Australian Government
Department of Health, Disability and Ageing

ASKMBS ADVISORY

Allied health services – Part B
Mental health treatment

Updated March 2026

Contents

The AskMBS advice service

AskMBS is located in the Australian Government Department of Health, Disability and Ageing. AskMBS is an email advice service providing advice to health professionals and other users of the Medicare Benefits Schedule (MBS) on the interpretation and application of MBS items, explanatory notes and associated legislation, to assist them in billing Medicare correctly.

This and other AskMBS advisories focus on a particular provider group or area of practice and allied mental health services have been selected as the focus of this issue. Here you will find targeted advice on 'hot' topics–that is, topics on which AskMBS gets many enquiries. Future advisories will be published on a quarterly basis as well as ad hoc, as required.

The complete MBS, including item descriptors and explanatory notes as well as a range of related information resources, is available at: MBS Online.

For the sake of brevity, the term 'Better Access' is used to refer to the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative.

Note that some of the information in this advisory is necessarily broad in nature, reflecting AskMBS responses to a range of enquiries on the same issue. Please contact AskMBS at askMBS@health.gov.au for clarification of any specific issues.

Disclaimer: The information in this advisory is current and accurate as of March 2026. Medicare policy changes over time in response to a range of factors, and providers of MBS services should maintain their awareness of current policy settings and item requirements by monitoring advice issued by the Department of Health, Disability and Ageing through channels such as direct communications and MBS Online, and by seeking clarification from AskMBS when necessary. Please note that advice provided by AskMBS does not constitute legal advice. Providers should seek their own legal advice if concerned about legal aspects of MBS services they provide.

1. Bulk billing

1.1. Am I required to bulk bill?

You are required to bulk bill only where a mandatory bulk billing requirement applies to specified items – as was briefly the case, for example, with the COVID-19 telehealth items following their introduction. Where bulk billing is not an item requirement, a Medicare provider is not required to bulk bill and is free to set the fee they charge for a professional service. This is called private or patient billing. This allows an allied health professional, for example, to charge a fee for an extended consultation which compensates them for the additional time spent.

Where a provider charges more than the Medicare benefit for a consultation (or any MBS item), the professional service cannot be bulk billed. The patient will be responsible for the difference between the benefit and the actual cost of the service. Under the principle of informed financial consent, patients should be made aware in advance of any out-of-pocket costs they may have to pay for a service.

1.2. When bulk billing a service, can I charge the patient an additional fee?

No. When bulk billing, a patient agrees to assign their Medicare benefit to the provider who accepts the benefit as full payment for the service. This condition is legislated in section 20A of the *Health Insurance Act 1973*. In these circumstances the provider will receive payment directly from Medicare. If you bulk bill a patient you cannot impose additional charges for that service—for example, it is not permitted to charge a 'gap fee' that results in out-of-pocket costs to the patient.

The restriction on additional charges for a bulk-billed service applies even if you use a separate invoice. No matter how the arrangement is described, if the practical effect is that you require patients to pay additional charges, then the professional service cannot be bulk billed.

For allied health services subsidised through private health insurance, many practices use payment systems such as HICAPS which allow for the patient to pay the gap between their private health cover and the cost of the service. Medicare rules do not allow the same approach for bulk billed services.

Note that patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for their allied health services. Patients cannot use their private health insurance ancillary cover to ‘top up’ the Medicare benefit/s paid for these services.

2. Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative

See a full list of Better Access MBS items at Appendices A and B. Full item descriptors can be viewed by searching MBS Online for the item number at www.mbsonline.gov.au.

For more information, see the following MBS explanatory notes which can be viewed by searching MBS Online for the note numbers.

