



Medicare Benefits Schedule Review Taskforce

Post Consultation Report from the Allied Health Reference Group

2019



Important note

This report does not constitute the final position on these items, which is subject to:

- Consideration by the MBS Review Taskforce;

Then

- Consideration by the Minister for Health; and
- Government.



Table of contents

1. Executive summary	8
1.1 Introduction	8
1.2 Review of the allied health MBS items	8
1.3 Main themes	8
1.4 Short term recommendations.....	9
1.5 Longer-term recommendations.....	10
1.6 Consumer impact	10
2. About the Medicare Benefits Schedule (MBS) Review	12
2.1 Medicare and the MBS.....	12
2.1.1 What is Medicare?	12
2.2 What is the MBS?	12
2.3 What is the MBS Review Taskforce?	12
2.3.1 What are the goals of the Taskforce?	12
2.4 The Taskforce's approach	13
2.4.1 What is a primary care reference group?	13
2.4.2 The scope of the primary care reference groups	15
3. About the Allied Health Reference Group	16
3.1 Allied Health Reference Group members	16
3.2 Conflicts of interest.....	18
3.3 Areas of responsibility of the Reference Group.....	18
3.4 Summary of the Reference Group's review approach.....	20
4. Main themes.....	21
5. Recommendations	22
5.1 Allied health individual services under chronic disease management plans (M3 items) 22	
5.1.1 Recommendation 1 – Encourage comprehensive initial assessments by allied health professionals	23
5.1.2 Rationale 1	25
5.1.3 Recommendation 2 – Expand allied health involvement under team care arrangements.....	27
5.1.4 Rationale 2	28
5.1.5 Recommendation 3 – Improve access to orthotic or prosthetic services	29
5.1.6 Rationale 3	30
5.2 Allied health group services under chronic disease management plans (M9 items) 32	



5.2.1	Recommendation 4 – Understand the effectiveness of group allied health interventions.....	32
5.2.2	Rationale 4	33
5.2.3	Recommendation 5 – Incentivise group therapy for chronic disease management.....	34
5.2.4	Rationale 5	34
5.3	Allied health services for autism, pervasive developmental disorder and disability (M10 items).....	34
5.3.1	Recommendation 6 – Improved access to paediatric allied health assessments	35
5.3.2	Rationale 6	36
5.3.3	Recommendation 7 – Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis.	36
5.3.4	Rationale 7	37
5.3.5	Recommendation 8 – Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis	38
5.3.6	Rationale 8	38
5.3.7	Recommendation 9 – Improve access to M10 treatment items as group therapy.....	39
5.3.8	Rationale 9	39
5.3.9	Recommendation 10 – Improve access to M10 items for patients with severe speech and language disorders.....	40
5.3.10	Rationale 10	41
5.3.11	Recommendation 11 – Improve access to the ASD and eligible disability assessment to people under 25.....	42
5.3.12	Rationale 11	42
5.3.13	Recommendation 12 – Improve allied health collaboration during assessments	43
5.3.14	Rationale 12	44
5.4	The role of telehealth in allied health care	44
5.4.1	Recommendation 13 – Improve access to allied health services via telehealth.....	44
5.4.2	Rationale 13	45
5.5	Non-dispensing pharmacists	46
5.5.1	Recommendation 14 – Allow non-dispensing pharmacists to access allied health items	46
5.5.2	Rationale 14	46



6. Longer-term recommendations	48
6.1 An allied health research base	48
6.1.1 Recommendation 15 – Support the codifying of allied health research and evidence.....	48
6.1.2 Rationale 15	49
6.2 Non-fee-for-service allied health payment models	50
6.2.1 Recommendation 16 - Pilot non-fee-for-service allied health payment models	50
6.2.2 Rationale 16	50
6.3 Communication between patients, allied health professionals and GPs	51
6.3.1 Recommendation 17 – Enhance communication between patients, allied health professionals and GPs.....	51
6.3.2 Rationale 17	51
6.4 The role of allied health in the Australian public health care system	52
6.4.1 Recommendation 18 - Expand the role of allied health in the Australian public health care system	52
6.4.2 Rationale 18	53
7. Impact statement.....	56
8. References	58
9. Glossary.....	67
Appendix A Full list of in-scope items	70
Appendix B Full list of recommendations.....	73
Appendix C Summary for consumers	86
Appendix D Selected evidence for the effectiveness of allied health care	104
Appendix E Example list of concerns for speech, language and hearing disorders	106



List of tables

Table 1: Allied Health Reference Group members	16
Table 2: Items 10951–10970	22
Table 3: Items 81100–81125	32
Table 4: Items 82000–82035	34
Table 5: Red flags to prompt GP or specialist referral for assessment items for diagnosis of language disorders	106



List of figures

Figure 1: Drivers of benefit growth, 2011-12 to 2016-17 for in-scope items.....	19
Figure 2: Top 10 in-scope items by service volume in 2016-17.....	20



1. Executive summary

1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees, primary care reference groups (PCRGs) and working groups.

1.2 Review of the allied health MBS items

The Allied Health Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The PCRGs provide recommendations to the Taskforce in a review report. Once endorsed by the Taskforce, the review reports are released for targeted stakeholder consultation. The Taskforce then considers the revised review reports, which include stakeholder feedback, before making recommendations to the Minister for consideration by Government.

1.3 Main themes

The Reference Group has recommended significant amendments to existing items and the creation of new items. These recommendations ensure that the MBS aligns with current clinical guidelines and provides access to high-quality allied health services. The final recommendations in this report (Recommendations 13–18) suggest ways to improve community-based allied health care in Australia.



The Reference Group's recommendations aimed to address nine broad themes.

- Ensure that clinical services align with best-practice guidelines.
- Increase access to allied health in primary care.
- Ensure that the list of eligible allied health professionals under the MBS reflects contemporary practice.
- Facilitate group-based allied health therapy where clinically appropriate.
- Ensure that patients with an Autism Spectrum Disorder (ASD), Pervasive Developmental Disorder (PDD) Complex Neurodevelopmental Disorder (CND) or disabilities have adequate access to high-quality allied health services.
- Strengthen evidence base for the provision of allied health care in Australia.
- Improve access to allied health services in rural and remote areas.
- Change the delivery model and focus of allied health in Australian primary care.
- Improve communication between allied health professionals and other health care professionals.

1.4 Short term recommendations

The Reference Group's short term recommendations are described below.

1. Introduce initial assessment appointments (of more than 40 minutes) for allied health professionals.
2. Increase the number of allied health appointments under team care arrangements (TCAs; item 721 and 723) by stratifying patients to identify those with more complex care requirements.
3. Introduce a new item for orthotic or prosthetic services under the MBS.
4. Conduct a systematic review of the evidence for group allied health interventions to inform future models of care.
5. Introduce a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.
6. Update the M10 descriptor to encompass Autism Spectrum Disorder, Complex Neurodevelopmental Disorder (CND) and Disabilities.
7. Increase the number of assessment items available for children with a potential ASD, CND or eligible disability diagnosis.
8. Allow up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis.



9. Allow M10 treatment items to be delivered as group therapy under the Helping Children with Autism (HCWA) program.
10. Include patients with severe speech/language disorders in the list of eligible disabilities under M10 items.
11. Increase the ASD, CND and eligible disability assessment and treatment age to 25.
12. Allow inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities, CND and ASD.
13. Expand the role of telehealth in allied health care.
14. Add non-dispensing pharmacists to the list of eligible allied health professionals under the MBS.

1.5 Longer-term recommendations

The Reference Group was also tasked with exploring longer-term issues. The following recommendations have been classified as longer-term recommendations as they require preliminary work and trial prior to implementation; they are not considered to be of lesser importance.

15. Build an allied health research base.
16. Pilot non-fee-for-service allied health payment models.
17. Enhance communication between patients, allied health professionals and general practitioners (GPs).
18. Expand the role of allied health in the Australian public health care system.

1.6 Consumer impact

The Reference Group has developed recommendations that are consistent with the Taskforce's objectives, with a primary focus on ensuring that patients have access to high-quality allied health care.

The Reference Group's recommendations will benefit consumers in the following ways.

- **Improving service quality.** Introducing initial assessment appointments for allied health services referred through TCAs will ensure that allied health services are performed in line with best-practice guidelines. This will ensure that patients are appropriately assessed during their first attendance with an allied health professional.
- **Ensuring consumers are adequately informed.** Enhancing communication between consumers, GPs and allied health professionals (Recommendation 16) will ensure that patients are adequately informed about their current and future treatment, and will facilitate consumers' involvement as active participants in their care. This



recommendation will also increase transparency for patients on the number of MBS-rebated appointments they can access under their chronic disease management (CDM) plan, and any out-of-pocket fees that may be payable to allied health care professionals.

- **Increasing access to services.** Increasing the number of allied health appointments for eligible patients with highly complex care requirements under CDM plans.
- **Providing flexibility in service delivery and peer support.** Expanding group therapy (after a systematic review of M9 items) will provide consumers with flexibility in the way that allied health care is provided, and enable more peer support. This will provide the option of having therapeutic interventions in group sessions if the consumer desires.
- **Ensuring care is evidence-based.** Building an allied health research base will ensure that current and future allied health services delivered to consumers is informed by an evidence base.



2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review is clinician-led, and there are no targets for savings attached to the review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.



- **Best-practice health services**—one of the core objectives of the MBS Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the review is to have an MBS that supports the delivery of services that are appropriate to the patient’s needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce’s approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce’s brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The Taskforce also established PCRGs to review MBS items largely provided by non-doctor health professionals. The clinical committees and PCRGs are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

2.4.1 What is a primary care reference group?

The Taskforce established the PCRGs to focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care. The MBS Review Taskforce established five PCRGs:



- Aboriginal and Torres Strait Islander Health Reference Group
- Allied Health Reference Group
- Mental Health Reference Group
- Nurse Practitioner Reference Group, and
- Participating Midwives Reference Group.

The PCRGs are similar to the clinical committees established under the MBS Review. Each PCRG reviewed in-scope items, with a focus on ensuring that individual items and usage meet the four goals of the Taskforce. They also considered longer-term recommendations related to broader issues (not necessarily within the current scope of the MBS) and provided input to clinical committees, including the General Practice and Primary Care Clinical Committee (GPPCCC). Each PCRG makes recommendations to the Taskforce, as well as to other committees, based on clinical expertise, data, and evidence.

The PCRGs are unique within the MBS Review for several reasons:

- **Membership:** Similar to clinical committees, the PCRGs include a diverse set of stakeholders, as well as an ex-officio member from the MBS Review Taskforce. As the PCRGs focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care, membership includes many non-doctor health professionals, as well as an ex-officio member from the GPPCCC. Each PCRG also includes a general practitioner (GP), a nurse, and two consumers.
- **Connection to the GPPCCC:** As part of their mandate from the Taskforce, the PCRGs were tasked with responding to issues referred by the GPPCCC. The PCRGs also reviewed some items delivered by GPs and proposed recommendations with implications for GP care. The GPPCCC ex-officio member on each PCRG helped to strengthen the connection between the two bodies and supported communication of the PCRGs' responses to the GPPCCC.
- **Newer items:** The items reviewed by the PCRGs have a shorter history than other items within the MBS; many were introduced only in the last decade. While this means that there is less historical data to draw on, it also means that there are fewer items under consideration that are no longer relevant, or that no longer promote best-practice interventions, compared to other committees.
- **Growth recommendations:** Several of the PCRGs' in-scope items have seen significant growth since their introduction, often with the potential to alleviate cost pressures on other areas of the MBS or the health system, or to increase access in low-access areas. As a result, many recommendations focus on adjusting items that are already working



well, or recommending expansion of recently introduced items to facilitate access to evolving models of health care delivery.

2.4.2 The scope of the primary care reference groups

All MBS items will be reviewed during the course of the MBS Review. Given the breadth of the review, and its timeframe, each clinical committee and PCRG developed a work plan and assigned priorities, keeping in mind the objectives of the review.

The PCRG review model approved by the Taskforce required the PCRGs to undertake three areas of work, prioritised into two groups.

- Priority 1 - Review referred key questions on draft recommendations from the GPPCCC and develop recommendations on referred in-scope MBS items.

As part of this work, the PCRGs also reviewed and developed recommendations on referred issues from other committees or stakeholders where relevant.

- Priority 2 - Explore long-term recommendations.

These included recommendations related to other MBS items beyond the PCRGs' areas of responsibility, recommendations outside the scope of existing MBS items, and recommendations outside the scope of the MBS, including recommendations related to non-fee-for-service approaches to health care.



3. About the Allied Health Reference Group

The Allied Health Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items within its area of responsibility, based on rapid evidence review and clinical expertise.

3.1 Allied Health Reference Group members

The Reference Group consists of 18 members, whose names, positions/organisations and declared conflicts of interest are listed alphabetically in Table 1.

Table 1: Allied Health Reference Group members

Name	Position/organisation	Declared conflict of interest
Ms Merrin Prictor (Chair)	Allied Health Consultant	Nil
Mr Roland Balodis	Departmental Advisor	Nil
Ms Joanne Baumgartner	Consumer Representative, Community Care Clinical Governance, eHealth Consumer Reference Group; Community Member, Tribunals, Australian Health Practitioners Regulation Agency; Assessor, National Alliance of Self Regulating Health Professionals, Audiology Australia	Receives sitting fee for assessing applications to join the National Alliance of Self-Regulating Health Professionals (NASRHP) and, during the period 26 October 2017 to 30 June 2019, the Australian Health Practitioner Regulation Agency (AHPRA)
Ms Karen Booth	Registered Nurse; General Practice Manager; President, Australian Primary Health Care Nurse Association	Nil
Ms Petrina Burnett	Consumer Representative, Breast Cancer Advisory Group, Cancer Australia, Breast Cancer Network Australia and Breast Cancer Trials Australia	Nil
Mrs Christine Coop	Occupational Therapist; Director, Enable Occupational Therapy in Mental Health	Nil
Ms Michelle Funder	Registered Osteopath; Director, Osteopathy Australia	Nil
Mr Adrian Henry	Registered Podiatrist	Nil



Name	Position/organisation	Declared conflict of interest
Ms Liz Kellett	Fellow of the Dietitians Association of Australia	Nil
Ms Rosalind Knox	Departmental Advisor	Nil
Ms Jenney McConnell	Registered Physiotherapist, private practice; Fellow of the Australian College of Physiotherapy	Nil
Dr Matthew McConnell	Public Health Physician, Rural Support Service, SA Health; Taskforce Ex-Officio	Nil
Assoc. Prof. Mark Morgan	General Practitioner and GPPCCC Ex-Officio	Associate Professor at Bond University, which teaches medical and allied health students. Chair of the RACGP Expert for Committee for Quality Care, providing advice to RACGP Board and CEO about quality and clinical matters. Collaborates with the Institute of Evidence Based Healthcare, which produces the Royal Australian College of General Practitioners (RACGP) Handbook of Non-Drug Interventions (HANDI).
Mr John Pearcy	Audiologist in independent practice; Full member of Audiology Australia; Queensland representative on the Board of Audiology Australia; Member of Independent Audiologists Australia	Board member of Audiology Australia (unpaid)
Mr Tim Perry	Consultant Pharmacist and GPPCCC Ex-Officio	Nil
Ms Caoimhe Scales	Accredited Exercise Physiologist	Nil
Dr Adam Smith	Registered Chiropractor; Board Secretary, Chiropractors Association of Australia QLD	Holds unpaid positions on several committees
Ms Robyn Stephen	Certified practising Speech Pathologist; Director and Principle Clinician at Melbourne Child Development; Consult Speech Pathologist at Melbourne Paediatric Specialists	Nil



3.2 Conflicts of interest

All members of the Taskforce, clinical committees and PCRGs are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically. A complete list of declared conflicts of interest can be viewed in Table 1.

It is noted that a number of Reference Group members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Reference Group and the Taskforce, it was agreed that this should not prevent members from participating in the review.

3.3 Areas of responsibility of the Reference Group

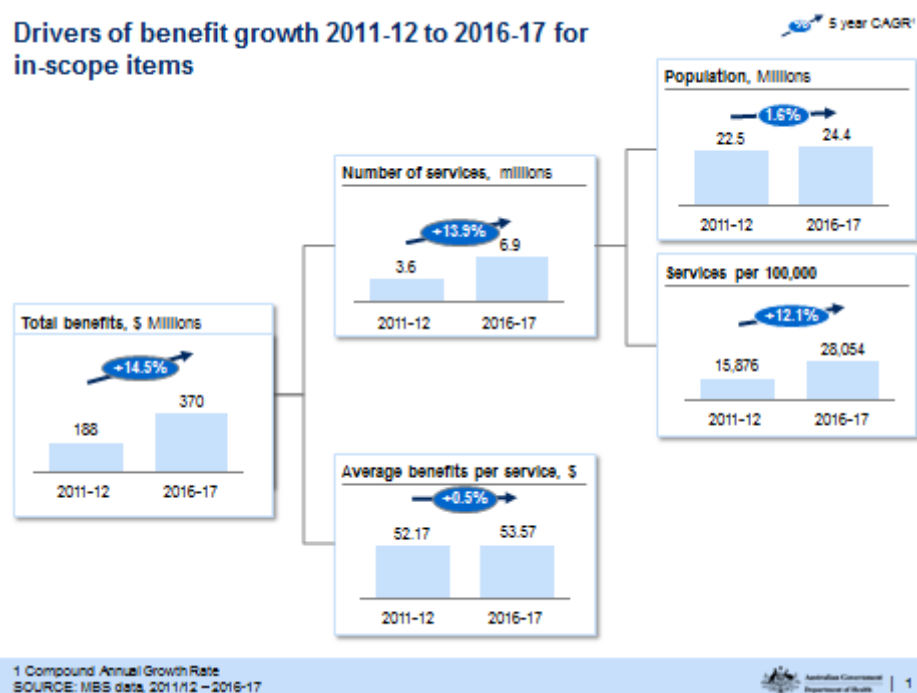
The Reference Group reviewed 26 MBS items in three main subgroups:

- M3 – allied health individual services, items 10951–10970.
- M9 – allied health group services, items 81100–81125.
- M10 – autism, pervasive development disorder and disability services, items 82005–82035.

