What number of allied health assessment or treatment services can be claimed per day?

Up to four assessment or treatment services may be provided to the same patient on the same day.

How do I find out what number of allied health services have been claimed?

You can find this information by:

- calling the Services Australia patient information line on 132 011.
- reviewing claims for the past three years through your Medicare account if linked in your www.My.Gov.au account. For claims made prior to this time, Service Australia will need to be contacted directly via the patient information line.
- checking claims via the Medicare Express Plus App, My Health Record app or through the My Health Record when linked with your www.My.Gov.au account.

Can an allied health practitioner provide non-referred assessment or treatment services?

Yes. However, these services will not be eligible for a Medicare rebate.

Where can I find information on Medicare services?

Information on the Medicare items, explanatory notes and fact sheets can be accessed via the following link - www.mbsonline.gov.au.

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 sheet is current as of the last updated date shown and does not account for MBS changes since that date.