- AN.0.78 – Better Access initiative
- AN.0.56 – GP mental health treatment plans and consultations
- AN.15.1 – Mental health case conferences
- AN.15.6 – Referral requirements for allied health and other primary health care services
- MN.6.2 – Provision of psychological therapy
- MN.6.3 – Referral requirements for Better Access treatment services
- MN.7.4 – Provision of focussed psychological strategies services
- MN.7.5 – Family and carer participation

2.1. What services are available to patients under Better Access?

Under Better Access, eligible patients can claim a Medicare benefit for up to 10 individual and 10 group therapy mental health treatment services per calendar year (1 January to 31 December). These services consist of:

- psychological therapy services - provided by eligible clinical psychologists (refer to explanatory note MN.6.2 – Provision of psychological therapy; and
- focussed psychological strategies (FPS) services - provided by eligible general practitioners (GPs), eligible prescribed medical practitioners (PMPs), eligible psychologists (registered), eligible occupational therapists, and eligible social workers (refer to explanatory note MN.7.4 – Provision of focussed psychological strategies

The 10 individual mental health treatment services can include:

- face-to-face consultations; or
- telehealth (video and phone) attendances; or
- a combination of face-to-face and telehealth attendances.

Patients can also access up to 10 group therapy mental health treatment services. These services are **in addition** to the 10 individual services.

The 10 group therapy mental health services can include:

face-to-face consultations; or

telehealth (video) attendances for patients residing in Modified Monash Model (MMM) 4-7 areas only i.e. patients in rural and remote areas.

Patients may also receive a referral for a course of individual mental health treatment services and group therapy mental health treatment services at the same time.

For more information on the Better Access initiative, see the factsheets on the department's website at: Better Access Initiative resource collection | Australian Government Department of Health, Disability and Ageing and the guidance material at: Mental health and suicide prevention resources | Australian Government Department of Health, Disability and Ageing

2.2. What are the patient eligibility requirements for Better Access services?

The Better Access initiative is available to eligible patients who have been assessed by a GP, PMP, psychiatrist or paediatrician as having a mental disorder requiring at least moderate care needs and who would benefit from a structured approach to the management of their treatment needs.

A mental disorder* means a significant impairment of any or all of an individual's cognitive, affective and relational abilities that:

a) may require medical intervention; and

b) may be a recognised, medically diagnosable illness or disorder; and

c) is not dementia, delirium, tobacco use disorder or mental retardation.

To be eligible for a Medicare benefit under Better Access, a patient must have either a mental health treatment plan (MHTP) or a psychiatrist assessment and management plan (PAMP) in place which identifies and documents the care the patient care needs, supporting a structured approach to treatment.

In addition, a Medicare benefit will only be paid if the patient has a valid referral for mental health treatment services. The referral must have been undertaken by either a GP or PMP at the general practice they are enrolled in for MyMedicare, or their usual medical practitioner. This includes a GP or PMP who is located at the medical practice that has provided the majority of a patient's care over the previous 12 months or will be providing the majority of a patient's care over the next 12 months. This restriction does not apply if a patient has received a direct referral from a psychiatrist or a paediatrician.

Information on MyMedicare, including eligibility requirements, how to register, and exemptions to eligibility requirements, is available on the MyMedicare website.

* Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10, Chapter 5, Primary Care Version), developed by the World Health Organisation, 1996

2.3. Are there family and carer participation services available under Better Access?

Yes. Under Better Access, a family member or carer can access Medicare benefits for up to 2 services per calendar if the patient consents to including their family member or carer in their mental health treatment, **and** the patient is not in attendance.

The family and carer participation services are designed to focus only on supporting the patient's treatment and recovery, not for a family or carer to discuss their own mental health.

Services may be accessed by a patient's family member or carer at any stage in their course of treatment and do not need to be accessed consecutively. These services will count towards:

- a patient's initial course of treatment under Better Access – a maximum of 6 services; and
- a patient's subsequent course of treatment under Better Access – the remaining services either up to the maximum of 6 services or remaining annual cap of up to a maximum of 10 services per calendar year.