In 2016-17, these items accounted for approximately 6.9 million services and \$370 million in benefits. Over the past five years, service volumes have grown by 12.7 per cent compounded annually (Figure 1).



Figure 1: Drivers of benefit growth, 2011-12 to 2016-17 for in-scope items

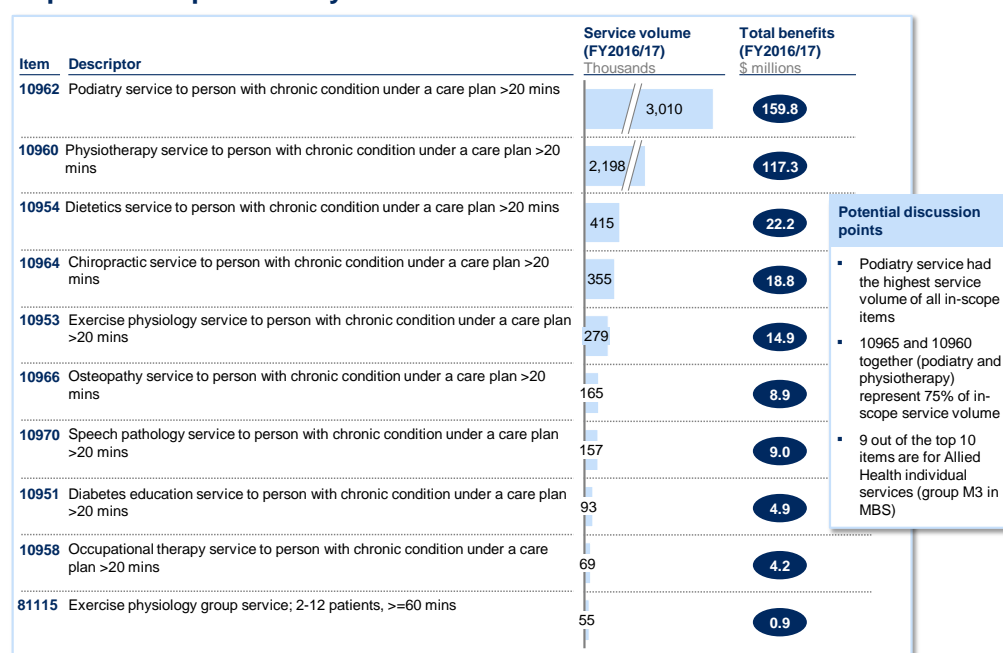


In 2016-17, podiatry had the highest service volumes of all in-scope items (3,010,000 services), with an approximate benefit cost of \$159.8 million (Figure 2).



Figure 2: Top 10 in-scope items by service volume in 2016-17

Top 10 in-scope items by service volume in 2016-17



SOURCE: MBS data, 2011/12 – 2016-17

 Australian Government
Department of Health

29

3.4 Summary of the Reference Group's review approach

The Reference Group completed a review of its items across four full meetings, over a four month period of time, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on utilisation of items (services, benefits, patients, providers and growth rates); service provision (type of provider, geography of service provision); patients (demographics and services per patient); co-claiming or episodes of services (same-day claiming and claiming with specific items over time); and additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical and allied health journals and other sources, such as professional associations.



4. Main themes

During its review, the Reference Group identified several themes that are relevant not just to the recommendations in this report, but also to the current challenges and future directions of allied health care in Australia. The Reference Group agreed that there are opportunities to:

1. **Expand allied health involvement in primary care.** There are opportunities to strengthen primary care teams by involving allied health professionals more frequently, and by enabling closer, more comprehensive communication. Better integration of allied health into primary care is likely to improve clinical outcomes and satisfaction for consumers. Recommendation 16 expands on how communication between medical practitioners and allied health professionals can be improved.
2. **Improve access to allied health for rural and remote populations.** There are far fewer allied health professionals in rural and remote regions, compared to metropolitan areas. The Reference Group agreed that there is a need to expand the allied health professional workforce in these areas, and to use remote care delivery models to fill this gap (for example, see Recommendation 14 on the role of telehealth in allied health care).
3. **Enhance preventive care and health promotion using allied health.** There is an opportunity to prevent the occurrence, or delay the onset, of chronic conditions (primary prevention) by facilitating access to appropriate allied health services for individuals with identifiable risk factors. The Reference Group agreed that this opportunity should be seized and linked to the broader approach to preventive health care in Australia, and the approach to do so should be based on a sound evidence base.
4. **Strengthen the evidence base for allied health.** The Reference Group agreed that there is an opportunity and a need to build an allied health research base (Recommendation 13) to target allied health interventions to provide cost-effective, high-value care.
5. **Improve data collection and transparency for allied health use across Australia.** There is limited available data linking allied health use across funding streams and patient journeys in Australia. Improving this data would enhance primary health network (PHN), state and federal understanding of the drivers of patient choice and clinical outcomes, as well as strengthening decision-making. It could also lead to cost savings and improved patient outcomes in the medium to long term.



5. Recommendations

5.1 Allied health individual services under chronic disease management plans (M3 items)

Table 2: Items 10951–10970

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
10951	Diabetes education service to person with chronic condition under a care plan >20 mins	62.25	92,688	\$4,937,916	5.0%
10952	Audiology education service to person with chronic condition under a care plan >20 mins	62.25	1,868	\$105,655	12.4%
10953	Exercise physiology service to person with chronic condition under a care plan >20 mins	62.25	279,323	\$14,908,153	20.9%
10954	Dietetics service to person with chronic condition under a care plan >20 mins	62.25	414,899	\$22,172,147	10.5%
10956 ¹	Mental health service to person with chronic condition under a care plan >20 mins	62.25	5,726	\$332,292	9.6%
10958	Occupational therapy service to person with chronic condition under a care plan >20 mins	62.25	69,219	\$4,158,674	16.1%
10960	Physiotherapy service to person with chronic condition under a care plan >20 mins	62.25	2,197,772	\$117,264,835	16.6%

¹ Also in the Mental Health Reference Group's area of responsibility.



Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
10962	Podiatry service to person with chronic condition under a care plan >20 mins	62.25	3,009,782	\$159,800,577	12.8%
10964	Chiropractic service to person with chronic condition under a care plan >20 mins	62.25	354,501	\$18,775,603	14.3%
10966	Osteopathy service to person with chronic condition under a care plan >20 mins	62.25	165,201	\$8,876,660	13.9%
10968 ¹	Psychology service for person with chronic condition under a care plan, >20 mins	62.25	28,390	\$2,131,564	23.1%
10970	Speech pathology service to person with chronic condition under a care plan >20 mins	62.25	156,592	\$9,025,165	7.3%

5.1.1 Recommendation 1 – Encourage comprehensive initial assessments by allied health professionals

The Reference Group recommends:

- a. creating a new item (109AA) for an initial allied health appointment of at least 40 minutes
- b. placing the following restrictions:
 - (i) claiming to the first attendance for a unique presentation and a maximum of one per patient, per provider, per calendar year
 - (ii) claiming by allied health professionals in the same practice providing care for the same unique presentation, and
 - (iii) co-claiming with M3 items (10950–10970) and M9 items for assessing the suitability of group sessions (81100, 82110 and 81120),
- c. the proposed item descriptor as follows:

**New Item 109AA – example text**

Initial allied health service provided to a person by an eligible allied health provider, if:

- a) the service is provided to a person who has:
 - i. a chronic condition; and
 - ii. complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and
- b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and
- c) the person is referred to the eligible allied health provider by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and
- d) the person is not an admitted patient of a hospital; and
- e) the service is provided to a patient for the first attendance for a unique presentation
- f) the service is provided to the person individually and in person; and
- g) the service is of at least 40 minutes duration; and
- h) an initial assessment service has not already been provided by an allied health provider of the sample profession (e.g. physiotherapy) for the same unique presentation in the same practice (where it is practical to gather this information); and
- i) after the service, the eligible allied health provider gives a written report to the referring medical practitioner mentioned in paragraph (c).
- j) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;
 - to a maximum of one service per eligible allied health provider per patient per year
 - Not to be claimed with items 81100, 82110, 81120 or 10950–10970.

- d. the proposed explanatory notes as follows:

**New Item 109AA Explanatory note – example text**

A unique presentation includes:

- A primary (presenting) complaint for which the allied health professional has not seen the patient before.
- A primary (presenting) complaint for which the allied health professional has seen the patient before, but where a significant change in the quality or severity of the complaint necessitates reassessment.

Allied health professionals in the same practice are expected to share information about the initial appointment findings, where clinically relevant.

5.1.2 Rationale 1

This recommendation focuses on providing high-quality care to patients, in line with professional standards. It is based on the following:

- It is standard practice for allied health professionals to undertake initial assessments.
- All allied health professionals governed by the Australian Health Practitioner Regulation Agency (AHPRA) must meet and abide by their specific board's regulations and codes to maintain registration. Service descriptors and scopes of practice set out by their associations facilitate meeting these requirements.
- Professional associations that are members of the National Alliance of Self Regulating Health Professions (NASRHP) set service descriptors and scopes of practice for their individual professions to align with NASRHP standards.
- Service descriptors set out by allied health professional associations distinguish between initial assessments and subsequent assessments. Examples of which can be drawn from the following references (1; 2; 3; 4; 5; 6). Notwithstanding some differences in structure across allied health professions, initial assessments tend to include the following activities:
 - Taking a more thorough history (as the patient is often new).
 - Conducting a bio-psycho-social assessment.
 - Reaching a diagnosis.
 - Setting goals and planning treatment.

The Reference Group agreed that these activities are not required (or take less time) in subsequent consultations.



- Differences between initial and subsequent appointments are already reflected in the private practice billing structure across all professions, and by the following subsidy schemes:
 - Return-to-work schemes across Australian states (7)
 - Private health insurance company rebate structures (8) (9)
 - The Department of Veterans' Affairs model (10), and
 - Motor and road traffic vehicle accident insurance schemes (11).
- The Reference Group agreed that creating an item for initial appointments under chronic care plans would promote best-practice care in the MBS.
- The Reference Group agreed that initial appointments should take at least 40 minutes, based on clinical experience and analysis of allied health professional service descriptors.
- The Reference Group further agreed that creating a new item for initial assessments would better align Schedule fees with the duration of service provided.
- To ensure that item 109AA is used in clinically appropriate circumstances, the Reference Group has recommended the following restrictions:
 - Cap item 109AA claims at one per patient, per provider, per year.

The Reference Group agreed that there should be an annual restriction of one claim per patient, per provider, per year in order to limit low-value use of item 109AA.
 - Restrict co-claiming of item 109AA with routine M3 and M9 appointments.

The Reference Group agreed that there are no circumstances in which it would be appropriate to claim both an initial and a routine attendance together. The Reference Group also agreed that there are no circumstances in which it would be appropriate to claim both an initial appointment and an M9 item for assessment of suitability for group therapy.
 - Restrict claiming to services provided for the first attendance for a unique presentation.

The Reference Group agreed that initial assessments provide high-value care for unique presentations (i.e. the first time seeing a patient with a given presenting complaint) because they provide more time in which to take an in-depth history, perform a comprehensive examination, identify a diagnosis and create a management plan.

The Reference Group agreed that once the allied health professional has seen a patient for a given presenting complaint, an additional initial assessment for this



presentation would be high value for the patient if there has been a significant change in the degree of severity of the presenting complaint.

- Restrict claiming by allied health professionals in the same practice providing care for the same unique presentation.

The Reference Group agreed that allied health professionals within the same practice are expected to share relevant clinical information about a patient's initial assessment if the patient changes allied health professionals within a practice.

The Reference Group further agreed that the content of initial assessments is sufficiently different between allied health professions that it is not appropriate to restrict different types of allied health professionals in the same practice from claiming item 109AA for a given patient. For example:

- A physiotherapist seeing a patient who has had an initial assessment within the past year with a different physiotherapist in the same practice cannot bill for item 109AA (unless it is for a different unique presentation).
- A dietitian seeing a patient who has had an initial assessment within the past year with an osteopath in the same practice can bill for item 109AA.
- The Reference Group agreed that use of this item should be reviewed in 12 to 24 months so that any abnormal claiming patterns can be analysed.

5.1.3 Recommendation 2 – Expand allied health involvement under team care arrangements

The Reference Group recommends:

- a. increasing the number of allied health appointments under GP Management Plans (GPMPs) and team care arrangements (TCAs) by stratifying patients to identify those with more complex care requirements (items 721 and 723)
 - b. creating a follow-on piece of work that identifies and details a model to stratify patients with a GPMP who could benefit from additional allied health appointments
- While it is unlikely that one single assessment tool will be satisfactory, assessment to stratify patients should include:
- a. Clinical judgement
 - b. Co-morbidities
 - c. Risk of deterioration in condition
 - d. Impairment

This work must include involvement of the allied health sector.



- c. consideration of the following:
 - (i) Patients identified under this stratification model could receive an additional envelope of appointments with an eligible allied health professional (for example, five or more) after accessing the first envelope of five appointments.
 - (ii) Multiple stratification dimensions could be used, including:
 - The number of chronic conditions a patient has (defined by chronic conditions eligible for a GPMP).
 - The severity of the chronic conditions.
 - The discretion of the referring practitioner, based on the number of chronic conditions and/or the severity of those conditions.
 - (iii) The follow-on piece of work should test and identify the most appropriate stratification approach,
- and
- d. implementation of the new model be phased, so that the effects of additional allied health appointments on health outcomes can be studied during a pilot period with consideration that this process could include:
 - (i) A pilot with a limited sample size of the population receiving TCAs.
 - (ii) A study of the health outcomes of patients in this pilot program over a multi-year period, compared with patients with TCAs who are not in the pilot patient sample (control group).
 - (iii) Targeted expansion of the increased number of allied health appointments to the rest of the chronic disease patient population in Australia, based on the findings from the pilot.

5.1.4 Rationale 2

This recommendation focuses on ensuring that the MBS provides access to high-quality, high-value care for consumers and the health care system. It is based on the following:

- The Reference Group agreed that a set of five MBS-funded allied health appointments is often insufficient to adequately treat patients with chronic conditions. It noted the following problems:
 - MBS data shows that 26 per cent of patients with TCAs use all five allied health appointments available under their care plans. This means that approximately 575,000 patients every year (based on 2016 data) reach their annual cap of MBS-funded allied health appointments and may be unable to access allied health services.



- Allied health services under TCAs are shared between allied health professionals, meaning that a patient often does not get a Schedule fee for seeing a given allied health professional more than one to three times in a year (unless they pay out of pocket).
- Patients who require more than five allied health appointments are often not adequately supported by other sources of funding. States, territories and PHNs: Demand-driven waiting times often restrict patient access, and patients are prioritised based on medical condition, not on capacity to pay. Forty-five per cent of Australians do not have private health insurance for general treatment (including allied health services) (12).
- Evidence indicates that allied health interventions are effective and cost-efficient (including mitigating downstream health care costs) in managing a range of chronic health conditions (Appendix D). However, there is limited evidence regarding the optimal annual number of allied health attendances for Australian patients with chronic disease. This has been complicated by the diverse range of treatments provided to patients with chronic disease, as well as the range of presenting conditions.
- The Reference Group agreed that this recommendation represents an opportunity to provide more allied health appointments to patients with highly complex conditions under TCAs, while studying the effects of this increase on outcomes through phased implementation (via a pilot). The Reference Group agreed that both clinical outcomes and cost-efficiency (including hospitalisations) should be measured during this pilot phase.
- The Reference Group agreed that there are several ways to stratify patients to identify those who may benefit from additional appointments, and that the follow-up piece of work should identify the most effective approach.

