# Example Better Access Patient / Practitioner Journey

***Refer to Note AN.0.78 - Better Access Initiative for more information.***

The patient has no prior mental health history, however, has had sustained low moods for 6 weeks and is not coping with the stress of day-to-day life. They need help.


The patient visits their MyMedicare registered practice or their usual medical practitioner to discuss their mental health needs.

The patient's GP undertakes an assessment and determines that the patient has a mental disorder. The GP prepares a Mental Health Treatment Plan (MHTP) and determines moderate intervention support is required. The patient is provided with a referral into Better Access.

**The GP will claim the relevant MHTP preparation MBS item for this appointment (refer Note AN.0.56 - GP Mental Health Treatment Plans and Consultation).**

The patient undergoes an initial course of treatment with an allied health professional (maximum of six services). The allied health professional develops a report for the referring GP.

**The allied health professional will claim the relevant MBS item for these appointments (refer Note MN.6.2 - Provision of Psychological Therapy OR Note MN.7.4 - Provision of Focussed Psychological Strategies).**

The patient returns to their GP to review their MHTP. If the patient requires additional mental health support through Better Access, they can be referred for an additional course of treatment (up to a maximum of 10 services annually).

Alternately, depending on the patient's individual support needs, the GP may refer the patient to other relevant services, including Medicare Mental Health Centres, Primary Health Networks or relevant digital supports.

**Both MHTP Reviews and ongoing mental health consultations for the patient are claimed using GP timed-tiered professional (general) attendance items (refer Note AN.0.9 - Using time-tiered professional (general) attendance items).**

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# GPs/PMPs: referral requirements to support patients accessing Better Access services

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 (refer **Note AN.0.78 - Better Access Initiative**). The referring practitioner decides how many services the patient will receive in a course of treatment. The maximum service limit for each course of treatment:

- Initial course of treatment – up to a maximum of 6 individual services.
- Subsequent course of treatment - remaining individual services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year). Note: these limits do not apply to group therapy services. Up to 10 group therapy services can be specified in a single referral.

The flow chart below outlines the typical considerations in considering whether Better Access services are an appropriate course of referral. For patients that already have a mental health treatment plan (MHTP) in place, the referring practitioner would review the existing MHTP as a new MHTP would only be prepared where exceptional circumstances exist (e.g. severe changes in the patient's prognosis).



## INITIAL DIAGNOSIS

Have you diagnosed the patient to have a mental disorder and consider them to have at least moderate mental health support needs?

**Yes** → **MHTP PREPARATION**

**No** → **NOT ELIGIBLE FOR BETTER ACCESS**

## NOT ELIGIBLE FOR BETTER ACCESS

Consider other available mental health supports that are more aligned to your patient's needs. You can find information on available Australian Government funded mental health supports that may be suitable for your patient via: https://www.health.gov.au/sites/default/files/2026-01/gp-resource-australian-government-funded-mental-health-supports.

## MHTP PREPARATION

Prepare a MHTP. Note: the preparation of a MHTP can only be undertaken by the patient's usual medical practitioner or a practitioner at a patient's MyMedicare registered practice.

There are no specific template requirements for the preparation of a MHTP. However, there are a range of template examples available on the General Practice Mental Health Standards Collaboration website: https://gpmhsc.org.au/guidelinesection/index/ec267899-19c4-4edb-82e1-9bc3f4a40a20/treatment-plan

**&** → **REFERRAL PREPARATION**

## REFERRAL PREPARATION

A referral is also required for your patient to access mental health support under Better Access.

Referring practitioners are not required to use a specific Medicare form to refer patients for these services. However, there are requirements for a referral to be valid. In line with MBS Note MN.6.3 - Referral Requirements for Better Access Treatment Services, a referral for mental health services under Better Access should be in writing (signed and dated by the referring practitioner [which can be by an electronic signature]) and **must** include:

- **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 Mental Health Treatment Plan or a Psychiatrist Assessment and Management Plan prepared.**

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.

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# Allied health professionals: referral requirements to support patients accessing Better Access services

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 (refer **Note AN.0.78 - Better Access Initiative**). Better Access services apply to people with a clinically diagnosed mental disorder as informed by the *World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version.* Patients can only be referred for treatment services under the Better Access initiative where they require at least a moderate level of mental health support.

The flow chart below outlines the typical considerations for a patient's allied health professional in accepting a referral and providing treatment services under Better Access.


## INITIAL REVIEW OF REFERRAL

Does the referral provide all required information, and does it specify the correct number of services the patient is eligible to receive under the initial course of treatment?

**Yes**

## PROVIDE SERVICES

Provide the services specified in the initial course of treatment to the patient. At the conclusion of the course of treatment, prepare a report for the referring practitioner to consider when determining the patient's need for further treatment services during a review of their mental health treatment plan.

**No**


## CONTACT THE REFERRING PRACTITIONER

If the referral for Better Access services does not specify the number of services or specifies the incorrect number of services (i.e. more than the services allowed per course of treatment and/or more than the maximum services allowed per calendar year), contact the referring practitioner to determine the required number of services.

**&**

## IF UNABLE TO CONTACT THE REFERRING PRACTITIONER, USE CLINICAL JUDGEMENT

If the referring practitioner can not be contacted to confirm the required number of services, use your 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 (refer **Note AN.0.78 - Better Access Initiative**); and
- the maximum number of services allowed in a calendar year.

Where the patient's maximum allocation per course of treatment is unknown, contact Services Australia on the Medicare Provider Enquiry Line (132 150) to confirm the patient's remaining allocation of services.

You must provide a report at the end of a course of treatment in line with standard practice. This enables the patient and referring practitioner to review progress and assess the need for further treatment.

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