For example, if a patient has received a referral for 6 services in their initial course of treatment, and 2 of these services are provided to a family member or carer, they will only receive 4 individual services. They will then need to see their referring practitioner for a review to determine if they require a subsequent course of treatment where they may receive the remaining 4 services.

For further information on involving another person in a patient's treatment, refer to explanatory note MN.7.5 – Family and carer participation

2.4. Are there mental health case conferencing services under Better Access?

Yes. There are 21 MBS items for the provision of mental health case conferencing services to establish and coordinate the management of the care needs of a patient involving a multidisciplinary team.

Mental health case conferences using these MBS items can be held for patients who have been referred for treatment under the Better Access initiative by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare or, regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner. GPs or PMPs, and eligible allied health professionals or other members of the multidisciplinary team (e.g. psychiatrists or paediatricians) do not need to have an existing relationship with the patient. However, they must have agreed to and must be able to provide advice on the treatment and care they can or will provide the patient for the management of their condition.

Further information can be found in explanatory note AN.15.1 – Mental health case conferences

2.5. What are the eligibility criteria for allied mental health professionals to deliver Better Access mental health treatment services?

To participate in Medicare, a practitioner must hold a current registration with a relevant Australian registering body, such as the Australian Health Practitioner Regulation Agency (Ahpra). The practitioner must also meet other requirements such as maintaining their qualifications and obtaining a provider number.

To provide Medicare services under the Better Access initiative, allied health professionals must be registered with Services Australia and hold a valid provider number. For information on the qualification requirements for allied health professionals who are able to provide mental health services under Medicare, refer to Schedule 1 (Qualification requirements for allied health professionals) in the Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024. To be able to provide services which attract a Medicare benefit, you will need to demonstrate that you meet one of these qualifications and are registered with the appropriate body:

Eligible clinical psychologists

Psychological therapy services under the MBS can only be provided by eligible clinical psychologists. A person is an eligible allied health professional in relation to the provision of a psychological therapy health service if the person:

holds general registration in the health profession of psychology with the Psychology Board of Australia; and is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Eligible registered psychologists, eligible occupational therapists and eligible social workers

A person is an eligible allied health professional in relation to the provision of a focussed psychological strategies health service if the person meets one of the following requirements:

d) the person holds general registration in the health profession of psychology with the Psychology Board of Australia; or

e) the person is a member of the Australian Association of Social Workers (AASW) and accredited by AASW as meeting the accreditation criteria set out in the document published by AASW titled 'AASW Accredited Mental Health Social Worker Application Criteria' as in force on 1 July 2022; or

f) the person:

   i. holds registration in the health profession of occupational therapy with the Occupational Therapy Board of Australia; and

   ii. is accredited by Occupational Therapy Australia as meeting the criteria for mental health endorsement as set out in the document published by Occupational Therapy Australia titled 'Occupational Therapy Australia Mental Health Endorsement Criteria' as in force on 1 March 2023.

More information on the eligibility criteria for the provision of psychological therapy services and focussed psychological strategies services are set out in explanatory notes MN.6.2 and MN.7.4 on MBS Online.

2.6. What approved strategies can be used when providing focussed psychological strategies services?

A range of acceptable strategies are approved for use by eligible allied health professionals utilising the FPS items. These include:

- psycho-education
- cognitive-behavioural therapy that involves cognitive or behavioural interventions
- relaxation strategies
- skills training
- interpersonal therapy
- eye movement desensitisation and reprocessing; and
- narrative therapy (for Aboriginal and Torres Strait Islander peoples).

2.7. Can patients in residential aged care facilities access Better Access services?

Yes. Medicare benefits are available for up to 10 individual and up to 10 group therapy mental health treatment services per calendar year to patients with an assessed mental disorder living in a residential aged care facility (RACF). Referral options to Better Access services will depend on a patient's circumstances.