5.1.5 Recommendation 3 – Improve access to orthotic or prosthetic services

The Reference Group recommends:

- a. creating a new item (109BB) in the M3 group for the delivery of orthotic or prosthetic services, lasting at least 40 minutes
- b. allowing this item to be claimed when referred by a GP as part of a CDM plan (item 721), including TCAs (item 723)
- c. specifying in the explanatory notes that eligible allied health professionals include prosthetists and orthotists
- d. capping the number of times this item can be claimed to once per patient, per calendar year
- e. the proposed item descriptor as follows:

**New Item 109BB – example descriptor**

Orthotic or prosthetic allied health service provided to a person by an eligible allied health provider, if:

- a) the service is provided to a person who has:
 - i. a chronic condition; and
 - ii. complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and
 - b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and
 - c) the person is referred to the eligible allied health provider by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and
 - d) the person is not an admitted patient of a hospital; and
 - e) the service is provided to the person individually and in person; and
 - f) the service is of at least 40 minutes duration; and
 - g) after the service, the eligible allied health provider gives a written report to the referring medical practitioner mentioned in paragraph (c).
 - h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;
- to a maximum of one service per year.

5.1.6 Rationale 3

This recommendation focuses on providing high-quality care to patients with complex care requirements who are at risk of deterioration who, if left untreated, are likely to require hospitalisation. An example is a high risk limb ulcer that may lead to amputation. It is based on the following:

Access to private orthotic and prosthetic services is limited to patients who can afford to pay the cost of the clinical service. Private health insurance rebates are available for prosthetic devices, but not for the clinical service.

Patients who cannot pay for these services have access to publicly funded services through the public hospital system. However, the hospital service is in high demand, so



programs stratify patients by risk. This means that there is a delay in getting the first appointment for patients with lower care requirements (who are often eligible for community care). For these patients, the wait can be several months, during which time their clinical condition can deteriorate. The patient may then present at a “crisis point” in their condition (13).

- Services provided by orthotists and prosthetists have been shown to improve clinical outcomes in several health conditions such as diabetes (14; 15), stroke and other neurological conditions (16; 17; 18), and arthritis (19).
- Early intervention in foot disease (especially for people with diabetes) is likely to reduce overall health care costs for patients (20).
- The Reference Group agreed that although podiatrists have a similar scope of practice, orthotists and prosthetists are uniquely positioned to provide orthotic and prosthetic services in complex cases. As such, the Reference Group agreed that their inclusion in the MBS would improve clinical outcomes.
- The Reference Group agreed that the total cost of this recommendation is likely to be low, as orthotic and prosthetic services will likely be an (appropriate) substitute for podiatry appointments under M3 items.
- There are 220 orthotists/prosthetists (in total) practising privately in Australia (21), compared to 3,462 privately practising podiatrists (22). This means that service volume is likely to be low.
- The Reference Group noted that state-funded equipment schemes are in place to fund orthoses or prostheses for patients with specific criteria, such as a functional disability. The specific gap in care is for clinical services to assess for suitability of orthoses or prostheses, and the Reference Group has recommended an item to fill this gap. The Reference Group acknowledged that there are other ways—outside the MBS and the remit of the Reference Group—to increase the funding for community-based orthotic and prosthetic services across Australia but has chosen this as one way to improve service delivery.
- The Reference Group agreed that the Australian Orthotic Prosthetic Association’s (AOPA) submission on this topic provides a detailed analysis of the evidence and the case for including orthotists and prosthetists, as per this recommendation. (23)



5.2 Allied health group services under chronic disease management plans (M9 items)

Table 3: Items 81100–81125

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
81100	Assessment of suitability for group diabetes education service >45 mins	79.85	1,871	\$127,085.65	8.30%
81105	Diabetes education group service; 2-12 patients, >=60 mins	19.90	1,135	\$19,238.25	-13.29%
81110	Assessment of suitability for group exercise physiology service >45 mins	79.85	10,440	\$709,080.94	12.86%
81115	Exercise physiology group service; 2-12 patients, >=60 mins	19.90	55,089	\$935,701.55	15.14%
81120	Assessment of suitability for group dietetics service >45 mins	79.85	1,200	\$81,489.70	-11.16%
81125	Dietetics group service; 2-12 patients, >=60 mins	19.90	2,649	\$44,905.45	-12.11%

5.2.1 Recommendation 4 – Understand the effectiveness of group allied health interventions

The Reference Group recommends:

- a. conducting a systematic review of current evidence to support evidence-based expansion of group allied health interventions.
- b. that this systematic review be conducted to specifically identify:
 - (i) The clinical scenarios (across all eligible allied health professions under the MBS) in which allied health group interventions provide high-value care to patients.
 - (ii) The ideal ratio of participants and allied health professionals for group therapy (including whether there are different types of professionals—i.e. a multidisciplinary team) in each of these high-value clinical scenarios.

and

- c. the expansion of allied health group therapy be targeted based on the findings of this systematic review, by:
 - (i) Expanding patient eligibility for M9 MBS items, and



(ii) Accessing funding outside of the MBS.

5.2.2 Rationale 4

This recommendation focuses on ensuring that patients have access to high-quality clinical services. It is based on the following:

- The Reference Group agreed that clinically appropriate group therapy is of high value for patients. Compared to individual therapy, group therapy:
 - Enhances socialisation and peer support.
 - Improves motivation and self-management.
 - Encourages patient independence while under clinical supervision.
 - Can be more cost-effective.
 - Can reduce waiting lists for services and help patients receive care faster.
 - Can enhance the delivery of integrated multidisciplinary care.
- M9 items under the MBS are currently limited to patients with type 2 diabetes. The Reference Group agreed that there are benefits to providing group therapy in other patient cohorts. During its review, it noted that the following patient cohorts may benefit from multidisciplinary group-based allied health interventions.
 - Patients with heart failure. Exercise-based rehabilitation programs have been shown to reduce hospitalisations and improve health-related quality of life for patients with heart failure (24). Dietitians are also recommended providers of group education sessions for heart failure, and for education and counselling regarding weight management and fibre, alcohol, saturated fat and/or caffeine intake (25).
 - Patients with cancer. The Clinical Oncology Society of Australia recommends that exercise led by accredited allied health professionals should be integrated into standard cancer care. (26) The Cancer Council of Victoria recommends including diet and exercise in group exercise programs (27).
 - Children with speech and language delay. Group therapy and individual therapy have been shown to lead to similar outcomes (28).
 - Patients receiving pulmonary rehabilitation. The Reference Group notes that an application to expand group therapy for pulmonary rehabilitation has been submitted to the MSAC (29).
- A systematic review would allow for equitable and cost-effective expansion of allied health group therapy interventions.
- Implementation of the clinical care guidelines recommended in this systematic review could be achieved through the MBS, or outside the MBS through a non-fee-for-service structure.



5.2.3 Recommendation 5 – Incentivise group therapy for chronic disease management

The Reference Group recommends introducing a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.

The impact of this incentive should be evaluated following a comprehensive trial period.

5.2.4 Rationale 5

This recommendation focuses on ensuring adequate access to high-quality allied health services for consumers. It is based on the following:

- The Reference Group agreed that current group therapy items for type 2 diabetes are underused. MBS data shows that claims for exercise physiology group services are growing at 15 per cent per year, while claims for group diabetes education and dietetics services are decreasing at 13 per cent and 12 per cent annually, respectively.
- The Reference Group agreed that group therapy items are underused because allied health professionals face barriers in organising and running group sessions. The following barriers limit access to group services for patients:
 - There are significant fixed costs associated with running group sessions—for example, the costs associated with renting or setting up a large room.
 - A significant time investment is required to organise the logistics to run group sessions.
 - Allied health professionals need to have a large enough group to cover the costs of providing the service, including when patients cancel or do not attend sessions.
- The Reference Group agreed that introducing a practice incentive payment for allied health professionals providing services under items 81105, 81115 and 81125 would increase the likelihood that they offer group therapy sessions, thereby increasing access for patients and providing a more beneficial modality for the delivery of this treatment.

5.3 Allied health services for autism, pervasive developmental disorder and disability (M10 items)

Table 4: Items 82000–82035

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
82000	Psychology service provided to a child (<13 years) by eligible psychologist, >=50 mins	99.75	10,258	\$1,300,698.90	10.16%



Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
82005	Speech pathology service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	4,697	\$506,641.70	8.21%
82010	Occupational therapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	1,146	\$110,386.60	9.11%
82015	Psychology service provided to a child (<15 years), for treatment of PDD or an eligible disability by eligible psychologist, >=50 mins	99.75	4,645	\$540,563.42	1.70%
82020	Speech pathology service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	20,016	\$1,741,776.00	2.41%
82025	Occupational therapy service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	10,154	\$928,442.45	10.15%
82030	Audiology, optometry, orthoptic or physiotherapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	533	\$40,521.53	70.49%
82035	Audiology, optometry, orthoptic or physiotherapy provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	1,245	\$118,236.05	30.81%

5.3.1 Recommendation 6 – Improved access to paediatric allied health assessments

The Reference Group recommends:

- amending the item descriptor for M10 items to Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) and Disability and remove Pervasive Developmental Disorder (PDD).
- updating the M10 explanatory notes to reference DSM V and incorporation of PDD under ASD in DSM V
- the list of eligible disabilities for M10 items should be extended to include:
 - Foetal Alcohol Syndrome Disorder (FASD);



- (ii) Lesch-Nyhan Syndrome; and
 - (iii) 22 g deletion Syndrome (previously Velocardiofacial Syndrome, and
- d. consideration be given to updating the descriptor of M10 items, specifically MBS Item 82030 and 82035, to include additional allied health providers (e.g. Dietetics and Exercise Physiology) who provide evidence-based interventions for persons with Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) and Disability.

5.3.2 Rationale 6

This recommendation focuses on ensuring that the MBS provides adequate access to paediatric allied health assessments. It is based on the following:

- This recommendation provides an update to the clinical terminology and condition examples aligning M10 items with other MBS specialist paediatric complex plan items.
- Throughout the MBS Review process, stakeholders have contacted the department seeking clarification on the existing MBS Item terminology and in particular the inclusion of Foetal Alcohol Syndrome Disorder and other Complex Neurodevelopmental Disorders. This recommendation is in line with the items currently under review by the Specialist and Consultant Physician Consultations and Psychiatry Clinical Committee.
- Following the MBS Review consultation process, stakeholders have communicated the need to update the descriptors of the M10 items to include additional allied health providers, including Dietetics and Exercise Physiology), who can provide evidence-based interventions to this target group.
- There may be ongoing work associated with this recommendation requiring further amendments ensuring all M10 item descriptors best encapsulate their targeted cohort and service provisions.

5.3.3 Recommendation 7 – Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis.

The Reference Group recommends:

- a. increasing the number of assessment items (82000, 82005, 82010 and 82030) available for children with a potential ASD, CND or eligible disability diagnosis.
- b. the number of allied health assessment appointments available for a child with a potential ASD, CND or eligible disability diagnosis be increased from four per lifetime to eight per lifetime, and



- c. a review by the referring practitioner be required between the first four and additional four appointments.

5.3.4 Rationale 7

This recommendation focuses on ensuring that the MBS provides adequate services to diagnose ASD and eligible disabilities and to form treatment plans (as per the MBS descriptors). It is based on the following:

National Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorder in Australia approved by the National Health and Medical Research Council [NHMRC]) recommends a progressive approach to diagnostic formulation, whereby additional clinical investigations are based on the clinical complexity of the individual.

The Guidelines recommend an initial comprehensive needs assessment which comprises Allied Health assessments of functioning and a medical evaluation. This determines treatment plans and whether the patient goes onto a diagnostic evaluation. For patients with complex or subtle presentations, accurate diagnosis requires a multidisciplinary consensus team. Eligible members of the consensus team, in addition to a medical practitioner, include Psychologists, Speech Pathologists and Occupational Therapists.

- The Reference Group agreed, based on an overview provided by two members working in this field, that allied health professionals typically require more than two attendances (and often up to four) to adequately assess a child with potential ASD for diagnostic purposes. Four assessment appointments do not always allow for adequate allied health input to reach consensus on a team diagnosis.
- As per the item descriptors in the MBS, the assessment items are to assist with the diagnosis or to contribute to the treatment plan. Currently there are a maximum of four sessions across eligible allied health professionals for assessment for diagnosis and treatment planning. As recommended in the National Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorder in Australia, a Comprehensive Needs Assessment for a treatment plan from Allied Health Professional Assessments forms part of the Diagnostic process.
- An important safeguard of this recommendation is that a review by the referring practitioner is required between the first four and additional four assessment appointments.
- The Reference Group noted that assessment services are not provided under the National Disability Insurance Scheme (NDIS), and that the MBS provides an important service to eligible children.



- The items as per the descriptors in the MBS are to assist with the Diagnosis or to contribute to the treatment plan. Other children with eligible disabilities require multiple allied health assessments due to the complexity of the disability. To gain access to the NDIS and other government-funded supports, families are required to submit evidence from Allied Health Professional assessments of the complexity of the child's presentation and the required treatment plan.
- As a current example, the parents of a three year old child with Cerebral Palsy have paid for the following assessments for their child. Each assessment listed was conducted by an Allied Health Professional who worked in a specialised field.
 - Speech Pathology – Paediatric Swallowing Assessment
 - Speech Pathology – Communication Device Assessment
 - Speech Pathology – Motor Speech Assessment
 - Occupational Therapy - Assessment for Home Modifications
 - Occupational Therapy - Assessment for Car Modification
 - Occupational Therapy - Assessment of Development (dressing, eating, toileting, upper body functions)
 - Physiotherapy - Aqua Therapy Assessment
 - Physiotherapy - Motor Development Assessment
 - Physiotherapy/Occupational Therapy – Equipment Prescription Assessment (wheelchair)
 - Orthotic Assessment
- To ensure equitable access to assessment services for patients with eligible disabilities, the recommended change to assessment items should apply to both ASD, CND and eligible disabilities under the MBS.

5.3.5 Recommendation 8 – Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis

The Reference Group recommends allowing up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis (items 82000, 82005, 82010 and 82030).

Note: Case conferencing involves the referring practitioner and other members of the multidisciplinary team assessing a child. The parent may also be present.

5.3.6 Rationale 8

This recommendation focuses on ensuring that the MBS provides adequate services to accurately diagnose ASD, CND and eligible disabilities. It is based on the following:



- National guidelines for ASD assessment (as highlighted in Recommendation 6) require the diagnostician to weigh input from an allied health diagnostician and other allied health informants (including allied health professionals) in making their diagnosis. Communication between the referring practitioner and allied health professionals is important in making an ASD diagnosis (30).
- The Reference Group agreed, based on an overview provided by two members working in this field, that allied health professionals often undertake case conferences specifically to determine whether a child meets the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) criteria for ASD or a different eligible disorder. It agreed that these interactions are an important part of the ASD diagnostic process and should be enshrined in the MBS.
- The Reference Group agreed that new items are not necessary for this purpose. Allowing current assessment items (and those added through Recommendation 6 to be used for case conferencing would provide adequate capacity for allied health professionals to assess children and liaise with the referring practitioner.
- Case conferences would not require the child to be present, but the parents of the child may be invited to attend.
- To ensure equitable access to assessment services for patients with eligible disabilities, the recommended change to assessment items should apply to both ASD *and* eligible disabilities under the MBS.

5.3.7 Recommendation 9 – Improve access to M10 treatment items as group therapy

The Reference Group recommends allowing M10 treatment items to be delivered as group therapy under the HCWA program, including:

- (i) allowing the 20 M10 treatment items for the HCWA program to be delivered as either group therapy (with two to four participants) or individual therapy;
- (ii) requiring at least one allied health professional to be present for the full group session;
- (iii) allowing all allied health professions to deliver these services when nominated on the care plan; and
- (iv) specifying a minimum duration of 60 minutes for group sessions.

5.3.8 Rationale 9

This recommendation focuses on ensuring that the MBS provides access to flexible, high-value care to children with ASD. It is based on the following:



- Evidence indicates that group-based social skill interventions are at least as effective as individual therapy for patients with ASD. Miller et al. conducted a systematic review of 44 studies on group-based ASD therapy and identified significant evidence demonstrating the usefulness of social skills groups as an intervention for adolescents with ASD (31). Tachibana et al. showed that for pre-school children with ASD, both individual and group interventions showed significant effects (compared to the control condition) on overall outcomes of “reciprocity of social interaction towards others.” (32).
- Group-based interventions provide social and support networks for families facing similar challenges.
- Children and adolescents need group opportunities to generalise social skills learnt in individual sessions to small, supported groups of peers. This is a stepping stone to using skills in larger groups, such as in kindergarten and at school. Children and adolescents also develop a social network and social supports in group treatment. Children and adolescents who have no friends often make long-term connections with other members in the groups.

5.3.9 Recommendation 10 – Improve access to M10 items for patients with severe speech and language disorders

The Reference Group recommends:

- a. including patients with severe speech/language disorders in the list of eligible disabilities under M10 items
- b. the list of eligible disabilities for M10 items be extended to include:
 - (i) Stuttering.
 - (ii) Speech Sound Disorder (SSD) (includes phonology and childhood apraxia of speech) that results in either:
 - Persistent difficulty with perception, production, and/or representation of consonants, vowels, syllables, words, and/or prosody (tones, rhythm, stress, and intonation) that interferes with speech intelligibility and/or acceptability. (33) (34) (35) (36).
 - Limitations in effective communication that interfere with social participation, academic achievement or occupational performance, individually or in any combination. (33)
 - (iii) Developmental language disorder, where the child or adolescent scores more than 1.5 standard deviations below the mean on a standardised language assessment.