To access Better Access services, Commonwealth-funded residents living in a RACF must receive a direct referral from a psychiatrist for mental health treatment services delivered by eligible general practitioners, eligible PMPs, eligible clinical psychologists, eligible registered psychologists, eligible social workers and eligible occupational therapists.

3. Referrals and reports

3.1. What is the difference between a mental health treatment plan and a referral?

Mental health treatment plan

A mental health treatment plan (MHTP) is a structured plan developed by a GP or PMP in collaboration with a patient to manage and treat their mental health condition/s. An MHTP is not a referral—rather, it outlines the patient's treatment goals, strategies, and support services, and enables them to access Medicare benefits for up to 10 individual and 10 group therapy mental health treatment services per calendar year (1 January to 31 December).

Before proceeding with an MHTP service, the GP or PMP at the patient's MyMedicare registered practice, or their usual medical practitioner, must:

- explain the MHTP process to the patient and, if appropriate, their carer (with consent)
- obtain and record the patient's agreement to proceed.

An MHTP must be documented in writing and include:

- assessment of the patient's mental disorder
- administration of an outcome measurement tool (unless clinically inappropriate)
- formulation of the disorder, including a provisional or formal diagnosis.

An MHTP does not expire and is considered a 'living document.' A new MHTP is only needed if there's a significant change in the patient's mental health.

Further information about MHTPs can be found in MBS explanatory note AN.0.56 – GP mental health treatment plans and consultations

Referral

A referral is a formal document prepared by a GP or PMP at the general practice a patient is enrolled in for MyMedicare, or their usual medical practitioner. Where appropriate, and with the patient's agreement, a copy of the MHTP can be attached to the referral. See section 3.2 below for referral requirements.

Referrals for mental health treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

For the purposes of Better Access mental health treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note MN.6.3 – Referral requirements for Better Access treatment services

3.2. What information needs to be included in a referral before I accept it?

Referring practitioners are not required to use a specific Medicare form to refer patients for Better Access mental health treatment services. Explanatory notes MN.6.3 – Referral requirements for Better Access treatment dervices and AN.15.6 – Referral requirements for allied health and Aboriginal and Torres Strait Islander health and wellbeing services set out the requirements when referring patients to MBS supported allied health services.

When preparing referrals under the Better Access initiative, the referral should be in writing (signed and dated by the referring practitioner) and include key information such as:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis;
- a list of any current medications;
- the number of services the patient is being referred for; and
- a statement about whether the patient has had a MHTP or a PAMP prepared.

A referral should include all of these details, and any additional information outlined in AN.15.6 – Referral requirements for allied health and other primary health care services, to assist with any auditing undertaken by the Department of Health, Disability and Ageing. For the same reason, it is a legislative requirement that the allied health professional retains the referral for 2 years from the date the service was rendered.

Eligible GPs and eligible PMPs who provide focussed psychological strategies services do so as part of an arrangement for the treatment of an assessed mental health disorder under an MHTP. Where appropriate, and with the patient's agreement, a copy of the MHTP can be attached to the referral.

Allied health professionals are not obliged to accept a referral if they have concerns. If there is any uncertainty about the intent or content of the referral, they should contact the referring practitioner for clarification. This clarification may be provided through an amended referral, via email, or by other correspondence.

3.3. Does a referral for Better Access mental health treatment services have to specify the number of services being referred?

A referral for Better Access services must specify the number of services a patient is being referred for.

Where an allied health professional under the Better Access initiative receives a referral that:

- does not specify the number of services;
- specifies a number of services above the maximum allowed for the course of treatment; or
- specifies a number of services above the maximum allowed for the calendar year (including any services the patient has already received that year),

the eligible allied health professional should contact the referring practitioner to determine the required number of services required. However, if the allied health practitioner is unable to get in contact with the referring practitioner to confirm the number of services, they can use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of services allowed for that particular course of treatment (as set out below); and
- the maximum number of services allowed in a calendar year.