Note: Further consultation will be needed to determine which language assessment to use. Options include the Pre-school Language Scale, Fifth Edition (37) and the Clinical Evaluation of Language Fundamentals (38), used in conjunction with functional impact reports.

and

- c. particularly for younger children, developing a list of concerns or “red flags” for GPs to use to help identify when children who may have these conditions should be referred for assessment (refer to Appendix E for a sample list).

5.3.10 Rationale 10

This recommendation focuses on ensuring that the MBS provides equitable access to assessment and treatment services for children with disabilities. It is based on the following:

- Evidence shows that allied health interventions improve outcomes for children with the following conditions.
 - **Stuttering.** Stuttering is a severe communication disorder that can worsen with age and become permanent if untreated. Early intervention is the most effective and efficient intervention. The Lidcombe program, delivered by a qualified speech pathologist, is the gold standard treatment for stuttering in children. (39) A meta-analysis ($n = 136$) of Lidcombe program clinical trials and short exposure experiments showed an odds ratio of 7.7 for recovery from stuttering for those exposed to the program (40).
 - **Developmental language disorder.** A Cochrane meta-analysis found that speech and language therapy appeared effective for children with phonological or vocabulary difficulties (but less effective for children with receptive difficulties). (41) Other research supports the effectiveness of speech and language therapy (42).
 - **Speech Sound Disorder (SSD) (includes phonology and childhood apraxia of speech).** Speech and language interventions, as provided by speech pathologists, have been shown to be effective in improving clinical outcomes in children with phonological difficulties (28). Research into the most effective therapies for childhood apraxia of speech (CAS) has expanded during the last five years. Murray et al. recommend that clinicians use a variety of treatment methods to improve outcomes. (43) Qualified speech pathologists deliver these treatments.
- The Reference Group agreed, based on clinical experience, that this patient cohort does not have adequate access to allied health services through CDM plans and TCAs because they are not often considered to have a “chronic condition”. These conditions are not



always eligible for support under the NDIS (based on clinical experience engaging with families with speech, language or stuttering conditions).

- Adding children with the above conditions to the list of eligible disabilities under the MBS would improve access to services through access to associated Schedule fees.
- The Reference Group agreed that any conditions added to the list of eligible disabilities under the MBS should be comparable to existing conditions on the list in terms of impact on quality of life.

5.3.11 Recommendation 11 – Improve access to the ASD and eligible disability assessment to people under 25

The Reference Group recommends increasing the age limits on the following items:

- a. 82000, 82005, 82010 and 82030 – from 13 to 25 years old
- b. 82015, 82020, 82025 and 82035 – from 15 to 25 years old, and
- c. Changing the relevant item descriptors to say “a child or young adult” instead of “child”.

5.3.12 Rationale 11

This recommendation focuses on ensuring that the MBS provides access to high-quality health services for young adults with ASD and/or eligible disabilities. It is based on the following:

- ASD is increasingly being diagnosed between the ages of 13 and 25, particularly in people with mental health illnesses, and in parents who may have undiagnosed ASD and may seek a diagnosis for themselves after their child has been diagnosed.
- There is a need to support young adults with ASD and disabilities as they go through important transitions, such as secondary to tertiary education, and education to employment; and to address evolving physical and mental health issues associated with moving into adulthood.
- Research has indicated that formal transition plans are often missing for tertiary students with ASD. Many students feel the need for extra support, and comorbid anxiety, depression and executive function difficulties are major contributors to student difficulties (44).
- National guidelines for ASD assessment (as highlighted in Recommendation 6) specify that allied health professionals should be involved in making an ASD diagnosis. (45)
- For patients over the age of 13 with a potential ASD diagnosis, there is no Schedule fee available for allied health assessment services. Patients require a diagnosis to access



allied health services through Helping Children (people) with Autism Plans/M10 items. If patients over 13 who require assessment for ASD and/or eligible disabilities cannot pay out of pocket for allied health assessment services, they may remain undiagnosed and without treatment.

- Extending current M10 items for ASD and CND to young adults under 25 years old would facilitate high-quality care for Australians presenting late with ASD.
- To ensure equitable access to services for patients with eligible disabilities, the recommended changes should apply to both ASD *and* eligible disabilities under the MBS.
- To ensure equitable access to treatment services for children and adolescents, the recommended increase in age to 25 should apply to both assessment *and* treatment sessions.
- The Reference Group noted that assessment services are not provided under the National Disability Insurance Scheme (NDIS) and that the MBS would provide an important service to eligible adolescent and young adults requiring an ASD assessment.

5.3.13 Recommendation 12 – Improve allied health collaboration during assessments

The Reference Group recommends:

- a. allowing inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities and ASD (items 82000, 82005, 82010 and 82030), and
- b. referrals be permitted:
 - (i) Within the first group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope).
 - (ii) Within the second group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope), if Recommendation 7 of this report is implemented.
 - (iii) In consultation and agreement with, but without a physical attendance by, the original referring practitioner (i.e. via telephone call, secure messaging):
 - For M10 items for ASD, the original referring practitioner is the referring paediatrician or psychiatrist.
 - For M10 items for eligible disabilities, the original referring practitioner is the referring specialist, consultant physician or GP.



5.3.14 Rationale 12

This recommendation focuses on ensuring that patients with potential ASD and eligible disabilities have access to timely diagnosis. It is based on the following:

- Based on clinical experience, the Reference Group agreed that there are instances where inter-disciplinary referral between allied health professionals facilitates a more timely diagnosis.

For example, a paediatrician may refer a child (using M10 items) to a speech pathologist for diagnosis of ASD. Based on information collected when assessing the patient, the speech pathologist may identify that the patient needs to see another allied health professional to meet the diagnostic requirements of the national guidelines for ASD assessment (as highlighted in Recommendation 6). Under the current system, the patient must return to the paediatrician to get a referral for an assessment appointment with the second allied health professional in order to be rebated under the MBS. Wait lists for specialists are often long, and requiring a patient to return to the referring practitioner for an additional allied health referral can slow down the ASD assessment phase.

- Throughout its discussions on this recommendation, Reference Group members who assess patients with potential ASD reported that inter-disciplinary referral between allied health professionals already occurs, but there are no Schedule fees for M10 items. Instead, patients who are referred to an allied health professional by another allied health professional for assessment of ASD or an eligible disability must pay the full cost of the service out of pocket or through private health insurance.
- To ensure equitable access to services for patients with eligible disabilities, the recommended changes should apply to both ASD *and* eligible disabilities under the MBS.

5.4 The role of telehealth in allied health care

5.4.1 Recommendation 13 – Improve access to allied health services via telehealth

The Reference Group recommends:

- a. undertaking a follow-on piece of work detailing the highest-value opportunities for telehealth integration into allied health care, to gather national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials and to identify:
 - (i) Telehealth interventions provided by allied health professionals with evidence for comparable or superior clinical outcomes (compared with face-to-face interventions).



- (ii) Cost savings associated with using telehealth in allied health care.
 - (iii) The views of consumers and feedback on telehealth use in allied health care.
 - (iv) Exploring the use of telehealth interventions to complement existing models of care, especially for rural and remote areas.
 - b. in the interim, creating a new MBS item for the provision of telehealth services for patients consulting with an allied health professional via teleconference, with the following restrictions:
 - (i) The patient must not be an admitted patient.
 - (ii) The patient must be located both within a telehealth-eligible area and at least 15 kilometres from the Allied Health Professional.
 - (iii) The patient must reside in a rural or remote region (defined as Modified Monash Regions 4 to 7).
 - (iv) The allied health professional must be a primary health care provider for the patient, defined as having had at least two consultations with the patient.
- and
- c. that the new item should only be claimable for types of allied health professionals who can deliver comparable outcomes via teleconference as in face-to-face consultations to ensure that there is no compromise in service delivery or standard of care.

5.4.2 Rationale 13

This recommendation focuses on improving access to effective telehealth services. It is based on the following:

- The Reference Group acknowledged that telehealth could be used to improve delivery of allied health care for rural and remote populations. However, it also noted that the current fee-for-service system under the MBS does not always create the right incentives for telehealth.
- There are 382 allied health professionals per 100,000 people in metropolitan areas, compared to just 136 in remote/very remote areas. (46) In rural and remote areas, one in five patients report that they experience longer-than-acceptable waits to access health services (47).
- The Reference Group agreed that this recommendation has the following benefits:
 - It would increase allied health service provision in remote, regional and rural areas. This would decrease the need for patients in rural and remote communities to travel (and take time off work) to receive allied health care.



- For providers already providing telehealth services, the recommendation would reduce out-of-pocket fees by allowing rebates for patients. This would relieve the financial burden on patients who already face the hardships of distance, limited service provision and inequitable access to services.
- The recommendation would increase local employment by creating opportunities for locally based allied health assistants (who may provide patient-side support).
- There is some evidence to support telehealth interventions in allied health care. A recent Australian review of allied health video consultation services found that clinical outcomes have generally been similar to outcomes for usual care, although it acknowledged large differences in the breadth and quality of evidence between different allied health professionals (48).

There is evidence that telephone counselling by a dietitian achieves dietary behaviour change and improves metabolic parameters in individuals with metabolic syndrome. Swanepoel and Hall (2010) conducted a systematic review of telehealth applications in audiology and found that outcome measures for conventional face-to-face services and remote telehealth services were similar, with no negative impact on patients who received telehealth services. Various types of audiological assessment were found to be viable, such as otoscopy, pure-tone audiometry, immittance audiometry, otoacoustic emission, and auditory brainstem response audiometry, with no clinically significant differences in results compared to face-to-face administration of these assessments (49)

5.5 Non-dispensing pharmacists

5.5.1 Recommendation 14 – Allow non-dispensing pharmacists to access allied health items

The Reference Group recommends adding an item to allow pharmacists to provide medication management services to patients with complex care requirements outside of usual retail pharmacy operations as part of TCAs under M3 MBS items (up to twice a year).

5.5.2 Rationale 14

This recommendation focuses on improving access to medication education and management. It is based on the following:

- Pharmacists are not included in the individual allied health services (items 10950–10970) for CDM items.
- An estimated 230,000 medication-related hospital admissions occur each year, with an estimated annual cost of \$1.2 billion (50). These admissions are potentially avoidable.
- Pharmacy-led medication reconciliation interventions were found to be an effective strategy to reduce medication discrepancies (51).



- Consultations undertaken by pharmacists located within primary health care clinics have been shown to be effective in identifying and resolving medication-related problems in patients with complex care requirements (52; 53).
- Several submissions to the MBS Review supported funding for pharmacists to deliver medication management services as a way of improving health outcomes and reducing medication-related hospitalisations. This included submissions from the Northern Territory Government, the Pharmaceutical Society of Australia and the Australian Healthcare and Hospitals Association.
- The Australian Medical Association (AMA) and the Pharmaceutical Society of Australia (PSA) has released a proposal to make non-dispensing pharmacists a key part of the future general practice health care team allowing potential of savings of public funds and avoidable hospitalisations (54).



6. Longer-term recommendations

6.1 An allied health research base

6.1.1 Recommendation 15 – Support the codifying of allied health research and evidence

The Reference Group recommends:

- a. building an allied health research base, and
- b. investing in allied health research—potentially funded by the Medical Research Future Fund (MRFF)—in the following ways.
 - (i) Collect and publish data on allied health usage patterns across all funding streams in one place. This data should provide transparency on which patients use which allied health interventions and should be publicly available. Information on both the therapy delivered and the outcome measures should be collected and included to build a robust data set for future research.
 - (ii) Identify priority areas for research, based on gaps in current research and burden of disease in the community. The Reference Group noted the following topics as high priorities.
 - Effective strategies for establishing behaviour change and self-management, as well as validated tools to measure this.
 - Effective multidisciplinary/integrated care approaches to CDM and primary prevention.
 - Interventions to address the burden of chronic disease in Australia and health inequities (for example, among Aboriginal and/or Torres Strait Islander peoples, rural and remote communities, people with low socio-economic status).
 - Long-term outcomes for patients with chronic disease receiving allied health interventions.
 - The frequency and intensity (“dose”) of allied health appointments that improve outcomes for patients.
 - The cost-effectiveness profiles of different allied health interventions.



- (iii) Collate available, high-quality evidence for allied health interventions into an easy-to-use guide for allied health and other health professionals.

6.1.2 Rationale 15

This recommendation focuses on ensuring impactful investment into allied health research. It is based on the following:

- The Reference Group identified three main issues with current allied health research:
 - Data collection and collation on allied health usage patterns across state, federal, private health insurance and privately funded allied health services is inadequate. For example, an Australian Bureau of Statistics survey revealed a 38 per cent average increase in services for 10 allied health professions between 2011-12 and 2014-15. It is not known why the Australian population is using more services (55).
 - High-quality evidence on the effectiveness of some allied health interventions is limited.
 - Available evidence has not been adequately translated into easy-to-use guidelines for health care professionals (including non-allied-health professionals, such as GPs).
- Investing in evidence-based allied health interventions would facilitate the provision of cost-effective, high-quality care to Australians. The Reference Group agreed that the proposals outlined in Recommendation 13 could identify the best ways to target allied health interventions to provide cost-effective, high-value care.
- The Reference Group noted the following specific issues regarding a lack of effective strategies to increase patient compliance:
 - Non-compliance with home exercises in musculoskeletal cohorts can be between 30 per cent and 50 per cent. This places an additional burden on patients and health care providers and may be partially to blame for poor clinical outcomes. Strong exercise adherence is linked to improved treatment outcomes in patients experiencing neck and back pain and osteoarthritis symptoms.
 - It is widely accepted that there is no gold standard for measuring adherence to unsupervised home-based exercise at present. A significant proportion of outcome measures used in the literature rely on patient self-report and are therefore susceptible to bias.
 - Good adherence requires an individual to change, alter or even maintain a behaviour. Reasons affecting adherence rates include perceived barriers such as a lack of time, work commitments, the patient's own beliefs or their self-efficacy regarding the exercise task. For patients with chronic pain, compliance will also decrease if the home exercise increases their pain. Improved tracking of patients'



coping strategies, pain and difficulties with home-based exercise should improve rehabilitation outcomes.

- Biomedical research tends to dominate Australian health research, but it is not always the most cost-effective way to improve outcomes for patients (56). The Reference Group agreed that this recommendation would provide an opportunity for the MRFF to invest in practical, policy-level research in allied health.

6.2 Non-fee-for-service allied health payment models

6.2.1 Recommendation 16 - Pilot non-fee-for-service allied health payment models

The Reference Group recommends:

- a. undertaking a piece of work to understand how bundled and other non-fee-for-service remuneration models could help to better integrate allied health into the Australian primary health care system, to include the following:
 - (i) Undertaking a cost-effectiveness analysis on the benefit of better integrating allied health into Australian primary health care.
 - (ii) Reviewing patient groups, diseases and conditions that would benefit most from such integration.
 - (iii) Designing and detailing remuneration models that would help to improve integration of allied health into the health care system.
 - (iv) Monitoring patient outcomes from increased allied health intervention.
 - (v) Determining a pilot approach for implementation of these findings.

and

- b. any pilot of a non-fee-for-service system for allied health care in Australia should preserve the autonomy of allied health professionals and should be voluntary for patients.

6.2.2 Rationale 16

This recommendation focuses on incentivising high value care. It is based on the following:

- The MBS fee-for-service system does not always provide the right incentives for high-value care.
- The fee-for-service system may not always improve patient outcomes via allied health care in the most timely or cost-effective way.
- There is some evidence that allied health improves patient outcomes and is cost-effective for the health care system (Appendix D).



- A research project could identify the most efficient and effective models to maximise the potential benefits of allied health care.

6.3 Communication between patients, allied health professionals and GPs

6.3.1 Recommendation 17 – Enhance communication between patients, allied health professionals and GPs

The Reference Group recommends:

- a. investing in a CDM pathway education campaign for allied health professionals and GPs (especially if the MBS Review results in significant changes). This should promote shared decision-making, which integrates a patient's values and care goals with the best available clinical evidence in order to make treatment decisions
- b. improving communication between allied health professionals and GPs by:
 - (i) Providing financial support for GPs and private allied health professionals to set up secure messaging systems. This would enable fast, confidential communication.
 - (ii) Promoting more formal referrals between GPs and allied health professionals. Referrals under CDM plans should take the form of a referral letter, similar to a referral to any other medical specialist (although these could still be sent virtually via a secure system).
 - (iii) Ensuring, where possible, that all referrals and communication are uploaded to My Health Record (for patients who have not opted out). This should include information on the number of used and available allied health appointments under a patient's CDM plan. This will allow allied health professionals and GPs to accurately inform patients about their care and likely associated costs.

and

- c. streamlining referrals from one allied health professional to another, in consultation with a GP. The above methods for enhancing communication between practitioners could foster faster communication when referral to another allied health professional may be appropriate.

6.3.2 Rationale 17

This recommendation focuses on simplifying and streamlining communication between allied health professionals, GPs and consumers. It is based on the following:

- The Reference Group identified several issues relating to communication between GPs, patients and allied health professionals.