In these circumstances, the allied health professional must provide a report at the end of a course of treatment in line with standard practice for these services. This enables the referring medical practitioner to consider the treating practitioner's report on the services provided to the patient, and the need for further treatment. The maximum number of individual services allowed in a calendar year for each course of treatment is as follows:

- Initial course of treatment – a maximum of 6 services.
- Subsequent course/s of treatment – a maximum of 6 services up to the patient's cap of 10 services. For example, if the patient received 6 services in their initial course of treatment, they can only receive 4 services in a subsequent course or courses of treatment.

These limits do not apply to group therapy services as up to 10 group therapy services can be specified in a single referral.

If the patient reaches the maximum number of services allowed in a calendar year during a course of treatment, the allied health professional can continue to use the referral to complete the course of treatment the following calendar year, where clinically appropriate. Note however that those services will count towards the patient's allocation of services for that year. Where the patient's maximum allocation per course of treatment is unknown, providers may contact Services Australia on the Medicare Provider Enquiry Line (132 150) to confirm the patient's remaining allocation of services.

Further to this, please note that AN.15.6 – Referral requirements for allied health and Aboriginal and Torres Strait Islander health and wellbeing services sets out referral requirements. While the department understands there may be an additional workload for psychologists should this information not be provided, including the additional requirements outlined in MN.6.3, the department encourages allied health professionals to review referrals in the first instance prior to seeing a patient to ensure requirements have been met.

3.4. Does a patient need a new referral each calendar year?

A referral remains valid until the patient has received all of the services specified in or available under the referral.

Where the number of mental health treatment services shown on the referral are not used by the end of the calendar year, the remaining mental health treatment services on the referral will be valid for use in the next calendar year. However, any mental health treatment services used in the next calendar year count towards the maximum cap of services for that calendar year.

3.5. What are the reporting requirements for Better Access services?

Allied health professionals who perform psychological therapy services or focussed psychological strategies services under the Better Access initiative must provide a report back to the referring practitioner after the completion of each course of treatment. The report informs the referring practitioner on the patient's progress and the treatments provided and allows the referring practitioner to determine if additional services are required.

On completion of the initial course of treatment, the treating eligible allied health professional providing the service must provide a written report to the referring practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder (e.g. if they require a subsequent course of treatment as the initial course of individual services is only up to 6 services, with the subsequent being no more than the maximum of 10 services per calendar year), noting further treatment under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

A written report must also be provided to the referring practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

A verbal report does not meet the legislative requirements for Medicare benefits to be payable. Further information about the reporting requirements relating to these services can be accessed in explanatory notes MN.6.2 – Provision of psychological therapy and MN.7.4 – Provision of focussed psychological strategies on MBS Online.

3.6. Where a referral names an allied mental health professional, can the patient choose to see someone else? Does the patient have to see the same provider for all services under the referral?

Where a referral includes the name of an allied health professional, the patient can still choose to see a different allied health professional in that same allied health discipline. If the patient chooses to see a different allied health professional in that discipline, it is not necessary for the patient to revisit their general practitioner or prescribed medical practitioner to obtain a new referral.

Any new allied health professionals should check the number of services the patient has already claimed with Services Australia (on 13 21 50) or access the Health Professional Online Services (HPOS) to view a patient's MHTP history, to ensure compliance with the legislative requirement that a patient be reviewed by the referring practitioner following the completion of the course of treatment.

4. Telehealth services

See a full list of Better Access MBS items at Appendices A and B. Full item descriptors can be viewed by searching MBS Online for the item number at www.mbsonline.gov.au.

For more information, see the following MBS explanatory notes which can be viewed by searching MBS Online for the note number.

- Note AN.1.1 – Eligibility criteria for MBS telehealth (video and phone)
- Note MN.6.2 – Provision of psychological therapy
- Note MN.7.4 – Provision of focussed psychological strategies

4.1. Can patients access Better Access mental health treatment services by telehealth?

Yes. Better Access telehealth (video and phone) services are available to patients with a diagnosed mental disorder who would benefit from a structured approach to their treatment needs. People who might otherwise have not been able to take up mental health treatment services, because of where they live, will have access to services from their home or other convenient locations via telehealth.

This improved access will allow people in need of a mental health treatment service, including those living in rural, remote and very remote areas, to receive prompt treatment, and reduce the potential inconvenience, time and expense of having to travel to larger regional centres or major cities for services with their treating GP or PMP, or eligible allied health professional.

Further information can be found at Better Access Initiative resource collection | Australian Government Department of Health, Disability and Ageing

4.2. What are the requirements for the Better Access telehealth mental health treatment services?

If an eligible person with a clinically diagnosed mental disorder is accessing individual Better Access mental health treatment services via their eligible GP or eligible PMP or their eligible allied health professional, they may be able to substitute their individual Better Access face-to-face treatment services via telehealth (video and phone).

It is important to note that Better Access telehealth focussed psychological strategies services provided by eligible GPs and eligible PMPs are exempt from the eligible telehealth practitioner requirement (previously referred to as the 'established clinical relationship' or '12-month rule'). Information can be found at www.health.gov.au/resources/collections/better-access-initiative-resource-collection

No specific equipment is required to provide Medicare-compliant telehealth services however eligible GPs, eligible PMPs and eligible allied health professionals must ensure that the video is maintained throughout the telehealth (video) service and that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. More information is provided on MBS Online on the Guidance on Technical Issues technology and technical issues page.

Further information on MBS telehealth Services, including Better Access telehealth services, can be found on MBS Online at MBS Online – MBS Telehealth Services and also at Better

Access Telehealth frequently asked questions | Australian Government Department of Health, Disability and Ageing

Other resources include Office of the Australian Information Commissioner website and the Australian Cyber Security Centre website

4.3. Can I use a phone service even if the patient and I have the capacity for it to be undertaken by a video service?

Better Access mental health treatment services via telehealth (video and phone) may not be appropriate for all patients, particularly if there is concern that a person is at risk of doing harm to themselves or others, or if the patient does not have access to reliable or affordable broadband and/or technology required for video. The Department of Health, Disability and Ageing has previously funded the Australian Psychological Society (APS) to provide information, resources and operational advice to eligible health practitioners on:

- the initial assessment requirements to ensure the person and their presentation is suitable to be a recipient of Better Access telehealth (video and phone) services
- risk management procedures for managing patients at risk of self-harm or harm to others when delivering services via video
- the principles for choosing high-quality, safe technology to deliver Better Access telehealth (video and phone) services.

In addition, each of the relevant professional associations has undertaken to promote and explain the Better Access telehealth (video and phone) initiative to their members and contribute to any directories identifying appropriately skilled health practitioners.

4.4. Can Better Access group therapy mental health treatment services be provided via telehealth?

Yes, but by video only. Under Better Access, a Medicare benefit can be provided for group therapy mental health treatment services for groups of 4 to 10 patients, if a patient meets the eligibility requirements. Eligible allied health professionals can still claim group therapy MBS items if 4 patients were due to attend and 1 patient is unable to attend, regardless of the reason. The referring practitioner (GP, PMP, psychiatrist or paediatrician) may advise that in addition to individual treatment services, patients may like to attend group therapy mental health treatment services. Group therapy mental health treatment services offer a structured and empathetic setting where patients can share personal experiences and connect with others facing similar challenges, which fosters mutual support.

A patient's referring practitioner will need to determine whether group therapy mental health treatment is suitable, safe, and clinically appropriate for the patient. There are several MBS items for the provision of group therapy mental health treatment services offered via video to improve access to services for people in rural, remote and very remote locations. Geographic eligibility for these services is determined according to Modified Monash Model (MMM) classifications.