- Consumers are often unaware of the number of rebated appointments that are available for allied health MBS items throughout their treatment, and that there is likely to be a gap payment. This can be due to a lack of information for consumers, leading to an assumption that the service will be free.
- Consumers are often unaware of why they have been referred to an allied health professional.
- Standardised CDM item forms lack scope for referral details, which means that allied health professionals have limited information to inform their treatment. This sometimes results in consumers needing to return to the referring practitioner, which is time-consuming, delays treatment and is less efficient.
- Inflexible communication methods between allied health professionals and GPs (often telephone is the only option) limits allied health professionals' ability to clarify components of a patient's care plan.
- Although software for secure communications is available, allied health professionals often cannot afford to invest in it.
- Consumers will benefit from the above recommendation because it will increase transparency in their care and improve the efficiency of CDM care pathways. The Reference Group noted, as an example, the work done by the Brisbane South PHN in improving communication between providers for CDM.

6.4 The role of allied health in the Australian public health care system

6.4.1 Recommendation 18 - Expand the role of allied health in the Australian public health care system

The Reference Group recommends:

- a. facilitating equitable access to clinically appropriate allied health services for individuals with identifiable risk factors for chronic disease in order to prevent the occurrence, or delay the onset, of chronic conditions (primary prevention)
- b. that this could be achieved in the following ways.
 - (i) Through the MBS:
 - Enable MBS-funded allied health services to be accessed through health assessment items.
 - Create a GP Primary Prevention Plan (GPPP) to provide access to evidence-based allied health interventions for people with identifiable risk factors who do not meet the criteria for a GPMP—for example, individuals with pre-diabetes, hypertension, hypercholesterolemia or high body mass index (BMI; overweight/obesity).



(ii) Outside the MBS:

- Expand publicly funded, community-based allied health group interventions aimed at lifestyle modification, potentially through state and territory funding.

and

c. eligible risk factors should include those with high prevalence and a large impact on health status such as those identified in the 2011 Australian Burden of Disease Study (57), including:

- (i) Tobacco use (accounting for 9.0 per cent of the total burden).
- (ii) High BMI, related to overweight and obesity (7.0 per cent of the total burden, based on enhanced analysis by the Australian Institute of Health and Welfare published in 2017, which used updated evidence of diseases associated with overweight and obesity and enhanced modelling techniques).
- (iii) Alcohol use (5.1 per cent of the total burden).
- (iv) Physical inactivity (5.0 per cent of the total burden).
- (v) High blood pressure (4.9 per cent of the total burden).

6.4.2 Rationale 18

This recommendation focuses on enhancing the complimentary role of allied health across the health system. It is based on the following:

- Allied health services are not leveraged enough to help Australia reach its strategic objectives for chronic disease. These objectives can be broken down into three desirable outcomes (58):
 - Reduce the proportion of Australians living with preventable chronic conditions or associated risk factors.
 - Meet the voluntary global targets outlined in the World Health Organization's Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020 (59).
 - Provide timely interventions to Australians with chronic conditions or associated risk factors to achieve optimal health outcomes.
- Currently, the MBS and state and territory government services are the primary avenues through which patients with chronic disease can access publicly funded community-based allied health services. The MBS does not enable equitable access to lifestyle modification interventions and primary prevention facilitated by allied health professionals for people with identifiable risk factors of chronic disease.



- Investing in preventive health care offers the opportunity to improve clinical outcomes, reduce the burden of disease in the community and deliver cost savings to the Australian health system.
- A report commissioned by the Australian National Preventive Health Agency (2012), titled *The Role of Australian Primary Health Care in the Prevention of Chronic Disease*, supported referral programs to reduce risk factors for chronic disease, including those delivered by allied health professionals (60). This review noted the following:
 - There is increasing evidence that brief interventions in general practice—especially for diet, physical activity, weight and multiple risk factors of chronic disease—are important and valuable, but insufficient to achieve and maintain behaviours and physiological changes.
 - Referral programs need to be of sufficient intensity (usually at least six sessions over several months) to be effective and sustainable.
 - Referral programs should be integrated into primary health care, with primary health care providers involved in initial assessment and long-term follow-up.
 - Maintenance of behaviour change is the major goal of long-term monitoring and support.
- There is evidence to support the efficacy of allied health interventions in reducing risk factors for and progression to chronic disease, including:
 - **Impaired glucose tolerance (pre-diabetes):** Exercise has been shown to improve blood glucose control, reduce cardiovascular risk factors, contribute to weight loss and improve well-being in patients with pre-diabetes (61). Improvements in diet and physical activity have specifically been shown to delay the incidence of type 2 diabetes in people with impaired glucose tolerance (pre-diabetes) (62). Other studies have shown that these interventions are also cost-effective. For example, a systematic review identified median incremental cost-effectiveness returns for diet and physical activity promotion programs of \$13,761 per quality adjusted life year (QALY) saved. For people with pre-diabetes, delivery of an exercise intervention by an accredited exercise physiologist brings expected annual savings in health system expenditure of \$1,977 per person (63).
 - **Hypertension:** Lifestyle modification, including increased physical activity and dietary changes, is considered a first-line treatment for patients with low-risk profiles aiming to reduce blood pressure while concurrently reducing the risk of cardiovascular events (63). The Activity, Diet and Blood Pressure Trial's (ADAPT) 16-week lifestyle modification program promotes weight loss; a low-sodium diet, high in fruit, vegetables and fish; increased physical activity; and reduced alcohol intake. It has been shown to lead to short- and medium-term benefits, with the potential



for long-term reduction of cardiovascular risk in patients treated for hypertension (64). It is recognised that allied health professionals (for example, exercise physiologists, physiotherapists, dietitians) play an important role in the management of patients with hypertension by influencing and reinforcing appropriate lifestyle behaviours to achieve blood pressure control (65) (66).



7. Impact statement

Both consumers and allied health professionals are expected to benefit from the recommendations in this report. In making its recommendations, the Reference Group's primary focus was ensuring consumer access to high-quality allied health services. The Reference Group also considered each recommendation's impact on allied health professionals to ensure that it was fair and reasonable.

Consumers will benefit from the Reference Group's recommendations through improved access to higher quality allied health services that complement primary care stewardship, particularly in chronic disease management, complex neurodevelopmental disorder management and high-quality group therapy.

- **Improved access to allied health services:** The Reference Group has recommended to expand the number of MBS-funded allied health consultations for patients who have complex and chronic conditions. The Reference Group's recommendation for expanding the number of MBS-funded consultations for patients with chronic conditions would help ensure that the best preventive and treatment outcomes are provided. The Reference Group's recommendation for new orthotic and prosthetic items would support timely and appropriate preparation and education for patients when given their prosthesis. Increasing the number of appointments for children being assessed for ASD or other eligible disabilities would help these patients to be correctly diagnosed and assessed by the appropriate range of allied health professionals. Including severe speech and language disorders in the M10 would recognise the impact of speech and language disabilities in the community, and provide an appropriate avenue for treatment. Improving allied health access to telehealth would promote timely allied health advice and follow up for patients in rural and remote regions.
- **Removing inefficiencies and barriers to care:** The Reference Group has recommended that available allied health services be expanded where they are integral to effective, holistic care. Allowing allied health services to be accessed through GP-led primary prevention plans would help patients with risk factors and chronic conditions receive appropriate allied health services early. Longer assessment consultations would ensure



that patients with complex or chronic conditions are provided with a comprehensive assessment and follow up care. Broadening assessment items to allow more appropriate allied health professionals to be involved in the diagnosis and case management of patients would expand patients' access to the most comprehensive healthcare available. Extending disability assessment and treatments for ASD and eligible disabilities to persons under the age of 25 would promote continuous support for young adults through important life transitions. Allowing practitioners to communicate with each other through case conferencing would support timely, appropriate care.

- **Improved patient access to high quality group therapies:** The Reference Group has recommended that group therapies be incentivised and expanded. Allowing M10 treatment items to be delivered as group therapy would help realise the social and support benefits of groups, particularly for children and carers. Increasing the schedule fee for certain group therapies would also improve the viability of these high-quality interventions as a business model.

Allied health professionals would benefit from the Reference Group's recommendations through a more accurate representation of their scope of practice being reflected in the MBS, and through the increased financial recognition of the care they provide. Allied health professionals, more broadly, would benefit from the Reference Group's recommendations by having increased choice in working models as allied healthcare becomes a financially and structurally viable option.

Consumers, allied health professionals and the Australian health care system would benefit from overall increased investment in allied health, particularly in allied health research and future models of allied health financing. These benefits would accrue from high-quality, cost-effective prevention and treatment outcomes that benefit patients and the community both now and into the future.



8. References

1. **Association, Australian Physiotherapy.** *National Physiotherapy Service Descriptors*. s.l. : APA, 2018.
2. **Chiropractic Board of Australia.** *Code of conduct: for chiropractors*. s.l. : AHPRA, 2014.
3. **Australia, Occupational Therapy Board of.** *Code of Conduct*. s.l. : AHPRA.
4. **Osteopathy Board of Australia.** *Code of Conduce*. s.l. : AHPRA, 2014.
5. **Australia, Pharmacy Board of.** *Code of Conduct*. s.l. : AHPRA, 2014.
6. **Osteopathy Australia.** *Osteopathy Service Descriptors*. s.l. : Osteopathy Australia,, 2018.
7. **Authority, State Insurance Regulatory.** *Workers Compensation (Physiotherapy, Chiropractic and Osteopathy Fees)*. s.l. : NSW Government Gazette No 126, 2017.
8. **Allied Health Reference Group member analysis.** *Osteopathy rebates in major private health funds. Unpublished analysis of rebates at health funds*. 2018.
9. **HICAPS.** HICAPS item number guides. *HICAPS*. [Online] 2018. [Cited: 5 September 2018.]
10. **Department of Veteran Affairs.** Dental and Allied Health fee schedules. *Department of Veteran Affairs*. [Online] Australian Government, 2018.
<https://www.dva.gov.au/providers/fees-schedules/dental-and-allied-health-fee-schedules>.
11. **Commission, Transport Accident.** Fee Schedules. [Online] Victorian Government, 2018.
<http://www.tac.vic.gov.au/providers/invoicing-and-fees/fee-schedules>.
12. **Australian Institute of Health and Welfare.** *Private health insurance expenditure 2015-16*. s.l. : Australian Government, 2018.
13. **The Australian Orthotic Prosthetic Association.** *Inclusion of Orthotic Services in Medicare*. Hartwell : Australian Orthotic Prosthetic Association, 2018.
14. *Guidance on footwear and offloading interventions to prevent and heal foot ulcers in patients with diabetes.* **Bus, S., Armstrong, D., van Deursen, R., Lewis, J., Caravaggi, C., & Cavanagh, P.** s.l. : International Working Group on the Diabetic Foot, 2015.



15. *The cost of diabetic foot: The economic case for the limb salvage team.* **Driver, VR., Fabbi, M., Lavery, L., & Gibbon, G.** s.l. : Journal of Vascular Surgery, 2010.
16. *Ankle-foot orthoses in stroke: Effects on functional balance, weight-bearing asymmetry and the contribution of each lower limb to balance control.* **Simons, C., van Asseldonk, E., van der Kooij, H., Geurts, A., Buurke, J.** s.l. : Clinical biomechanics, 2009.
17. *Orthotic devices after stroke and other non-progressive brain lesions.* **Weerdesteyn, V., de Nit, M., van Duijnhoven, H., Geurts, A.** s.l. : Cochrane Database of Systematic Reviews,, 2009.
18. *Best practice statement: Use of ankle-foot orthoses following stroke.* **NHS Quality Improvement Scotland.** s.l. : NHS, 2009.
19. *The effectiveness of off-loading knee orthoses in the reduction of pain in medial compartment knee osteoarthritis: A systematic review.* **Feehan, N., Trexler, G., & Barringer, W.** s.l. : Journal of Prosthetics and Orthotics, 2012.
20. *Orthotic Service in the NHS: Improving Service Provision.* **Hutton, J., & Hurry, M.** s.l. : York Health Economics Consortium, 2009.
21. **Allied Health Professions Australia.** *Briefing paper for the Department of Health.* s.l. : Unpublished paper, 2017.
22. **Department of Health.** *The National Health Workforce Dataset.* Canberra : Australian Government, 2016.
23. **Association, The Australian Orthotic and Prosthetic.** *Inclusion of Orthotic Services in Medicare.* [Online] <https://www.aopa.org.au/documents/item/704>.
24. *Exercise-based rehabilitation for heart failure.* **Taylor RS, Sagar V, Davies EJ, Briscoe S, Coats AJS, Dalal H, Lough F, Rees K, Singh SJ, Mordi IR.** s.l. : Cochrane Database of Systematic Reviews, 2014.
25. **Queensland Health.** *FEEDS: An evidenced-based demand management toolkit for dietetic services.* s.l. : The State of Queensland, 2017.
26. **Clinical Oncology Society of Australia.** *COSA Position Statement on exercise in cancer care.* s.l. : COSA.
27. **Cancel Council Victoria.** *Nutrition. Cancer Council Vic.* [Online] 1 May 2016. [Cited: 5 September 2018.] <https://www.cancervic.org.au/living-with-cancer/nutrition>.



28. **James Law, Zoe Garrett, Chad Nye.** *Speech and language therapy interventions for children with primary speech and language delay or disorder*. s.l. : Cochrane Database of Systematic Reviews, 2003.
29. **Department of Health.** 1405 - MBS Item Number for Pulmonary Rehabilitation. *Medical Services Advisory Commission*. [Online] Australian Government, 2017.
30. **AutismCRC.** <https://www.autismcrc.com.au/knowledge-centre/resource/national-guideline>. [Online]
31. *Social Skill Group Interventions for Adolescents with Autism Spectrum Disorders: a Systematic Review*. **Amber Miller, Ty Vernon, Victoria Wu, Krysta Russo,** s.l. : Review Journal of Autism and Developmental Disorders, 2014.
32. *Meta-analyses of individual versus group interventions for pre-school children with autism spectrum disorder (ASD)*. **Yoshiyuki Tachibana, Celine Miyazaki, Masashi Mikami, Erika Ota, Rintaro Mori, Yeonhee Hwang, Akiko Terasaka, Eriko Kobayashi, Yoko Kamio.** s.l. : PLoS One, 2018.
33. **American Psychiatric Association.** 2013, Vol. p. 44.
34. **International Expert Panel on Multilingual Children's Speech.** p. 1 : s.n., 2012.
35. **McLeod, S., & Baker, E.** *Children's speech: An evidence-based approach to assessment and intervention*. Boston, MA : Pearson, 2017.
36. *International aspirations for speech-language pathologists' practice with multilingual children with speech sound disorders: Development of a position paper*. **McLeod, S., Verdon, S., Bowen, C., and the International Expert Panel on Multilingual Children's Speech.** 4, s.l. : *Journal of Communication Disorders*, 2013, Vol. 46.
37. **Pearson Clinical Assessment.** *Preschool Language Scales, Fifth Edition - Australian and New Zealand Language Adapted Edition (PLS-5)*. Pearson Clinical Assessment. [Online] 2018. <https://www.pearsonclinical.com.au/products/view/521>.
38. **Pearson.** *Clinical Evaluation of Language Fundamentals- Fifth Edition*. Pearson Clinical. [Online] 2013. <https://www.pearsonclinical.com/language/products/100000705/clinical-evaluation-of-language-fundamentals-fifth-edition-celf-5.html>.
39. *Randomised controlled trial of the Lidcombe programme of early stuttering intervention*. *The BMJ* [online]. 22 September 2005. **Jones, Mark, Onslow, Mark, Packman, Ann, Williams, Shelley, Ormond, Tika, Schwarz, Ilsa and Gebbski, Val.** 2005.



40. Stuttering. In P. Sturme & M. Hersen(eds), *Handbook of Evidence - based practice in clinical psychology: vol 1. Child and adolescent disorders* (pp. 185 -207. Hoboken, NJ: Wiley).

Onslow, M., Jones, M., Menzies, R., O’Brain, S., & Packman, A . 2012.

41. Speech and language therapy interventions for children with primary speech and language delay or disorder. **Law, J., Garrett, Z., Nye, C.** s.l. : Cochrane Database of Systematic Reviews, 2003, Vol. 21 July 2003.

42. Is speech and language therapy effective for children with primary speech and language impairment? Report of a randomized control trial. **Broomfield J, Dodd B.** 6:628-640, s.l. : International Journal of Language and Communication Disorders, 2011, Vol. 46.

43. **Elizabeth Murray, Patricia McCabe, and Kirrie J. Ballard,.** A Systematic Review of Treatment Outcomes for Children with Childhood Apraxia of Speech. s.l. : American Journal of Speech-Language Pathology, 2014.

44. **Cai, R. Y., & Richdale, A. L.** Educational experiences and needs of higher education students with autism spectrum disorder. s.l. : Journal of Autism and Developmental Disorders, 2016.

45. **Prof Andrew Whitehouse, Dr Kiah Evans, Prof Valsamma Eapen, Prof Margot Prior, A/Prof John Wray,.** The diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia: A national guideline. Draft version for community consultation. s.l. : Autism CRC, 2017.