To be eligible for telehealth group therapy mental health treatment services under Better Access, the patient must be located in a Modified Monash Model (MMM) area 4-7 at the time of the consultation, and at least 15 kilometres apart by road from the allied health professional delivering the service. The patient or eligible allied health professional is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation item. More information about MMM areas, including a search tool to identify the classification of a specific location, is available at: Modified Monash Model

5. Eating disorder treatment services

For more information, see the following MBS explanatory notes which can be viewed by searching MBS Online for the note number at www.mbsonline.gov.au:

- MN.16.1 – Eating disorders – General explanatory notes
- MN.16.3 – Eating disorder psychological treatment (EDPT) services

5.1. What allied mental health items are patients with an eating disorder eligible for?

Once patients have a valid eating disorders treatment and management plan (EDP) in place, they are eligible for up to 40 eating disorder psychological treatment (EDPT) services (and up to 20 dietetic services) for 12 months from the date the EDP is finalised. An EDP must be completed by a medical practitioner in general practice, a GP, paediatrician or psychiatrist. A patient must have a valid EDP in order to access EDPT services.

To ensure an integrated, team-based approach to care, the patient must be reviewed by their managing medical practitioner after each course of eating disorder psychological treatment (i.e. after 10, 20, 30 EDPT services). The patient must also be reviewed by a psychiatrist or paediatrician before they can have more than 20 eating disorder psychological treatment services. For the purposes of EDPT items, a course of treatment is defined as the number of services requested in the referral, to a maximum of 10 services.

For the purposes of counting a patient's allocation of eating disorder services, services provided under the following items are included: 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 92182, 92184, 92186, 92188, 92196, 92198, 92200, 2721, 2723, 2725, 2727, 283, 285, 286, 287and items in Groups M6, M7 and M16 (excluding items 82350 and 82351). Note that if any services are provided to a patient using the Better Access items after the EDP is in place, these services count towards the patient's allocation of EDPT services.

Any 'unused' EDPT services from a patient's allocation under one EDP cannot be carried across to a new EDP developed for that patient. After 12 months, if the patient continues to meet the eligibility criteria and the managing practitioner is of the opinion that the patient would continue to benefit from a comprehensive approach to the treatment of their eating disorder, a new EDP can be developed. This will enable the patient to claim up to 40 EDPT services in the following 12-month period.

The items for EDPT services are restricted to allied health professionals who are eligible to provide services under the Better Access initiative.

5.2. What is an eating disorder psychological treatment service?

A range of acceptable treatments has been approved for use by professionals in this context. The approved treatments are:

- Family Based Treatment for Eating Disorders (EDs) (including whole family, parent-based therapy, and parent-only or separated therapy)
- Adolescent Focussed therapy for EDs
- Cognitive Behavioural Therapy for EDs (CBT-ED)
- CBT-Anorexia Nervosa (AN) (CBT-AN)

- CBT for Bulimia Nervosa (BN) and Binge-Eating Disorder (BED) (CBT-BN and CBT-BED)
- Specialist Supportive Clinical Management (SSCM) for EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for EDs.

Health professionals are expected to practise within their scope of practice and provide services for which they have received adequate training.

5.3. Can a patient with an eating disorder treatment management plan also have a mental health treatment plan?

Patients are encouraged not to have an eating disorder treatment management plan (EDP) and an MHTP at the same time. However, in exceptional circumstances, a patient with comorbid mental health issues may require another plan to access a particular service.

Any Better Access mental health treatment services provided before an EDP has commenced will not count towards the 40 EDPT services. However, any Better Access mental health treatment services that are provided after the EDP has commenced do count towards the allocation of Better Access mental health treatment services, as long as the eligible patient still has an MHTP, valid referral and review requirements in place.

Further information on EDPs and their interaction with other treatment plans can be found at: Eating disorders | Australian Government Department of Health, Disability and Ageing

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5.4. What are the reporting requirements for eating disorder psychological treatment services?

As with Better Access services, allied health professionals providing EDPT services are required to provide the referring medical practitioner with a written report after each course of treatment on assessments carried out, treatment provided and recommendations for future management of the patient's condition.

One difference between the EDPT and Better Access requirements is that a report for the EDPT is required after the first service, as clinically required following subsequent services, and after the final service in a course of treatment. For the purposes of EDPT items, a course of treatment is defined as the number of services requested in the referral to a maximum of 10 services.

Written reports should include, at a minimum:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition.

Appendix A–Better Access services mental health treatment services

Psychological therapy services by eligible clinical psychologists

Item No.	Service Type	Service length (mins)
80000	Face to face (consultation rooms)	30-50
80005	Face to face (call-out)	30-50
91166	Telehealth (video attendance)	30-50
91181	Telehealth (phone attendance)	30-50
80010	Face to face (consultation rooms)	50+
80015	Face to face (call out)	50+
91167	Telehealth (video attendance)	50+
91182	Telehealth (phone attendance)	50+

Focussed psychological services by eligible registered psychologist

Item No.	Service Type	Service length (mins)
80100	Face to face (consultation rooms)	20-50
80105	Face to face (call out)	20-50
91169	Telehealth (video attendance)	20-50
91183	Telehealth (phone attendance)	20-50
80110	Face to face (consultation rooms)	50+
80115	Face to face (call out)	50+
91170	Telehealth (video attendance)	50+
91184	Telehealth (phone attendance)	50+

Focussed psychological services by eligible occupational therapists

Item No.	Service Type	Service length (mins)
80125	Face to face (consultation rooms)	20-50
80130	Face to face (call out)	20-50
91172	Telehealth (video attendance)	20-50
91185	Telehealth (phone attendance)	20-50
80135	Face to face (consultation rooms)	50+
80140	Face to face (call out)	50+
91173	Telehealth (video attendance)	50+

Item No.	Service Type	Service length (mins)
91186	Telehealth (phone attendance)	50+

Focussed psychological services by eligible social workers

Item No.	Service Type	Service length (mins)
80150	Face to face (consultation rooms)	20-50
80155	Face to face (call out)	20-50
91175	Telehealth (video attendance)	20-50
91187	Telehealth (phone attendance)	20-50
80160	Face to face (consultation rooms)	50+
80165	Face to face (call out)	50+
91176	Telehealth (video attendance)	50+
91188	Telehealth (phone attendance)	50+

Appendix B–Better Access mental health treatment group therapy services

Provider	Item no.	Mode of delivery	Service length
Clinical psychologist	80020	In person	60+ minutes
Clinical psychologist	80021	Telehealth*	60+ minutes
Clinical psychologist	80022	In person	90+ minutes
Clinical psychologist	80023	Telehealth*	90+ minutes
Clinical psychologist	80024	In person	120+ minutes
Clinical psychologist	80025	Telehealth*	120+ minutes
Psychologist	80120	In person	60+ minutes
Psychologist	80121	Telehealth*	60+ minutes
Psychologist	80122	In person	90+ minutes
Psychologist	80123	Telehealth*	90+ minutes
Psychologist	80127	In person	120+ minutes
Psychologist	80128	Telehealth*	120+ minutes
Occupational therapist	80145	In person	60+ minutes
Occupational therapist	80146	Telehealth*	60+ minutes
Occupational therapist	80147	In person	90+ minutes
Occupational therapist	80148	Telehealth*	90+ minutes
Occupational therapist	80152	In person	120+ minutes
Occupational therapist	80153	Telehealth*	120+ minutes
Social worker	80170	In person	60+ minutes
Social worker	80171	Telehealth*	60+ minutes
Social worker	80172	In person	90+ minutes
Social worker	80173	Telehealth*	90+ minutes
Social worker	80174	In person	120+ minutes
Social worker	80175	Telehealth*	120+ minutes

*MBS item limited to patients located in Modified Monash Model area 4-7.