46. **Australian Institute of Health and Welfare.** Workforce Data. s.l. : AIHW, 2012.

47. **Wellington, R.** Rural health suffers as demand for allied health exceeds supply. Health Voices. s.l. : Consumers Health Forum of Australia, 2016. 19.

48. **Melissa Raven, Petra Bywood,.** Allied health video consultation services. s.l. : Primary Health Care Research and Information Service (PHCRIS), 2013.

49. **Swanepoel de W, Hall JW,.** A systematic review of telehealth applications in audiology. s.l. : Telemed J E Health, 2010.

50. **Roughead, E. E., Semple, S. J., & Rosenfeld, E.** The extent of medication errors and adverse drug reactions throughout the patient journey in acute care in Australia. s.l. : International Journal of Evidence-Based Healthcare, 2016.

51. **Mekonnen, A. B., McLachlan, A. J., & Brien, J. E.** Pharmacy-led medication reconciliation programmes at hospital transitions: a systematic review and meta-analysis. s.l. : Journal of Clinical Pharmacy and Therapeutics, 2016.



52. **Tan, E. C. K., Stewart, K., Elliott, R. A., & George, J.** *Pharmacist consultations in general practice clinics: The Pharmacists in Practice Study (PIPS)*. s.l. : Research in Social and Administrative Pharmacy, 2014.
53. **Batterham, R., Lawson, M., & Minogue, R.** *Pharmacy and General Practice Disease Management Collaboration Final Report*. 2003.
54. **Association, Australian Medical.** <https://ama.com.au/article/general-practice-pharmacists-improving-patient-care>. [Online]
55. **Statistics, Australian Bureau of.** *Health Service Usage and Health Related Actions*. Canberra, Australia : s.n., 2013-14.
56. **Wilsdon, Richard Jones and James.** *The Biomedical Bubble*. s.l. : Nesta, 2018.
57. **Welfare, Australian Institute of Health and.** *Australian Burden of Disease Study*. Canberra : Australian Government, 2011.
58. **Australia's Health Ministry Advisory Council.** *National Strategic Framework for Chronic Conditions*. Canberra : Australian Government, 2017.
59. **World Health Organization.** *Global Action Plan for the Prevention and Control of NCDs 2013-2020*. Genva : WHO LIBRARY CATALOGUING-IN-PUBLICATION DATA, 2013.
60. **Harris, M., & Lloyd, J.** *The role of Australian primary health care in the prevention of chronic disease*. Canberra : Australian National Preventative Health Agency, 2012.
61. *Standards of Medical Care in Diabetes*. **American Diabetes Association**. 2018, *The Journal of Clinical and Applied Research and Education*, Vol. 41.
62. *Diet, physical activity or both for prevention or delay of type 2 diabetes mellitus and its associated complications in people at increased risk*. **Hemmingsen, B, et al.** 12, 2017, *Cochrane Database of Systematic Reviews*.
63. **Deloitte Access Economics.** *Value of Accredited Exercise Physiologists in Australia*. Canberra : Deloitte Access Economics Pty Ltd, 2015.
64. *A lifestyle program for treated hypertensives improves cardiovascular risk factors: a randomized controlled trial*. **Burke, V, et al.** 3, 2006, *Atherosclerosis. Supplements*, Vol. 7, p. 386.
65. *The seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure*. **Chobanian, AV, et al.** 19, 2003, *JAMA*, Vol. 289, pp. 2560-72.



66. Australian Association for Exercise and Sports Science Position Statement on Exercise and Hypertension. **Sharman, JE and Stowasser, M.** 2009, *Journal of Science and Medicine in Sport*, Vol. 12, pp. 252-257.
67. **Mosalman Haghighi M, Mavros Y, Fiatarone Singh MA,.** The Effects of Structured Exercise or Lifestyle Behavior Interventions on Long-Term Physical Activity Level and Health Outcomes in Individuals With Type 2 Diabetes: A Systematic Review, Meta-Analysis, and Meta-Regression. s.l. : *J Phys Act Health*,, 2018.
68. **Gibson TB, Driver VR, Wrobel JS, Christina JR, et al,.** Podiatrist care and outcomes for patients with diabetes and foot ulcer. s.l. : *Int Wound Journal*, 2014.
69. **McCarthy B, Casey D, Devane D, Murphy K, Murphy E, Lacasse Y,.** Pulmonary rehabilitation for chronic obstructive pulmonary disease. s.l. : *Cochrane Database of Systematic Reviews*, 2015.
70. **Crossley KM, Vicenzino B, Lentzos J, et al,.** Exercise, education, manual-therapy and taping compared to education for patellofemoral osteoarthritis: a blinded, randomised clinical trial. s.l. : *Osteoarthritis Cartilage*, 2015.
71. **Marsh JD, Birmingham TB, Giffin JR, et al,.** Cost-effectiveness analysis of arthroscopic surgery compared with non-operative management for osteoarthritis of the knee. s.l. : *BMJ Open*, 2016.
72. **Froholdt A, Holm I, Keller A, et al.** No difference in long-term trunk muscle strength, cross-sectional area, and density in patients with chronic low back pain 7 to 11 years after lumbar fusion versus cognitive intervention and exercises. s.l. : *Spine J*, 2011.
73. **Lisa Hauk.** Low Back Pain: American College of Physicians Practice Guideline on Noninvasive Treatments. s.l. : *Am Fam Physician*, 2017.
74. **Mak MK, Wong-Yu IS, Shen X, Chung CL,.** Long term effects of exercise and physical therapy in people with Parkinson's disease. s.l. : *Nat Rev Neurol*, 2017.
75. **Williams M, Williamson E, Heine P, et al.** Strengthening And stretching for Rheumatoid Arthritis of the Hand (SARAH). A randomised controlled trial and economic evaluation. *Health Technology Assessment*. s.l. : *Health Technology Assessment*, 2015.
76. Early Identification of Speech, Language, and Hearing Disorders. Information for the Public. [Online] **American Speech-Language-Hearing Association**. [Cited: 10 September 2018.] <https://www.asha.org/public/early-identification-of-speech-language-and-hearing-disorders/#identif>.



77. **NICE.** Phototherapy for Psoriasis. NICE. [Online] n/a n/a 2016. <http://pathways.nice.org.uk/pathways/psoriasis#path=view%3A/pathways/psoriasis/phototherapy-for-psoriasis.xml&content=view-index>.
78. Over 150 potentially low-value health care practices: an Australian study. **Elshaug, Adam, et al.** 2012, *The Medical Journal of Australia*, pp. 556-560.
79. AIHW. National health expenditure data cubes - current and constant prices 1985-86 to 2013-14. Canberra : **Australian Institute of Health and Welfare**, 2018.
80. **Australian Health Ministers' Advisory Council.** National Strategic Framework for Chronic Conditions. Canberra : Australian Government, 2017.
81. AIHW. Evidence for chronic disease risk factors. **Australian Institute of Health and Welfare.** [Online] 19 April 2016. <https://www.aihw.gov.au/reports/chronic-disease/evidence-for-chronic-disease-risk-factors/contents/behavioural-and-biomedical-risk-factors>.
82. **Harris, M and Llyod, J.** The role of Australian primary health care. Canberra : Australian National Preventive Health Agency, 2012.
83. **Australian Government Department of Health.** Australian National Diabetes Strategy 2016-2020. Canberra : Commonwealth of Australia, 2015.
84. **ESSA, DAA & ADEA.** Extending eligibility under Medicare 'Allied Health Group Services for patients. Brisbane : Exercise & Sports Science Australia, 2016.
85. AIHW. Risk factors to health. **Australian Institute of Health and Welfare.** [Online] 07 August 2017. <https://www.aihw.gov.au/reports/biomedical-risk-factors/risk-factors-to-health/contents/risk-factors-and-disease-burden>.
86. **ESSA.** Exercise & Sports Science Australia Submission to the Medicare Benefits Schedule Review to the attention of the Allied Health Reference Group. Brisbane : **Exercise & Sports Science Australia**, 2018.
87. Prevention of type 2 diabetes in the prediabetic population. **Maji, D and Roy RU, Das S.** 11, 2006, *Journal of the Indian Medical Association*, Vol. 103, pp. 609-611.
88. Economic Evaluation of Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among Persons at Increased Risk: A Systematic Review for the Community Preventive Services Task Force. **Li, R, et al.** 6, 2015, *Ann Intern Med*, Vol. 163, pp. 452-60.
89. **Dietitians Association of Australia.** Chronic Disease Prevention and Management in Primary Health Care . Deakin : Dietitians Association of Australia, 2015.



90. **Chou R, et al.** *Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. s.l. : Ann Intern. Med., 2007.*

91. **JONES, Mark, ONSLOW, Mark, PACKMAN, Ann, WILLIAMS, Shelley, ORMOND, Tika, SCHWARZ, Ilsa and GEBSKI, Val, 2005, Randomised controlled trial of the Lidcombe programme of early stuttering intervention. The BMJ [online]. 22 September 2005.**

92. *International Expert Panel on Multilingual Children's Speech (2012). Multilingual children with speech sound disorders: Position paper. Bathurst, Australia: Research Institute for Professional Practice, Learning and Education (RIPPLE), Charles Sturt University. Retrieved from <http://www.csu.edu.au/research/multilingual-speech/position-paper>*

93. **McCormack, J., McLeod, S., & Crowe, K. (2019).** What do children with speech sound disorders think about their talking? *Seminars in Speech and Language, 40*(02), 94-104. doi:10.1055/s-0039-1677760

94. **McCormack, J., Harrison, L. J., McLeod, S., & McAllister, L. (2011).** A nationally representative study of the association between communication impairment at 4-5 years and children's life activities at 7-9 years. *Journal of Speech, Language and Hearing Research, 54*(5), 1328-1348. doi:10.1044/1092-4388(2011/10-0155)

95. **McLeod, S., & Crowe, K. (2018).** Children's consonant acquisition in 27 languages: A cross-linguistic review. *American Journal of Speech-Language Pathology, 27*, 1546–1571. doi:10.1044/2018_AJSLP-17-0100

96. **McLeod, S., Crowe, K., & Shahaeian, A. (2015).** *Intelligibility in Context Scale: Normative and validation data for English-speaking preschoolers. Language, Speech, and Hearing Services in Schools, 46*(3), 266-276. doi:10.1044/2015_LSHSS-14-0120

97. **McLeod, S., Harrison, L. J., & McCormack, J. (2012).** *Intelligibility in Context Scale: Validity and reliability of a subjective rating measure. Journal of Speech, Language, and Hearing Research, 55*, 648-656. doi:10.1044/1092-4388(2011/10-0130)

98. **McLeod, S., Harrison, L. J., & Wang, C. (2019).** A longitudinal population study of literacy and numeracy outcomes for children identified with speech, language, and communication needs in early childhood. *Early Childhood Research Quarterly, 47*, 507-517. doi:10.1016/j.ecresq.2018.07.004

99. **Morgan, A., Ttofari Eecen, K., Pezic, A., Brommeyer, K., Mei, C., Eadie, P., Dodd, B. (2017).** Who to refer for speech therapy at 4 years of age versus who to “watch and wait”? *The Journal of Pediatrics, 185*, 200-204.e201. doi:10.1016/j.jpeds.2017.02.059



100. **Reilly, S., McKean, C., Morgan, A., & Wake, M.** (2015). *Identifying and managing common childhood language and speech impairments*. *BJM*, 350. doi:10.1136/bmj.h2318



9. Glossary

Term	Description
AHPRA	Australian Health Practitioner Regulation Agency
ASD	Autism spectrum disorder
BMI	Body mass index
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
CAS	Childhood apraxia of speech
CDD	Complex Neurodevelopmental Disorder
CDM	Chronic disease management
Change	When referring to an item, “change” describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS
Department, The	The Australian Government Department of Health
GP	General practitioner
GPMP	GP Management Plan
GPPCCC	General Practice and Primary Care Clinical Committee
HCWA program	Helping Children with Autism program
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs



Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit on consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers
Minister, The	Minister for Health
Misuse (of MBS item)	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
MRRF	Medical Research Future Fund
MSAC	Medical Services Advisory Committee
NASRHP	National Alliance of Self Regulating Health Professionals
NDIS	National Disability Insurance Scheme
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
NHMRC	National Health and Medical Research Centre
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
Obsolete services / items	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures
PBS	Pharmaceutical Benefits Scheme
PDD	Pervasive development disorder



PHN	Primary health network
Reference Group, The	Allied Health Reference Group of the MBS Review
Services average annual growth	The average growth per year, over five years to 2014-15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
Systematic Review	A literature review using systematic methods to collect information, data and available research findings. Following critical appraisal of the information, results are synthesised to provide a level of evidence on the effectiveness of the healthcare intervention.
Taskforce, The	MBS Review Taskforce
Total benefits	Total benefits paid in 2014-15 unless otherwise specified.



Appendix A Full list of in-scope items

Items 10951–10970

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
10951	Diabetes education service to person with chronic condition under a care plan >20 mins	62.25	92,688	\$4,937,916	5.0%
10952	Audiology education service to person with chronic condition under a care plan >20 mins	62.25	1,868	\$105,655	12.4%
10953	Exercise physiology service to person with chronic condition under a care plan >20 mins	62.25	279,323	\$14,908,153	20.9%
10954	Dietetics service to person with chronic condition under a care plan >20 mins	62.25	414,899	\$22,172,147	10.5%
10956 ²	Mental health service to person with chronic condition under a care plan >20 mins	62.25	5,726	\$332,292	9.6%
10958	Occupational therapy service to person with chronic condition under a care plan >20 mins	62.25	69,219	\$4,158,674	16.1%
10960	Physiotherapy service to person with chronic condition under a care plan >20 mins	62.25	2,197,772	\$117,264,835	16.6%
10962	Podiatry service to person with chronic condition under a care plan >20 mins	62.25	3,009,782	\$159,800,577	12.8%
10964	Chiropractic service to person with chronic condition under a care plan >20 mins	62.25	354,501	\$18,775,603	14.3%
10966	Osteopathy service to person with chronic condition under a care plan >20 mins	62.25	165,201	\$8,876,660	13.9%
10968 ¹	Psychology service for person with chronic condition under a care plan, >20 mins	62.25	28,390	\$2,131,564	23.1%

² Also in the Mental Health Reference Group's area of responsibility.



Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
10970	Speech pathology service to person with chronic condition under a care plan >20 mins	62.25	156,592	\$9,025,165	7.3%

Items 81100–81125

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
81100	Assessment of suitability for group diabetes education service >45 mins	79.85	1,871	\$127,085.65	8.30%
81105	Diabetes education group service; 2-12 patients, >=60 mins	19.90	1,135	\$19,238.25	-13.29%
81110	Assessment of suitability for group exercise physiology service >45 mins	79.85	10,440	\$709,080.94	12.86%
81115	Exercise physiology group service; 2-12 patients, >=60 mins	19.90	55,089	\$935,701.55	15.14%
81120	Assessment of suitability for group dietetics service >45 mins	79.85	1,200	\$81,489.70	-11.16%
81125	Dietetics group service; 2-12 patients, >=60 mins	19.90	2,649	\$44,905.45	-12.11%

Items 82000–82035

Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
82000	Psychology service provided to a child (<13 years) by eligible psychologist, >=50 mins	99.75	10,258	\$1,300,698.90	10.16%
82005	Speech pathology service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	4,697	\$506,641.70	8.21%
82010	Occupational therapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	1,146	\$110,386.60	9.11%
82015	Psychology service provided to a child (<15 years), for treatment of PDD or an eligible disability by eligible psychologist, >=50 mins	99.75	4,645	\$540,563.42	1.70%



Item	Descriptor	Schedule fee	Services FY2016-17	Benefits FY2016-17	Services 5-year annual avg. growth
82020	Speech pathology service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	20,016	\$1,741,776.00	2.41%
82025	Occupational therapy service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	10,154	\$928,442.45	10.15%
82030	Audiology, optometry, orthoptic or physiotherapy service provided to a child (<13 years) for diagnosis or contribution to PDD/disability treatment plan, >=50 mins	87.95	533	\$40,521.53	70.49%
82035	Audiology, optometry, orthoptic or physiotherapy provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	1,245	\$118,236.05	30.81%



Appendix B Full list of recommendations

Recommendation 1 – Encourage comprehensive initial assessments by allied health professionals

The Reference Group recommends:

- a. creating a new item (109AA) for an initial allied health appointment of at least 40 minutes
- b. placing the following restrictions:
 - (iv) claiming to the first attendance for a unique presentation and a maximum of one per patient, per provider, per calendar year
 - (v) claiming by allied health professionals in the same practice providing care for the same unique presentation, and
 - (vi) co-claiming with M3 items (10950–10970) and M9 items for assessing the suitability of group sessions (81100, 82110 and 81120),
- c. the proposed item descriptor as follows:

**New Item 109AA – example text**

Initial allied health service provided to a person by an eligible allied health provider, if:

- a) the service is provided to a person who has:
 - i. a chronic condition; and
 - ii. complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and
- b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and
- c) the person is referred to the eligible allied health provider by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and
- d) the person is not an admitted patient of a hospital; and
- e) the service is provided to a patient for the first attendance for a unique presentation
- f) the service is provided to the person individually and in person; and
- g) the service is of at least 40 minutes duration; and
- h) an initial assessment service has not already been provided by an allied health provider of the same profession (e.g. physiotherapy) for the same unique presentation in the same practice (where it is practical to gather this information); and
- i) after the service, the eligible allied health provider gives a written report to the referring medical practitioner mentioned in paragraph (c).
- j) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;
 - to a maximum of one service per eligible allied health provider per patient per year
 - Not to be claimed with items 81100, 82110, 81120 or 10950–10970.

- d. the proposed explanatory notes as follows:

**New Item 109AA Explanatory note – example text**

A unique presentation includes:

- A primary (presenting) complaint for which the allied health professional has not seen the patient before.
- A primary (presenting) complaint for which the allied health professional has seen the patient before, but where a significant change in the quality or severity of the complaint necessitates reassessment.

Allied health professionals in the same practice are expected to share information about the initial appointment findings, where clinically relevant.

Recommendation 2 – Expand allied health involvement under team care arrangements

The Reference Group recommends:

- e. increasing the number of allied health appointments under GP Management Plans (GPMPs) and team care arrangements (TCAs) by stratifying patients to identify those with more complex care requirements (items 721 and 723)
- f. creating a follow-on piece of work that identifies and details a model to stratify patients with a GPMP who could benefit from additional allied health appointments While it is unlikely that one single assessment tool will be satisfactory, assessment to stratify patients should include:
 - a. Clinical judgement
 - b. Co-morbidities
 - c. Risk of deterioration in condition
 - d. Impairment

This work must include involvement of the allied health sector.

- g. consideration of the following:
 - (iv) Patients identified under this stratification model could receive an additional envelope of appointments with an eligible allied health professional (for example, five or more) after accessing the first envelope of five appointments.
 - (v) Multiple stratification dimensions could be used, including:
 - The number of chronic conditions a patient has (defined by chronic conditions eligible for a GPMP).
 - The severity of the chronic conditions.
 - The discretion of the referring practitioner, based on the number of chronic conditions and/or the severity of those conditions.



(vi) The follow-on piece of work should test and identify the most appropriate stratification approach,

and

h. implementation of the new model be phased, so that the effects of additional allied health appointments on health outcomes can be studied during a pilot period with consideration that this process could include:

(iv) A pilot with a limited sample size of the population receiving TCAs.

(v) A study of the health outcomes of patients in this pilot program over a multi-year period, compared with patients with TCAs who are not in the pilot patient sample (control group).

(vi) Targeted expansion of the increased number of allied health appointments to the rest of the chronic disease patient population in Australia, based on the findings from the pilot.

Recommendation 3 – Improve access to orthotic or prosthetic services

The Reference Group recommends:

- a. creating a new item (109BB) in the M3 group for the delivery of orthotic or prosthetic services, lasting at least 40 minutes
- b. allowing this item to be claimed when referred by a GP as part of a CDM plan (item 721), including TCAs (item 723)
- c. specifying in the explanatory notes that eligible allied health professionals include prosthetists and orthotists
- d. capping the number of times this item can be claimed to once per patient, per calendar year
- e. the proposed item descriptor as follows:

**New Item 109BB – example descriptor**

Orthotic or prosthetic allied health service provided to a person by an eligible allied health provider, if:

- a) the service is provided to a person who has:
 - i. a chronic condition; and
 - ii. complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a shared care plan or under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and
 - b) the service is recommended in the person's Team Care Arrangements, multidisciplinary care plan or shared care plan as part of the management of the person's chronic condition and complex care needs; and
 - c) the person is referred to the eligible allied health provider by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and
 - d) the person is not an admitted patient of a hospital; and
 - e) the service is provided to the person individually and in person; and
 - f) the service is of at least 40 minutes duration; and
 - g) after the service, the eligible allied health provider gives a written report to the referring medical practitioner mentioned in paragraph (c).
 - h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit;
- to a maximum of one service per year.

Recommendation 4 – Understand the effectiveness of group allied health interventions

The Reference Group recommends:

- a. conducting a systematic review to support evidence-based expansion of group allied health interventions.
- b. that this systematic review be conducted to specifically identify:
 - (i) The clinical scenarios (across all eligible allied health professions under the MBS) in which allied health group interventions provide high-value care to patients.



- (ii) The ideal ratio of participants and allied health professionals for group therapy (including whether there are different types of professionals—i.e. a multidisciplinary team) in each of these high-value clinical scenarios.

and

- c. the expansion of allied health group therapy be targeted based on the findings of this systematic review, by:
 - (i) Expanding patient eligibility for M9 MBS items, and
 - (ii) Accessing funding outside of the MBS.

Recommendation 5 – Incentivise group therapy for chronic disease management

The Reference Group recommends introducing a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.

Recommendation 6 – Improved access to paediatric allied health assessments

The Reference Group recommends:

- a. amending the item descriptor for M10 items to Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) and Disability and remove Pervasive Developmental Disorder (PDD).
- b. updating the M10 explanatory notes to reference DSM V and incorporation of PDD under ASD in DSM V
- c. the list of eligible disabilities for M10 items should be extended to include:
 - (i) Foetal Alcohol Syndrome Disorder (FASD);
 - (ii) Lesch-Nyhan Syndrome; and
 - (iii) 22 q deletion Syndrome (previously Velocardiofacial Syndrome, and
- d. consideration be given to updating the descriptor of M10 items, specifically MBS Item 82030 and 82035, to include additional allied health providers (e.g. Dietetics and Exercise Physiology) who provide evidence-based interventions for persons with Autism Spectrum Disorder (ASD), Complex Neurodevelopmental Disorder (CND) and Disability.

Recommendation 7 – Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis

The Reference Group recommends:



- a. increasing the number of assessment items (82000, 82005, 82010 and 82030) available for children with a potential ASD, CND or eligible disability diagnosis.
- b. the number of allied health assessment appointments available for a child with a potential ASD, CND or eligible disability diagnosis be increased from four per lifetime to eight per lifetime, and
- c. a review by the referring practitioner be required between the first four and additional four appointments.

Recommendation 8 – Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis

The Reference Group recommends allowing up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis (items 82000, 82005, 82010 and 82030).

Note: Case conferencing involves the referring practitioner and other members of the multidisciplinary team assessing a child. The parent may also be present.

Recommendation 9 – Improve access to M10 treatment items as group therapy

The Reference Group recommends allowing M10 treatment items to be delivered as group therapy under the HCWA program, including:

- (i) allowing the 20 M10 treatment items for the HCWA program to be delivered as either group therapy (with two to four participants) or individual therapy;
- (ii) requiring at least one allied health professional to be present for the full group session
- (iii) allowing all allied health professions to deliver these services when nominated on the care plan; and
- (iv) specifying a minimum duration of 60 minutes for group sessions.

Recommendation 10 – Improve access to M10 items for patients with severe speech and language disorders

The Reference Group recommends:

- d. including patients with severe speech/language disorders in the list of eligible disabilities under M10 items
- e. the list of eligible disabilities for M10 items be extended to include:
 - (iv) Stuttering.
 - (v) Speech Sound Disorder (SSD) (includes phonology and childhood apraxia of speech) that results in either:



- Persistent difficulty with perception, production, and/or representation of consonants, vowels, syllables, words, and/or prosody (tones, rhythm, stress, and intonation) that interferes with speech intelligibility and/or acceptability. (33) (34) (35) (36).
 - Limitations in effective communication that interfere with social participation, academic achievement or occupational performance, individually or in any combination. (33)
- (vi) Developmental language disorder, where the child or adolescent scores more than 1.5 standard deviations below the mean on a standardised language assessment.

Note: Further consultation will be needed to determine which language assessment to use. Options include the Pre-school Language Scale, Fifth Edition (37) and the Clinical Evaluation of Language Fundamentals (38), used in conjunction with functional impact reports.

and

- f. particularly for younger children, developing a list of concerns or “red flags” for GPs to use to help identify when children who may have these conditions should be referred for assessment (refer to Appendix E for a sample list).

Recommendation 11 – Improve access to the ASD and eligible disability assessment to people under 25

The Reference Group recommends increasing the age limits on the following items:

- a. 82000, 82005, 82010 and 82030 – from 13 to 25 years old
- b. 82015, 82020, 82025 and 82035 – from 15 to 25 years old, and
- c. Changing the relevant item descriptors to say “a child or young adult” instead of “child”.

Recommendation 12 – Improve allied health collaboration during assessments

The Reference Group recommends:

- a. allowing inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities and ASD (items 82000, 82005, 82010 and 82030), and
- b. referrals be permitted:
 - (i) Within the first group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope).



- (ii) Within the second group of four allied health assessment appointments under M10 items (i.e. the referral can come from an allied health professional for the second, third or final appointment of this envelope), if Recommendation 7 of this report is implemented.
- (iii) In consultation and agreement with, but without a physical attendance by, the original referring practitioner (i.e. via telephone call, secure messaging):
 - For M10 items for ASD, the original referring practitioner is the referring paediatrician or psychiatrist.
 - For M10 items for eligible disabilities, the original referring practitioner is the referring specialist, consultant physician or GP.

Recommendation 13 – Improve access to allied health services via telehealth

The Reference Group recommends:

- a. undertaking a follow-on piece of work detailing the highest-value opportunities for telehealth integration into allied health care, to gather national evidence, building on existing research on telehealth interventions conducted at the state and territory level and in federally funded trials and to identify:
 - (i) Telehealth interventions provided by allied health professionals with evidence for comparable or superior clinical outcomes (compared with face-to-face interventions).
 - (ii) Cost savings associated with using telehealth in allied health care.
 - (iii) The views of consumers and feedback on telehealth use in allied health care.
 - (iv) Exploring the use of telehealth interventions to complement existing models of care, especially for rural and remote areas.
- b. in the interim, creating a new MBS item for the provision of telehealth services for patients consulting with an allied health professional via teleconference, with the following restrictions:
 - (i) The patient must not be an admitted patient.
 - (ii) The patient must be located both within a telehealth-eligible area and at least 15 kilometres from the allied health professional.
 - (iii) The patient must reside in a rural or remote region (defined as Modified Monash Regions 4 to 7).
 - (iv) The allied health professional must be a primary health care provider for the patient, defined as having had at least two face-to-face consultations with the patient.

and



- c. that the new item should only be claimable for types of allied health professionals who can deliver comparable outcomes via teleconference as in face-to-face consultations to ensure that there is no compromise in service delivery or standard of care.

Recommendation 14 – Allow non-dispensing pharmacists to access allied health items

The Reference Group recommends adding an item to allow pharmacists to provide medication management services to patients with complex care requirements outside of usual retail pharmacy operations as part of TCAs under M3 MBS items (up to twice a year).

Recommendation 15 – Support the codifying of allied health research and evidence

The Reference Group recommends:

- d. building an allied health research base, and
- e. investing in allied health research—potentially funded by the Medical Research Future Fund (MRFF)—in the following ways:
 - (i) Collect and publish data on allied health usage patterns across all funding streams in one place. This data should provide transparency on which patients use which allied health interventions and should be publicly available. Information on both the therapy delivered and the outcome measures should be collected and included to build a robust data set for future research.
 - (ii) Identify priority areas for research, based on gaps in current research and burden of disease in the community. The Reference Group noted the following topics as high priorities.
 - Effective strategies for establishing behaviour change and self-management, as well as validated tools to measure this.
 - Effective multidisciplinary/integrated care approaches to CDM and primary prevention.
 - Interventions to address the burden of chronic disease in Australia and health inequities (for example, among Aboriginal and/or Torres Strait Islander peoples, rural and remote communities, people with low socio-economic status).
 - Long-term outcomes for patients with chronic disease receiving allied health interventions.
 - The frequency and intensity (“dose”) of allied health appointments that improve outcomes for patients.
 - The cost-effectiveness profiles of different allied health interventions.



- (iii) Collate available, high-quality evidence for allied health interventions into an easy-to-use guide for allied health and other health professionals.

Recommendation 16 - Pilot non-fee-for-service allied health payment models

The Reference Group recommends:

- a. undertaking a piece of work to understand how bundled and other non-fee-for-service remuneration models could help to better integrate allied health into the Australian primary health care system, to include the following:
 - (i) Undertaking a cost-effectiveness analysis on the benefit of better integrating allied health into Australian primary health care.
 - (ii) Reviewing patient groups, diseases and conditions that would benefit most from such integration.
 - (iii) Designing and detailing remuneration models that would help to improve integration of allied health into the health care system.
 - (iv) Monitoring patient outcomes from increased allied health intervention.
 - (v) Determining a pilot approach for implementation of these findings.
- and
- b. any pilot of a non-fee-for-service system for allied health care in Australia should preserve the autonomy of allied health professionals and should be voluntary for patients.

Recommendation 17 – Enhance communication between patients, allied health professionals and GPs

The Reference Group recommends:

- a. investing in a CDM pathway education campaign for allied health professionals and GPs (especially if the MBS Review results in significant changes). This should promote shared decision-making, which integrates a patient's values and care goals with the best available clinical evidence in order to make treatment decisions
- b. improving communication between allied health professionals and GPs by:
 - (i) Providing financial support for GPs and private allied health professionals to set up secure messaging systems. This would enable fast, confidential communication.
 - (ii) Promoting more formal referrals between GPs and allied health professionals. Referrals under CDM plans should take the form of a referral letter, similar to a referral to any other medical specialist (although these could still be sent virtually via a secure system).
 - (iii) Ensuring, where possible, that all referrals and communication are uploaded to My Health Record (for patients who have not opted out). This should include information on



the number of used and available allied health appointments under a patient's CDM plan. This will allow allied health professionals and GPs to accurately inform patients about their care and likely associated costs.

and

- c. streamlining referrals from one allied health professional to another, in consultation with a GP. The above methods for enhancing communication between practitioners could foster faster communication when referral to another allied health professional may be appropriate.

Recommendation 18 - Expand the role of allied health in the Australian public health care system

The Reference Group recommends:

- a. facilitating equitable access to clinically appropriate allied health services for individuals with identifiable risk factors for chronic disease in order to prevent the occurrence, or delay the onset, of chronic conditions (primary prevention)
- b. that this could be achieved in the following ways.
 - (i) Through the MBS:
 - Enable MBS-funded allied health services to be accessed through health assessment items.
 - Create a GP Primary Prevention Plan (GPPP) to provide access to evidence-based allied health interventions for people with identifiable risk factors who do not meet the criteria for a GPMP—for example, individuals with pre-diabetes, hypertension, hypercholesterolemia or high body mass index (BMI; overweight/obesity).
 - (ii) Outside the MBS:
 - Expand publicly funded, community-based allied health group interventions aimed at lifestyle modification, potentially through state and territory funding.

and

- c. eligible risk factors should include those with high prevalence and a large impact on health status such as those identified in the 2011 Australian Burden of Disease Study (57), including:
 - (i) Tobacco use (accounting for 9.0 per cent of the total burden).
 - (ii) High BMI, related to overweight and obesity (7.0 per cent of the total burden, based on enhanced analysis by the Australian Institute of Health and Welfare published in



2017, which used updated evidence of diseases associated with overweight and obesity and enhanced modelling techniques).

- (iii) Alcohol use (5.1 per cent of the total burden).
- (iv) Physical inactivity (5.0 per cent of the total burden).
- (v) High blood pressure (4.9 per cent of the total burden).



Appendix C Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

Recommendation 1: Encourage comprehensive initial assessments by allied health professionals

Item	What it does	Committee recommendation	What would be different	Why
New item: (109AA) initial assessment appointments of more than 40 minutes for allied health professionals	Allows allied health professionals to receive funding for more comprehensive and complex initial assessments of patients.	Introduce initial assessment appointments (of more than 40 minutes) for allied health professionals.	The new item would allow allied health professionals to receive a higher schedule fee where a unique initial assessment takes longer than 40 minutes to complete. All other attendance items will remain the same.	This recommendation focuses on providing high-quality care to patients, in line with professional standards. Allied health professionals already provide initial assessments; however, at present they are only funded for assessments over 20 minutes. Creating an additional tier will encourage allied health professionals to complete comprehensive assessments for more complex patients or patients with chronic needs, as other medical assessment items do across the schedule.



Recommendation 2: Expand allied health involvement under team care arrangements (TCA)

Item	What it does	Committee recommendation	What would be different	Why
721 and 723	GP management plans (GPMs) currently allow for a maximum of five MBS allied health appointments.	Increase the number of allied health appointments under team care arrangements (TCAs; item 721 and 723) by stratifying patients to identify those with more complex care requirements.	Access to allied health appointments would be increased for patients who have more complex needs (such several chronic conditions, complex conditions or severe chronic conditions – the specific criteria are yet to be defined) requiring more than five allied health appointments.	This recommendation focuses on ensuring that the MBS provides access to high-quality, high-value care for patients and the health care system. MBS data shows that a quarter of patients with TCAs reach their cap of 5 allied health care appointments, and may not be able to access more services. This recommendation would allow those with an identified clinical need for more appointments to have access.



Recommendation 3: Improve access to orthotic or prosthetic services

Item	What it does	Committee recommendation	What would be different	Why
New item: (109BB) for delivery of orthotic or prosthetic services, lasting at least 40 minutes when referred by a GP as part of a CDM plan	Allows MBS funded orthotic or prosthetic service to be provided to eligible patients (i.e. who have a chronic condition, complex care needs)	Introduce a new item for orthotic or prosthetic services under the MBS, lasting at least 40 minutes when referred by a GP as part of a chronic disease management plan, maximum one service per year	Currently, private health insurance rebates are available for prosthetic devices, but not for the clinical service provided by the orthotists and prosthetists. This new item would provide MBS funding for clinical services, and reduce the cost to seek private services, which is particularly helpful where the public hospital system may be in high demand with long delays.	This recommendation focuses on improving timely access to care to patients with complex care requirements who are at risk of hospitalisation. The Reference Group recognised that as a clinical service for delivery of orthotics or prostheses is not funded by the MBS, and so many patients may seek services from the public hospital instead. Public hospital services are often in high demand and triage by urgency, so many low-risk patients currently have to wait for several months, in which time their condition may worsen. The Reference Group also recognise that services especially provided by orthotists and prosthetists have been shown to improve outcomes for many chronic diseases as such as diabetes, arthritis and stroke.

**Recommendation 4: Understand the effectiveness of group allied health interventions**

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Conduct a systematic review to support evidence-based expansion of group allied health interventions.	The allied health professionals, government departments and the public would have access to research that establishes the effectiveness of group allied health services for a range of conditions, such as heart failure, cancer, childhood speech and language delay, and chronic pulmonary disease.	This recommendation focuses on ensuring that patients have access to high-quality clinical services. Currently, M9 items under the MBS are currently limited to patients with type 2 diabetes. The Reference Group recommends that multidisciplinary group-based allied health interventions may be highly beneficial for a wide range of conditions that currently do not have MBS funding. A systematic review will allow for the most effective expansion of MBS-funded group therapy.



Recommendation 5: Incentivise group therapy for chronic disease management

Item	What it does	Committee recommendation	What would be different	Why
81105, 81115 and 81125	These items fund group services for 2 to 12 patients for chronic disease management (such as diabetes education, exercise physiology and dietetics).	Introduce a practice incentive payment for allied health professionals who provide group therapy.	Allied health professionals would receive an additional practice incentive payment for conducting group therapy sessions.	<p>This recommendation focuses on ensuring adequate access to high-quality allied health services. MBS data shows that group therapy items are experiencing a decline in use, which is attributed to the barriers that allied health professionals face in organising and running group sessions. These barriers include significant overhead costs, time investments to run group sessions, and issues around patients not attending or cancelling sessions.</p> <p>Introducing a practice incentive payment will increase the likelihood that they offer group sessions.</p>



Recommendation 4: Improve access to complex paediatric allied health assessments

Item	What it does	Committee recommendation	What would be different	Why
82000, to 82035	These items fund allied health services to children with autism or any other pervasive developmental disorder (PDD) through the Helping Children with Autism program, and to children with an eligible disability through the Better Start for Children with Disability program. Children with both ASD and PDD and an eligible disability can access either program, but not both.	Amend the item descriptor to ' <i>Autism, Complex Neurodevelopmental Disorder and Disability</i> '. Extend the list of eligible disabilities to include Foetal Alcohol Syndrome Disorder (FASD), Lesch-Nyham Syndrome and 22 q Deletion Syndrome (previously Velocardiofacial Syndrome).	The item descriptor and examples of eligibility.	This recommendation provides an update to the clinical terminology and condition examples aligning M10 items with other MBS Specialist paediatric complex plan items.


Recommendation 7: Improve access to complex paediatric allied health assessments for children with a potential ASD, CND or eligible disability diagnosis

Item	What it does	Committee recommendation	What would be different	Why
82000, 82005, 82010, 82030	These items fund referred psychologist (82000), speech pathology (82005), occupational therapy (82010) and audiology, optometry, orthoptic or physiotherapy (82030) consultations for children under 13 years, for diagnosis or management of Complex Neurodevelopmental Disorder (CND) or a disability treatment plan with a maximum of 4 services in total, for any combination of the above items.	Increase the number of MBS appointments available for children with a potential autism spectrum disorder (ASD) or eligible disability diagnosis, where a review by the referring practitioner should be required between the first four and additional four appointments.	Allied health professionals would be able to access more than 4 total assessments across psychology, speech pathology, occupational therapy, audiology, optometry, orthoptic and physiotherapy consultations. The number of allied health assessment appointments available for a child with a potential ASD, CND or eligible disability diagnosis would increase from four per lifetime to eight per lifetime.	This recommendation focuses on ensuring that the MBS provides adequate services to diagnose ASD and eligible disabilities. The Reference Group agreed that allied health professionals typically require between two and four attendances to adequately assess a child with ASD. Four assessment appointments do not always allow for adequate allied health input to reach a diagnosis. Assessment services are not provided under the National Disability Insurance Scheme (NDIS); therefore, the MBS provides an important service to eligible children.


Recommendation 8: Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis

Item	What it does	Committee recommendation	What would be different	Why
82000, 82005, 82010, 82030	These items fund referred psychologist (82000), speech pathology (82005), occupational therapy (82010) and audiology, optometry, orthoptic or physiotherapy (82030) consultations for children under 13 years, for diagnosis or management of CND or a disability treatment plan with a maximum of 4+4 services over a lifetime, for any combination of the above items.	Allow up to two assessment items to be used for case conferencing for children with a potential ASD or eligible disability diagnosis.	Allied health professionals would be able to have up to 2 dedicated attendances for case conferencing, in addition to assessment attendances across psychology, speech pathology, occupational therapy, audiology, optometry, orthoptic and physiotherapy consultations.	This recommendation focuses on ensuring that the MBS provides adequate services to accurately diagnose ASD and eligible disabilities. Communication between the referring clinician and allied health professionals is important in making a diagnosis, and case conferencing is an effective method that should be incentivised and acknowledged as part of the MBS.

**Recommendation 9: Improve access to M10 treatment items as group therapy**

Item	What it does	Committee recommendation	What would be different	Why
All M10 items	These items refer to allied health autism and disability services	Allow M10 treatment items to be delivered as group therapy under the Helping Children with Autism (HCWA) and disability program	M10 treatment items could be delivered as group therapy with two to four participants with at least one allied health professional, for a minimum of 60 minutes.	This recommendation focuses on ensuring that the MBS provides access to flexible, high-value care to children with ASD or disability. Available evidence shows that group-based interventions are also effective therapy for patients with ASD, and allow patients to develop their social skills and provide support networks for families of patients.


Recommendation 10: Improve access to M10 items for patients with severe speech and language disorders

Item	What it does	Committee recommendation	What would be different	Why
All M10 items	These items refer to allied health autism and disability services	Include children with severe speech/language disorders, in the list of eligible disabilities under M10 items. The Reference Group proposes developing a list of concerns or “red flags” for GPs to help identify when children may have these conditions.	Children with severe language and speech disorders, such as stuttering, developmental language disorder and speech sound disorder (SSD) (including phonology and childhood apraxia of speech) would have access to M10 items.	This recommendation focuses on ensuring that the MBS provides fair access to allied health services for children with disabilities. Currently, children with severe language and speech disorders do not have access to adequate allied health services through CDM plans and TCAs because they are not often considered to be “chronic conditions”. Evidence shows that allied health interventions improve outcomes with severe language and speech disorders.


Recommendation 11: Improve access to the ASD and eligible disability assessment to people under 25

Item	What it does	Committee recommendation	What would be different	Why
82000, 82005, 82010, 82030, 82015, 82020 82025, 82035	These items refer to ASD and eligible disability allied health assessments and treatments	Increase the ASD and eligible disability assessment and treatment age to 25.	Patients between 13 to 25 who require assessment for ASD and eligible disabilities would have access to allied health assessment and services, where otherwise they would have to pay out-of-pocket, and potentially not access services and remain undiagnosed and without treatment.	This recommendation focuses on ensuring that the MBS provides access to high-quality health services for young adults with ASD and/or eligible disabilities particularly as diagnosis also occurs for young people aged 13 to 25. The Reference Group recognises there is a need to support young adults with ASD and disabilities as they go through important life transitions, such as high school to tertiary education and employment.



Recommendation 12: Improve allied health collaboration during assessments

Item	What it does	Committee recommendation	What would be different	Why
82000, 82005, 82010, 82030	These items refer to ASD and eligible disability allied health assessments and treatments	Allow inter-disciplinary referral between allied health professionals during the assessment phase for ASD and eligible disabilities.	Allied health professionals would be allowed to on-refer to other allied health professionals as part of the attendances for the assessment of the patient only (currently a maximum of 4 in total), rather than requiring the medical practitioner to conduct the referral.	This recommendation focuses on ensuring that patients with potential ASD and eligible disabilities have access to timely diagnosis. The Reference Group agreed that there are instances where inter-disciplinary referral between allied health professionals facilitates a timely diagnosis. This already occurs, but without the medical practitioner referral, the patient must pay the full cost of the service out-of-pocket or through private health insurance, which may affect equitable access to a timely referral where patients are uninsured or cannot afford the out-of-pocket cost.



Recommendation 13: Improve access to allied health services via telehealth

Item	What it does	Committee recommendation	What would be different	Why
New item: telehealth attendance with an allied health professional	The new item would allow patients who reside in a rural or remote region in a telehealth eligible area to access telehealth consultations with an allied health professional who is already managing them face-to-face and can provide the same outcomes in a tele-health consultation as a face-to-face consultation.	<p>A new item should be created for patients consulting with an allied health professional via teleconference.</p> <p>Further research into the highest value opportunities to expand the role of telehealth in allied health care.</p>	Patients in eligible rural and remote regions would be able to obtain timely and appropriate advice from their treating allied health professional remotely, instead of having to travel potentially long distances to attend a face-to-face appointment.	<p>This recommendation focuses on improving access to telehealth services. The Reference Group agrees that access to a telehealth item would increase allied health services in remote, regional and rural areas, and reduce the need for patients to travel (and take time off work) to receive care.</p> <p>For allied health professionals already providing telehealth services, an MBS item would reduce out-of-pocket fees for patients.</p>

**Recommendation 14: Allow non-dispensing pharmacists to access allied health items**

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Add non-dispensing pharmacists to the list of eligible allied health professionals under the MBS.	Pharmacists would be able to provide specialised MBS-funded medication education and management to patients with complex care requirements.	This recommendation focuses on improving access to medication education and management. Currently, pharmacists are not allowed to claim individual allied health services. An estimated 230,000 medication-related hospital admissions occur every year. It is widely acknowledged that the involvement of pharmacists as part of multidisciplinary care teams significantly reduces the risk of medication-related admissions from medication errors and interactions, inappropriate dosages and treatments.

**Recommendation 15: Support the codifying of allied health research and evidence**

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Build an allied health research base, with investment in allied health research—potentially funded by the Medical Research Future Fund.	Health systems, government and non-government organisations, patient advocacy groups would have a trusted source of evidence-based recommendations for allied health treatments.	This recommendation focuses on ensuring impactful investment into allied health research. The Reference Group has identified issues with current research: there is limited information on how allied health services are used in Australia, and a lack of evidence to support many allied health treatments. Investing in evidence-based allied health interventions would assist in deciding on which high-quality care should be funded.

**Recommendation 16: Pilot non- fee-for-service allied health payment models**

Item	What it does	Committee recommendation	What would be different	Why
Nil	N/A	The Reference Group recommends that different ways to integrate allied health providers into primary health, other than paying for each individual service that is provided, be investigated and trialled.	A successful pilot that explores different ways for allied health services to be delivered could result in new packages of services that would reduce costs for the patient and the health system, whilst improving access to allied health services and incentivising allied health professionals to aim for the best outcome for patients.	This recommendation focuses on promoting high value care. The Reference Group agrees that the MBS fee-for-service system does not always provide the right incentives for high-value care, and may not always be the most timely or cost-effective way. A research project and pilot could identify the most efficient and effective models to maximise the potential benefits of allied health care.


Recommendation 17: Enhance communication between patients, allied health professionals and GPs

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Invest in a CDM pathway education campaign for allied health professionals and GPs, and provide financial support for GPs and allied health professionals to set up shared formal referral, communication and health records processes.	<p>A CDM pathway education campaign would ensure that consumers and health professionals are aware of available services.</p> <p>Investing in formal communications and referral systems would ensure that allied health professionals would be able to communicate important health information appropriately and accurately, and store patient information in a way that assists everyone involved in the patient's care.</p>	<p>This recommendation focuses on simplifying and streamlining communication between allied health professionals, GPs and consumers. Consumers and GPs are often unaware of the nature of MBS funded allied health services, including gap payments. Currently allied health professionals are unable to directly contribute to a patient's medical records, and have limited options when communicating with the patient's treating doctors, often only by telephone.</p>


Recommendation 18: Expand the role of allied health in the Australian public health care system

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	<p>Enable MBS-funded allied health services to be accessed through health assessment items.</p> <p>Create a GP Primary Prevention Plan (GPPP) to provide access to allied-health services to patients with risk factors early.</p> <p>Expand publicly funded, community-based allied health group interventions aimed at lifestyle modification.</p>	<p>A GPPP and access to allied health services through other health assessments would help ensure that patients with chronic illnesses and risk factors are linked into the right allied health services as early as possible.</p> <p>Investing in publicly funded, community-based allied health group interventions aimed at living a healthier lifestyle would help reduce preventable risk factors such as tobacco use, obesity, excessive alcohol use, physical inactivity and high blood pressure.</p>	<p>This recommendation focuses on enhancing the complimentary role of allied health across the health system. Allied health services are not currently used effectively as they could be in preventing disease, and worsening of chronic illnesses. There is evidence to support early use of allied health services to prevent disease and disability, especially for common conditions such as pre-diabetes, obesity and high blood pressure.</p>



Appendix D Selected evidence for the effectiveness of allied health care

During the Reference Group's discussions, several pieces of evidence were found to support the effectiveness and cost-effectiveness of allied health care interventions in a range of clinical conditions. A summary of this evidence for individual interventions is provided below, organised by patient cohort.

- Diabetes

Mosalman et al. showed that medical nutrition therapy (three to 12 encounters within the first three to six months, and one to six encounters within the following six to 15 months) was effective in improving a range of clinical indicators in diabetes, including decreases in the HbA1C percentage. (67)

Gibson et al. showed that patients with type 2 diabetes who had podiatry treatments before the onset of a foot ulcer were less likely to be hospitalised or to have an amputation in the following 24 months. Patients who had three or more podiatry visits had a lower risk of lower limb amputation, compared to those who had fewer visits. (68)

- Chronic obstructive pulmonary disease

McCarthy et al. showed that eight to 12 weeks of pulmonary rehabilitation for chronic obstructive airways disease is effective in relieving dyspnoea and fatigue, improving emotional function, reducing hospital admissions and reducing pharmacological requirement. (69)

- Degenerative musculoskeletal conditions

Crossley et al. showed that eight treatments of physiotherapy for osteoarthritis (approximately 60 minutes in duration) consisting of exercise, education, manual therapy and taping are significantly more effective than osteoarthritis education alone. (70)

Marsh et al. showed that a 12-week physiotherapy program is significantly less expensive and results in less time off work than arthroscopic debridement for a degenerative knee. (71)

- Low **back** pain

Froholdt et al. showed that a four-week cognitive intervention and exercise program (10 face-to-face treatments) significantly improved muscle strength, compared with patients who underwent lumbar fusion and standard post-operative physiotherapy. (72)

Clinical guidelines recommended by the American College of Physicians state that patients with chronic low back pain should be directed towards non-pharmacological management of multidisciplinary rehabilitation for their low back pain. (73)

- Parkinson's disease



Mak et al. showed that four weeks of intensive gait training or eight weeks of balance training in patients with Parkinson's disease have a positive impact on a variety of functional indicators that persist for three to 12 months after the completion of treatment. (74)

- Rheumatoid arthritis

Williams et al. showed that six weeks of daily home exercises and strategies to maximise adherence in rheumatoid arthritis patients with pain and dysfunction of the hands and/or wrists are effective in improving hand function over usual care. Usual care was defined as joint protection education and general exercise advice. (75)



Appendix E Example list of concerns for speech, language and hearing disorders

Table 5 provides a sample list of signs for language disorders, using developmental progression information. While the table is based on language disorders and is sourced from the American Speech-Language-Hearing Association (76), similar tables for hearing loss, voice disorders, stuttering and speech sound disorders exist. Speech Pathology Australia provides similar tables.

Table 5: Red flags to prompt GP or specialist referral for assessment items for diagnosis of language disorders

Age	Sign
Birth–3 months	Not smiling or playing with others
4–7 months	Not babbling
7–12 months	Making only a few sounds; not using gestures, like waving or pointing
7 months–2 years	Not understanding what others say
12–18 months	Saying only a few words
1½–2 years	Not putting two words together
2 years	Saying fewer than 50 words
2–3 years	Having trouble playing and talking with other children
2½–3 years	Having problems with early reading and writing (for example, your child may not like to draw or look at books)

Source: Reference Group member input